INTERIM REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Virginia's Medical Malpractice Laws

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Interim Report of the Joint Subcommittee
Studying Virginia's Medical Malpractice Laws
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1985

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

INTRODUCTION

House Joint Resolution No. 20 (Appendix A) was passed by the 1984 Session of the General Assembly. The Resolution called for creation of a joint subcommittee to study Virginia's medical malpractice laws. The joint subcommittee was requested to evaluate the effect and need for continuation of various changes made in 1976 in response to the "medical malpractice crisis." House Joint Resolution No. 20 specifically requested the joint subcommittee to evaluate the need for (i) continuation of the malpractice review panels, (ii) continuation of the limitation on the amount of recovery ("the cap") in malpractice actions, and (iii) reinstitution of a malpractice closed-claim reporting procedure. The joint subcommittee's study was not limited to these issues, however. Issues to be studied in addition to those specifically mentioned in House Joint Resolution No. 20 were agreed to at the initial meeting. These issues included evaluation of the current malpractice insurance rate-making structure, the procedures applicable in panel proceedings and the sometimes unique procedural and substantive provisions of the law applicable to medical malpractice trials.

The membership of the joint subcommittee was appointed in accordance with House Joint Resolution No. 20. The Speaker of the House of Delegates appointed Delegates Clifton A. Woodrum and John G. Dicks, III, from the House Committee for Courts of Justice; John Ward Bane, Esquire, of Hampton, as a citizen member representing the Virginia State Bar; and George M. Nipe, M.D., of Harrisonburg, as a citizen member representing the Virginia Medical Society. The Senate Committee on Privileges and Elections appointed Senator Wiley F. Mitchell, Jr., from the Senate Committee for Courts of Justice; R. Carter Scott, III, Esquire, of Richmond, as a citizen representative of the Virginia Bar Association; and John N. Simpson of Richmond Memorial Hospital as a citizen representative of the Virginia Hospital Association.

Delegate Woodrum was elected chairman of the joint subcommittee and Senator Mitchell was elected vice-chairman. The joint subcommittee held seven meetings in Richmond between June 5, 1984, and January 8, 1985. Each meeting was well attended by interested members of the public.

EXECUTIVE SUMMARY

Following a comprehensive study and evaluation of Virginia's medical malpractice laws, the joint subcommittee makes the following recommendations:

1. That a mandatory, annual, closed-claim reporting requirement be reinstituted to ensure that objective statistical data on medical malpractice claims are readily available for rate-making and general informational purposes;

2. That State Corporation Commission approval of malpractice insurance rates be continued in lieu of adopting a competitive market approach to rate-making;

3. That the malpractice review panels be retained, but that the credibility of the panels be improved by assuring the impartiality of the panel members and clarifying the role of panel members in evaluating the claim; and

4. That the limitation on medical malpractice recovery be retained at the present time;

5. That retention of the collateral source rule, in view of retaining the cap, is in the best public interest; and

6. That the joint subcommittee be allowed to continue its study, in conjunction with an ongoing study of similar issues by the Medical Society of Virginia, and complete its evaluation of the need for modifications in current law with respect to the (i) use of the contingent fee in malpractice actions, (ii) abrogration of the collateral source rule, (iii) need for retention of or increase in "the cap," (iv) weight to be given a panel decision in subsequent litigation, (v) need for clarification of the evidentiary standard in proceedings before the panel, (vi) desirability of modifying the statute of limitations to provide for a date of discovery accrual time and/or a shortened tolling period for minors, (vii) need to clarify the law pertaining to the qualification of expert witnesses, and (viii) need to clarify a standard of care.

BACKGROUND

Beginning in 1975 a number of states attempted to formulate reasonable legislative responses to the so-called "medical malpractice crisis." The crisis was caused in large part by the withdrawal of a number of private carriers from the medical malpractice insurance business and the corresponding increase in premiums charged by the remaining carriers. In 1975, the Virginia General Assembly authorized the creation of a commission to study the alternatives for assuring the continued availability of malpractice insurance and the means by which the direct and indirect costs of malpractice claims could be contained. (See Senate Document No. 29, 1976.)

The major revisions made in 1976 in response to the "medical malpractice crisis" may be summarized as follows: 1) Creation of a Joint Underwriting Association designed to ensure the availability of malpractice insurance (The Joint Underwriting Association was abolished in 1980; however, the State Corporation Commission was authorized to reactivate the Association at any time if it found that malpractice insurance was not being made reasonably available); 2) Adoption of a voluntary procedure for pre-trial evaluation of medical malpractice claims designed to reduce the costs and accelerate the process of litigation by providing a screening process for separating frivolous from meritorious claims and providing the plaintiff with an expert witness; and 3) Adoption of a reporting procedure to provide a central repository in the Bureau of Insurance for information regarding closed malpractice claims to be used in insurance rate-making.

The Commission made a number of other recommendations which were not adopted or in some instances not considered by the General Assembly. The Commission suggested that malpractice losses (premium costs) should be distributed over a broader base. This approach to cost containment had been recommended by the State Corporation Commission in its 1975 report "Medical Malpractice Insurance in Virginia: The Scope and Severity of the Problem and Alternative Solutions." The Commission believed that for purposes of loss distribution the emphasis should be placed on hospitals rather than individual practitioners. It was argued that a hospital-based distribution plan would provide a more objective and effective risk management approach. House Bill No. 884 (1976) incorporated this recommendation. The bill was carried over but failed in 1977.

Changes in the tort system relative to the ad damnum clause, the collateral source rule and the use of medical malpractice screening panels were also suggested. The Commission recommended that the ad damnum clause be abolished in actions for personal injury and wrongful death. It was argued that because its use bears no relation to the amount of damages actually incurred by the plaintiff and is not used by the trier of fact in setting the amount of recovery, the use of an ad damnum clause in pleadings only confuses the public. This recommendation was rejected by the General Assembly in 1976 (Senate Bill No. 119) and again in 1977 (House Bill No. 404). Twenty-one states have modified their laws to proscribe the use of ad damnum clauses in medical malpractice cases.[1]

The Commission also recommended that Virginia law be modified to allow for the introduction of evidence relating to collateral sources of compensation in any action for personal injuries or wrongful death. The Commission recommendation did not require the judgment awarded to a plaintiff to be reduced by amounts received from a collateral source. This recommendation has not been before the General Assembly in the form of a bill. Eight states

currently allow such evidence to be introduced and permit the trier of fact to determine the appropriate weight to be given the evidence in determining the damages to be awarded.[2] Ten states provide that the trier of fact is to determine the amount of damages to be awarded without knowledge of any collateral source payments received. All or part of the amount of these payments may then be deducted from the award to arrive at the amount of the judgment.[3]

Additional changes in Virginia's medical malpractice laws have been considered over the years. The standard of care in actions based upon alleged malpractice was codified in 1977. In 1979, the statute was clarified to provide that the statutory standard applies in proceedings before a panel and that the trier of fact is to determine whether the statewide or local standard applies. House Bills No. 668 and 669 (Appendix B1 and Appendix B2) were carried over during the 1984 Session. The bills would allow evidence of nationwide standards of practice for specialists to be admitted in certain circumstances.

Much concern over the limitation on recovery has been evident. Since 1976 seven bills have been introduced. These bills would either repeal or increase the ceiling. In 1981 a joint subcommittee was created to study the effect of the limitation. The subcommittee did not submit a report. However, the chairman of that subcommittee introduced two bills (House Bills No. 951 and 952) in 1982. One bill would have repealed the ceiling, while the other would have increased it. Both bills failed. The ceiling was increased in 1983 from $100,000 to $500,000 for hospitals and from $750,000 to $1 million for other health care providers (House Bill No. 473). Two bills affecting the ceiling were carried over in 1984. House Bill No. 664 would repeal the ceiling. House Bill No. 1011 would increase the ceiling beyond $1 million to the limits of the health care provider's liability coverage. (Appendix B3 and Appendix B4).

Additionally, since 1981 a number of bills relating to the statute of limitations in malpractice actions have been introduced. The bills were designed to provide an escape from the perceived harshness of the statute of limitations. Each bill would have allowed for an optional "date of discovery" accrual date. That is, the statute of limitations would not begin to run until the time when the injury was discovered or reasonably should have been discovered. None of these bills passed.

Numerous modifications in the screening panel process have been considered. Senate Bill No. 115 (1976) provided for voluntary, pre-trial review of malpractice claims by a legal-medical screening panel and prescribed certain procedures governing the screening process. Since 1976 thirty states have adopted some form of medical review panel.[4] In eight of those states, review by the panel is voluntary, as it is in Virginia. In 1981, Nevada, North Dakota and Rhode Island repealed their laws providing for mandatory pre-trial screening. Tennessee's law expired in June of 1983. Of the twenty-six states which currently provide for pre-trial screening, ten do not allow the panel decision to be admitted in a subsequent judicial proceeding. Connecticut and New Jersey admit only a unanimous panel decision.

In 1979, provisions were made for a hearing before the panel upon request of either party. The chairman was granted discretion to allow for the taking of depositions. Discovery was allowed in accordance with the Rules of the Supreme Court. In 1984 the law was further amended to eliminate the opportunity for use of panel review as an alternative to discovery. Before the panel members are appointed, the parties are required to certify that all discovery has been completed. As a result of this modification the panel members need not sift through voluminous medical records in preparation for the panel review unless the parties actually intend to proceed with the review.

In 1982, § 38.1-389.3 was repealed. That section, enacted in 1976 as part of Senate Bill No. 115, required reports on all closed malpractice claims to be filed with the Commissioner of Insurance. House Bill No. 896 (1984) (Appendix B5) would have reinstated the reporting requirement. In addition, the bill would require the Commissioner to prepare annual reports based upon the statistical data reported and identify all sums paid during the previous year. The information compiled would be available to any interested person. The bill failed in the Senate Committee for Courts of Justice.

In part because of the interest which the bills affecting the medical malpractice laws have generated over the years, this joint subcommittee was created. The joint subcommittee conducted an in-depth review of the changes made in 1977, an evaluation of the effect of these changes on

the public, insurance industry and the legal and medical professions, including the hospital industry, and an evaluation of the need for additional changes. In order to facilitate its study, the joint subcommittee divided the issues under study into three broad classifications, although there was necessarily some overlap. These classifications were insurance issues, review panel issues and trial issues.

CONSIDERATIONS AND FINDINGS

INSURANCE ISSUES

The joint subcommittee was primarily concerned with (i) assessing the fairness of the rate-making process vis-a-vis the insurance industry, the medical professions and the consumers of health care services and (ii) determining whether reinstitution of a closed-claim reporting mechanism was necessary or desirable. Substantial testimony and documentary evidence were received. (See Appendix C.) The joint subcommittee members looked at historical trends and the current climate in the malpractice insurance industry both nationally and in Virginia. They reviewed the process by which rates are calculated and also how that process is regulated. Among those actively participating in this portion of the study were the Bureau of Insurance, the Medical Society of Virginia, the Virginia Trial Lawyers Association, Delegate Bernard S. Cohen of Alexandria, St. Paul's Fire and Marine Insurance Company, the Virginia Insurance Reciprocal, the American Insurance Association, and various actuarial consultants representing these groups.

It was noted that the "insurance crisis" of the mid-1970's was an availability crisis. During that period the number of malpractice carriers dwindled rapidly, raising the fear that insurance would be unavailable or so expensive as to be unaffordable. There are currently only three primary providers of malpractice coverage in Virginia. However, the joint subcommittee found that availability was not a problem for most health care providers. (Particular availability problems for OB-GYNs were noted, however, and will be discussed later.) The focus of concern today is the affordability of malpractice coverage.

Some of those addressing the subcommittee suggested that premiums being charged are too high based on the actual losses incurred. The Bureau of Insurance report for 1981-82 shows that no money was paid out by insurance companies on 75% of the 2,726 malpractice claims disposed of during that period. For all claims closed between December 1976 and November 1981, 95% were disposed of by payment, if any, of less than $25,000. This indicates that the bulk of the premium dollar is being used for the less costly claims. It was argued that the actual experience of the insurance companies in Virginia has thus demonstrated that their incurred losses are minimal.

Critics of the current rate-making process also suggested that the insurance companies had been over-reserving for losses. The joint subcommittee heard testimony from Tim Graham, an analyst with the Medical Services Division of St. Paul's, that by 1983 approximately $800.000 had been paid on primary claims made in 1976. The reserve for these claims was $1.7 million. Noting that the average time for closing a claim is nine years, this would indicate no significant deviation in the reserves-to-claims-paid ratio. The experience of the Virginia Insurance Reciprocal was similar. For the years 1977 (all claims closed) and 1978 (70% of claims closed) a 5% differential between claims disposition and reserves held was experienced by the Virginia Insurance Reciprocal.

The joint subcommittee found that malpractice premiums had remained relatively stable in Virginia, especially when compared with states such as Florida and New York. The Virginia Insurance Reciprocal had increased premiums by only about 10% since 1977. Representatives of the insurance industry attributed much of the credit for this apparant stability to the cap on recovery and the conservative approach to the statute of limitations in Virginia. However, no data substantiating these assertions was available. The joint subcommittee attempted to compare premium charges in Virginia with those in other states. However, it found that these comparisons are not reliable. Even those states which have a cap, have caps substantially different from Virginia's. In addition, there are too many other variations in the laws applicable to malpractice claims in the various states which could account for the differences.

Upon reviewing the often conflicting data presented, the joint subcommittee concluded that

the current rate-making process seems to result in fair premium charges. The evidence suggests that current premium charges have only a minor impact on total health care costs. Information provided by the Virginia Hospital Rate Review Program showed that nationally the median malpractice insurance premium expense per inpatient day is $1.87. This generally works out be less than 1% of the median total per-day inpatient expense for hospitals. Similar evidence regarding the relationship between premium charges and premium expenses of other health care providers, such as physicians, was not available.

While rate increases have been sought and granted frequently over the years, the joint subcommittee found that there were sufficient checks and balances to ensure basic fairness. There is now a competitive atmosphere among the three major providers. The insurers other than St. Paul's have developed their own experience base. Monitoring of rate increases by the State Corporation Commission (S.C.C.) provides protection against excessive increases. While the joint subcommittee found sufficient competition to ensure a healthy industry, it does not recommend that rate-making be left solely to competitive market factors. Continued S.C.C. involvement in the rate-making process appears to be in the public interest at this time. Additionally, the joint subcommittee was encouraged that the Medical Society of Virginia uses an independent actuary to conduct evaluations of St. Paul's rate filings. Independent monitoring such as this should discourage overreaching in rate increases.

However, concern was expressed regarding the availability of information necessary to properly evaluate the rate filings. From 1977 to 1982, the Bureau of Insurance collected data pertaining to closed medical malpractice claims in Virginia pursuant to § 38.1-389.3. In 1981, the Bureau requested that the mandatory reporting requirements applicable to insurers and attorneys be repealed. The Bureau experienced a number of problems with the law. The reporting mechanism was alleged to be expensive and inefficient. The primary reasons for seeking repeal of § 38.1-389.3 were that (i) the data base of 700 claims disposed of by payment was too small to provide any meaningful information for rate-making, (ii) the data base was incomplete as there was no satisfactory mechanism for ensuring compliance with the reporting requirement, specifically compliance by the attorneys, (iii) the data on closed-claims was of no use in rate-making without other information on current claims to keep the data timely and on premium and investment income which is necessary to make a rate of return analysis, and (iv) the information contained in the reports and the information which was otherwise needed for rate-making was available from other sources, primarily from the insurers. Section 38.1-389.3 was repealed in 1982.

The discussions regarding reinstitution of a closed-claim reporting requirement focused on House Bill No. 896 (1984) (Appendix B5). The Bureau of Insurance opposed the bill during the 1984 Session, arguing that the burden placed on the Bureau was not justified by any favorable impact on its regulation of the malpractice insurance industry. Proponents of the bill argued that a central repository for closed-claim data was necessary, even if the information was not used primarily in rate-making. It was suggested that a reporting requirement would facilitate investigation and prosecution of disciplinary actions involving health care providers and provide an accessible source of information which would be valuable to a number of groups, including professional disciplinary boards and legislators. It was pointed out that the need for information by these latter groups is even more significant if, as some people predict, we are on the brink of another malpractice crisis.

At the request of Mr. Woodrum, representatives of the Bureau of Insurance, the Hospital Association, the Medical Society, the Trial Lawyers Association, and the insurance industry reviewed House Bill No. 896 and reached a compromise on reporting requirement legislation. The group proposed that House Bill No. 896 be amended to require each insurer or, if there is no insurer, each health care provider involved in a malpractice claim finally disposed of to file a report on the claim with the Bureau of Insurance. The draftsmen suggested that the problems of noncompliance would not be as great as under the prior law because the majority of the reports would be filed by insurers. In order to relieve some of the burden on the insurers, the proposal provides that the reports may be filed annually and may cover all claims disposed of during the year. In addition to requiring information on each claim, which is similar to that which was required under the repealed reporting provision, the proposal requires that the report include a statistical summary if more than one claim is covered in the report.

The initial proposal also included a provision requiring the Commissioner of Insurance to

forward the report to the licensing board having jurisdiction over the health care provider involved in the claim. Considerable discussion was held on this point. It was suggested that even indirect participation in the professional disciplinary process by the Bureau of Insurance was inappropriate. Additionally, because the reports would cover claims which had been settled as well as those in which malpractice had been adjudicated, it was feared that cross-reporting would impede settlement. Many health care providers and members of the public would perceive a settlement as an admission of wrongdoing if the fact of settlement were reported to the licensing board.

The Virginia Medical Society advised the joint subcommittee that it will be looking into the issue of professional discipline over the coming year. The joint subcommittee found that the concerns raised regarding cross-reporting were legitimate. The joint subcommittee concluded that the disciplinary issues could be resolved better within the profession since those issues were beyond the scope of its authority. Therefore, the joint subcommittee adopted this recommendation and deleted the cross-reporting requirement from the proposal.

The joint subcommittee also modified the proposal to include a direct statement that identification in the report of the parties to the claim was prohibited. (See Appendix E1.) By preserving the confidentiality of the parties the joint subcommittee seeks to encourage compliance and thereby assure a readily accessible source of data on medical claims to be used by those concerned with monitoring the malpractice climate.

MEDICAL PANEL ISSUES

One of the more popular responses to the "malpractice crisis" of the 1970's was the institution of a screening procedure for evaluation of malpractice claims prior to litigation. The screening process was intended to expedite the procedures for evaluating complex medical malpractice claims. It was hoped that this would instill greater confidence in the legal system. The joint subcommittee's evaluation of the review panel process focused on the efficiency and credibility of the panels.

The Virginia panel procedure was instituted in 1977 to provide the parties with a relatively quick and inexpensive evaluation of the merits of the claim. William H. Daughtrey, Jr., J.D., Associate Professor of Business Law at Virginia Commonwealth University, recently conducted a review of the operation of the panels. Dr. Daughtrey summarized the findings contained in his paper Medical Malpractice Review Panels: Data and Comments on Their Operation in Virginia for the joint subcommittee. Dr. Daughtrey also surveyed the circuit court judges across the state for their opinions on how the panels were working. Additionally, the Medical Society of Virginia, in conjunction with the Virginia Supreme Court, compiled available information on the panels which have been requested since 1977. The findings of the Medical Society were presented to the joint subcommittee by Kenloch Nelson, M.D. (Appendix D.) The Medical Society also conducted a survey of attitudes towards the panels by physicians and attorneys who had been involved in panel proceedings.

Dr. Daughtrey found that the average time lapse between the request for a panel and the panel disposition was ten months. Unfortunately, comparable data on the time lapse between the giving of the notice of claim and disposition at trial was not available for those cases which by-pass the panel process. Dr. Daughtrey explained that circuit court records throughout the Commonwealth would need to be searched to obtain this information. It is impossible to determine from the available data whether the panels actually speed up the process. However, the joint subcommittee heard from a number of attorneys, physicians and insurance company representatives involved in panel proceedings that generally claims were disposed of more quickly by panels than through litigation.

The question which most concerned the joint subcommittee was whether the panel proceeding merely involved a duplication of the effort and expense of a subsequent trial with no discernable benefit. Of twenty physicians responding negatively to the panels in the Medical Society survey, fifteen indicated that their objection was based, at least in part, on the fact that the panel decision was not binding on either party and carried no weight at a subsequent trial.

Dr. Nelson concluded from his analysis of the cases in which panels were requested that the panels encouraged settlement of the claim. Between November 1976 and December 31, 1983, 776

panels were requested. Fifty-one percent (396) were requested by a defendant. Dr. Nelson was able to obtain information on the disposition after the panel was requested for 396 claims against a physician or hospital. Significantly, the distribution of favorable opinions did not correspond with the almost equal distribution of requests for panels. A decision for the defendant was rendered 212 times out of a possible 268 opinions (79%). In an additional nine cases the panel found that the defendant had failed to comply with the appropriate standard of care but that the failure was not the proximate cause of the claimants's injury. One hundred and forty-one requests for panels did not result in the convening of a panel. Of these one hundred and forty-one cases, sixty (43%) were settled after the request for a panel was made. Ten cases proceeded directly to trial, of which five were nonsuited. No further action was taken in sixty of these cases. Sixty-seven of the two hundred and sixty-eight claims disposed of after the panel was held were settled. In one hundred and thirty-three no further action was taken. Dr. Nelson also found that, on the average, settlement was reached within nine months of the request for the panel.

The joint subcommittee concluded from its review of this data that the panels lead to final disposition of a significant number of malpractice claims without the expense, publicity and emotional trauma of a trial. The joint subcommittee recognized, however, that the more substantial malpractice claims generally by-pass the panel and proceed directly to trial. In concluding that the benefits of the panel process outweigh the economic and psychological detriments caused by potential duplication of effort, the joint subcommittee also relied on more intangible data.

The joint subcommittee found a number of the comments of the physicians responding to the Medical Society survey to be of particular interest. Specifically, it found that the physicians favoring the panels look upon them as their only meaningful opportunity for peer review. Many commented favorably on the panel members' preparation and familiarity with the cases. Because of the increasingly complex nature of health care practices, these factors are extremely important to the defendant health care providers. Additionally, the physicians appreciate the fact that this initial review is conducted with less publicity than a trial. These factors contribute to a less hostile perception of the medical malpractice tort system.

The finding that the panels serve a legitimate and beneficial function did not preclude the joint subcommittee members from further review to determine the need for modifications in the panel process. They were especially concerned that the credibility of the panels be improved. For example, they heard a number of health care providers argue that the panel process was meaningless because its decision was not binding.

The concept of giving the panel decision some presumption of correctness at a subsequent trial was discussed at length. The joint subcommittee also considered a proposal to preclude the introduction of the written panel decision at a subsequent trial. It was argued that admission of the written decision merely confuses the jury by giving the decision an aura of correctness to which it is not entitled under the law. In addition, it was noted that the standard of proof upon which the panel decision is based is not the same as that upon which the jury must base its decision. This proposal was ultimately rejected by a majority of the joint subcommittee. The majority was of the opinion that the "confusion factor" could be eliminated by proper instructions and that the admissibility of the written decision is an important settlement-inducing factor.

It was agreed by the joint subcommittee that the issue of the proper weight to be accorded a panel decision required further study. This issue will be considered during the requested continuation of the study.

The joint subcommittee also discussed the need for assuring the impartiality of the panel members. Many of those who addressed the joint subcommittee had been involved in a panel proceeding as a member, counsel or a party. While few could point to specific instances where the impartiality of the panel was in question, all noted a lack of standards for ensuring impartiality. This issue is currently handled on a case-by-case basis. The joint subcommittee also heard concerns expressed regarding the proper composition of the panel.

With respect to the impartiality of the panel the joint subcommittee proposes that (i) the statutory definition of impartiality as it applies to the medical malpractice review panel

members be expanded to exclude any health care provider who has been consulted by the parties and (ii) the panel members be specifically reminded of their obligation to be impartial by requiring the notice of appointment to the panel to include the applicable statutory definition of impartiality and the oath of impartiality to which the panel will subscribe. (Appendix E2.) The joint subcommittee found that a lack of impartiality is not a significant problem. However, the members believe it is important to the credibility of the panel process that the perception of the members of the panel as impartial investigators, evaluators and experts is preserved and heightened.

The questions surrounding the proper composition of the panel are related to the perception of health care providers that the panels involve a peer review. The joint subcommittee recognizes this as an important function of the panels. The joint subcommittee recommends that every effort be made to ensure that representatives of the defendant's particular specialty are appointed to the panel. Additionally, the joint subcommittee recommends inclusion of an affirmative statutory statement of the duty of the panel members to apply their own particular expertise to the facts of the case. This provision is designed to confirm the investigatory function of the panel.

The joint subcommittee concluded that the seven-member legal-medical screening panels serve an important function in a significant number of malpractice cases. It found that the panels are able to effectively evaluate a complex claim in a relatively short period of time at reduced cost to the parties. It further found that both claimants and health care providers have confidence in the panel process.

TRIAL-RELATED ISSUES

The joint subcommittee addressed a number of diverse issues under this category. The discussions focused on the need for changes in the laws governing the statute of limitations, standards for qualification of expert witness, the appropriate standard of care to be applied, the cap on recovery, the collateral source rule and the use of the contingency fee. Substantial input was received from various health care providers and their professional associations, members of the bar representing plaintiffs and defendants in malpractice cases, persons who had been plaintiffs, and representatives of the insurance industry. The joint subcommittee agreed that the issues raised were complex and the effects of any changes in these laws could be substantial. Therefore, the joint subcommittee saw no need for change in the cap or collateral source rule at this time and a majority of the members concluded that additional time for study and evaluation is needed for review of the remaining issues. (See Appendix E4.)

A summary of the discussions held and conclusions reached with respect to these issues follows.

A. Statute of Limitations

The joint subcommittee considered two major modifications of the law in this area. The first would have provided that a cause of action for malpractice would not accrue (i.e., the statute of limitations would not begin to run) until the earlier of when the injury suffered by the plaintiff was actually discovered or, by the exercise of reasonable care, should have been discovered. This is referred to as a date of discovery accrual rule. The second modification concerned the application of the statute of limitations to claims involving minors. Currently, the two-year statute of limitations does not begin to run until the minor reaches his eighteenth birthday.

According to information supplied by the American Trial Lawyers Association, thirty-eight states currently have some form of discovery accrual rule applicable in medical malpractice cases. (See Appendix F.) Such a rule is designed to correct a perceived harshness caused by strict application of the statute of limitations. For example, if the injurious effect of a medical procedure performed in 1984 were not to manifest until 1987, the claim for malpractice would nonetheless be barred under current law. The same would be true if a foreign object (e.g., scissors or a sponge) was discovered to have been left in a patient during surgery years earlier. The discovery accrual rule is generally used only with respect to tort claims involving latent defects or injuries which are not readily apparent through no fault of the injured party. (See, e.g., § 8.01-249 of the Code of Virginia, with respect to actions involving claims of fraud, mistake and undue influence.)

The Medical Society of Virginia and the Virginia Insurance Reciprocal are opposed to adoption of a discovery accrual rule. It was argued that such a rule would have an adverse impact on insurance rates and premiums because an additional element of uncertainty would be added. It was also suggested that such a change would adversely affect the way in which health care providers view the legal system. Again, this would be due to the uncertainty with respect to the life expectancy of a potential claim.

Proponents of the discovery accrual rule noted that there would be relatively few cases in which the discovery accrual rule would play a role. In the majority of cases, the injury is readily apparent. The proponents argue that because of the small number of cases affected, any adverse impact from the change on insurance rates and premiums would be negligible. As an alternative to a pure date of discovery rule, it was noted that a number of states have placed an outside limit on the life of the claim. Twenty-six states currently have such limits. (See Appendix F.) These limits range from a broad limit of one year from the date of discovery, whenever that may be, to a less open-ended approach involving a maximum number of years from the date of the act constituting the basis for the claim.

The opponents also argued that the need for relief from the harshness of strict application of the statute of limitations has been satisfied by two recent Virginia Supreme Court cases. It was argued that the court broadened the continuing treatment rule sufficiently to protect innocent plaintiffs in Farley v. Goode, 219 Va. 969 (1979) and adopted a modified discovery rule in Locke v. Johns-Manville, 221 Va. 951 (1981). However, there was considerable disagreement over the interpretation to be given to these cases. Proponents of the discovery rule suggested that statutory adoption of the rule would be less confusing for all, including juries.

Concern was expressed over how the issue of when an injury was "discoverable" would be handled. All agreed that ultimately the issue involves a question of fact. However, it was suggested that this would necessitate additional technical expert testimony tending to confuse the jury and increase the time and expense associated with a trial.

A majority of the joint subcommittee agreed that additional information was necessary on the effects of a discovery rule on insurance rate-making and premiums and on the cost in time and money. It was suggested that a more in-depth analysis of a discovery rule having a maximum limit from the date of the act would be desirable. (See e.g., § 1-15, North Carolina Statutes.)

Medical malpractice claims involving minors require separate analysis. The joint subcommittee was very concerned about the particular problems facing OB-GYN's nationwide and in Virginia. They noted the statistics from states such as Florida indicating that a number of OB-GYN's are giving up the practice because of high insurance premiums and a pervasive atmosphere of fear of malpractice claims. The joint subcommittee heard from a number of practicing OB-GYN's, including Dr. Daniel Crooks of Richmond and committee member Dr. George Nipe. All noted an increasing tendency among these physicians to practice "defensive medicine," thereby increasing the cost of medical care. Substantial increases in premiums for OB-GYN's have contributed to increased costs for patients. The OB-GYN's in Virginia are also becoming more concerned with the availability of malpractice insurance than with the cost. (See Appendix F.)

Eighteen states have adopted special statutes of limitations for minors in malpractice cases. (See Appendix G.) Without these special provisions, physicians in these states would face lengthy limitations periods, as they do in Virginia. Proponents of a special provision for minors argue that a maximum of twenty years, assuming an injury at birth, is too long. In general, the fact that the minor is injured is known long before he reaches the age of majority.

Opponents of a change argue that the current tolling provisions during minority or other disability are necessary to protect the rights of those who cannot protect themselves. Additionally, it was suggested that a modification of this law would be yet another example of "special treatment" under the law for medical defendants.

The joint subcommittee recognized that there were legitimate concerns raised on both sides of this issue. The joint subcommittee members were particularly concerned with the plight of the OB-GYN's and would like to continue to exploring alternatives for averting a potential "crisis" in

this area. It was agreed that the continued study would evaluate a modified limitations period for minors.

B. Standard of Care/Qualification of Experts

The issues concerning the appropriate standard of care to be applied in malpractice actions and the standards for qualification of experts were discussed together. Frequently, the discussions focused on concerns about the increasing use of "hired guns" or "professional witnesses" as experts. Many of the attorneys who addressed the joint subcommittee indicated a belief that the current standard of care provision worked to the disadvantage of plaintiffs. They noted a reluctance on the part of health care providers to testify against their peers, especially when they are from the same geographic area. The problem of finding an expert is complicated by some judicial interpretations of the standard of care provisions to require that an expert witness demonstrate a high degree of familiarity with the particulars of the locality in which the alleged malpractice occurred. This effectively precludes the use of experts who practice anywhere outside of that locality.

Many proponents of a change in the standard of care provisions suggested adoption of a national standard of care. They noted that medical education is essentially the same nationwide and that health care providers throughout the country have access to and use the same medical journals, etc., to continue their education. Furthermore, they noted that the quality of medical care provided in Virginia is as good as, if not better than, that available elsewhere. Therefore, the proponents concluded that the standard by which the defendant should be judged is that of a reasonably prudent practitioner of the same specialty as the defendant, acting under the same or similar circumstances as the defendant.

It was suggested that the "same or similar circumstances" language was sufficiently broad to allow for admission of evidence of the necessary vagaries of local practice, economics, geography, etc. Under this proposal, any health care provider who could demonstrate sufficient familiarity with the subject at issue would be "qualified" to testify. The extent of his qualifications as particularly applicable to the defendant's actions would be open to attack by appropriate questioning. It was noted that this is how expert witnesses are handled in other types of civil cases.

Some opponents of a change argue that a shift to a national standard of care might open the door for more frequent use of professional witnesses who make the principle portion of their income from testifying as witnesses and not from practicing any particular form of the healing arts. Health care providers, in general, feel that the use of professional witnesses often compromises a just and fair outcome. Additionally, they were concerned that such a change would not take into account the differences in the availability of medical technology in the various localities throughout the state.

The Medical Society pointed out that the problems associated with the qualification of expert witnesses in the different courts throughout the state could be resolved without adoption of a national standard of care. The Medical Society offered to make available a list of physicians for each specialty who would review and evaluate malpractice claims for plaintiffs and defendants.

The joint subcommittee considered, but deferred decision on, a proposal to provide for a national standard of care with a provision that if a local standard was shown by a preponderance to be more appropriate that standard would apply. It found that there was a need to clarify the law with respect to the qualification of experts. However, it concluded that the question of the appropriate standard of care required further study due to uncertainty over the impact of a change to a national standard. Some argued that the change would involve only semantics and would reflect the standard as it is applied in most cases today. Ultimately, it was agreed that representatives of the Medical Society and the Trial Lawyers Association would work together to propose a bill for consideration by the joint subcommittee. The proposal is to provide for a clearer standard of care, taking into account the particulars of the circumstances under which the defendant was acting, and clarify the criteria for qualifying expert witnesses. Because of time constraints under which the joint subcommittee was operating, this could not be accomplished in time to provide an opportunity for review and discussion. The joint subcommittee hopes that these issues can be resolved quickly during a continued study next year.

C. Limitation on Recovery/Collateral Source Rule

Perhaps the most difficult issues facing the joint subcommittee concerned the limitation on recovery ("the cap") in medical malpractice actions. Answers to questions about the need for and effects of the cap are not easy to come by. The available data is difficult to assess. Information from the other five states which have an absolute cap similar to Virginia's is of little use for comparison. Each cap is slightly different. For example, Nebraska provides for certain payments above $100,000 but below the $1 million cap to be made from an excess liability fund. New Mexico excludes punitive damages and medical care payments from the cap. In addition, the laws of these other states relating to the collateral source rule and the statute of limitations are different. Their effect on the malpractice climate cannot be isolated. Evaluation of the effect of the cap is further complicated by the fact that the issues are fraught with emotion.

Health care providers and their insurers view the cap as a security blanket, knowing the limits in coverage that should be carried. Health care providers believe that because of the cap they will continue to be able to obtain insurance. The insurance industry suggests that the cap is primarily responsible for keeping rate increases at a minimum, and premium levels, at a low. It was noted that any adverse impact on this climate would be felt by the consumer in decreased availability and increased costs of medical services.

Opponents of the cap, however, argue that it is unfair to penalize an innocent party by limiting his recovery in order to provide a favorable insurance climate for the one who caused the injury. They also note that the impact of the cap is felt most by those who are severely injured. (The arguments of the opponents and proponents of the cap are outlined in the Medical Society Position Paper and the Virginia Trial Lawyers Association Paper found in Appendix H.)

A majority of the joint subcommittee members believe that the cap serves a legitimate function. Based upon the testimony and materials presented, the joint subcommittee concluded that there was no current "crisis" with respect to the availablity and cost of malpractice insurance and medical care. It concluded that this was due, in part, to the cap. It was noted that very few claims or awards approach the monetary limits imposed by the cap. For those that do, a majority of the joint subcommittee believes that a properly structured settlement could adequately provide for the injured plaintiff. Some members of the joint subcommittee felt that the benefits of structured settlements to an injured plaintiff had been overrated. Concern was expressed over the actual value of future benefits accruing to the injured party. It was suggested that the joint subcommittee look more closely at structured settlements as a part of the continued study with respect to minors.

In deciding that retention of the cap was desirable for the present, the joint subcommittee also relied upon its finding that continued application of the collateral source rule was desirable. The collateral source rule bars the use of evidence of payments received by an injured party from a third party source as a result of the injury. The theory underlying the rule is that the negligent defendant should not receive any benefit by reduction in the damages he has to pay simply because the injured party had the foresight to contract for payment in the event of his injury. That is, the law should not treat the defendant as a third party beneficiary of the plaintiff's contract with another for benefits. The joint subcommittee reviewed the laws of a number of states which have modified the collateral source rule as it applies in malpractice actions. (See Appendix F.) The New York statute was discussed most favorably. However, the joint subcommittee concluded that the collateral source rule should be retained in its present form at this time. It was reasoned that allowing the injured plaintiff to retain his independently obtained source of benefit lessens the adverse impact of the cap. The joint subcommittee noted that these collateral source benefits are significant. By some estimates, as much as 90% of the population would have some collateral benefits due to them in the event of a serious injury.

Some members of the joint subcommittee noted that confusion exists with respect to whether the cap applies to the total recovery or to each health care provider individually. Because there is currently a case pending before the Supreme Court of Virginia involving this issue (Potomac Hospital Corporation v. Josephine A. Dillon, Committee, Record No. 840438), the joint subcommittee deferred taking a position on this issue at this time. However, they did find that there was some potential for confusion with respect to the interpretation to be given to §§ 8.01-38 and 8.01-581.15.

The ambiguity arises due to the inclusion of hospitals within the definition of "health care provider" as used in Chapter 21.1 of Title 8.01. (See § 8.01-581.1 of the Code of Virginia.) In order to eliminate any confusion, the joint subcommittee recommends an amendment to § 8.01-38 to clarify that the $1 million cap imposed pursuant to § 8.01-581.15 does not apply to hospitals but that the $500,000 cap for hospitals is controlling. (Appendix E3.)

On balance, a majority of the joint subcommittee believes retention of the cap and the collateral source rule to be desirable at this time. It recognizes that this is not a long-term solution. As hospital and medical costs increase, the cap will necessarily have to be adjusted. The joint subcommittee members indicated that as a part of the continued study they would like to continue to evaluate the effects of the cap and application of the collateral source rule.

Additionally, upon request of a number of people, particularly health care providers, the joint subcommittee agreed to evaluate the impact of the contingency fee on the malpractice climate. Many of those who addressed the joint subcommittee expressed a belief that the contingency fee encourages the filing of frivolous claims and results in an apparent conflict of interest between attorney and client with respect to settlement of a claim. A majority of the joint subcommittee disagreed with this analysis but welcomed the opportunity to study the issue in greater detail.

CONCLUSION

The joint subcommittee made significant progress in its evaluation of Virginia's medical malpractice laws and the effects of the laws on the overall malpractice environment. A great deal of information was received from various interested individuals and groups. Often, this information was contradictory. However, the joint subcommittee was able to establish a good working relationship with and among these persons.

The joint subcommittee was unable to complete the study this year because of the complexity of the issues involved. The study should be continued to afford the joint subcommittee an opportunity to properly evaluate all the information it has received and to monitor the work of the Medical Society of Virginia with respect to issues related to this study.

When this study began, the representatives of the various competing interests viewed each other with suspicion, if not hostility. As the study progressed, however, original positions began to soften somewhat. The groups began and continue discussions on various points. Instead of talking at each other, they have begun to talk to each other. This study can be completed next year; the foundation has been laid.

Respectfully submitted,

Clifton A. Woodrum

Wiley F. Mitchell, Jr.

John G. Dicks, III

John Ward Bane

George M. Nipe, M.D.

R. Carter Scott, III

John N. Simpson

FOOTNOTES

[1]Alabama, Alaska, Arizona, Arkansas, Delaware, Hawaii, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Nebraska, New Mexico, New York, Ohio, Rhode Island, Texas, Utah, Washington, Wisconsin.

[2]Arizona, California, Delaware, Kansas, Nebraska, Rhode Island, South Dakota, Washington.

[3]Alaska, Florida, Idaho, Illinois, Indiana, Iowa, New York, North Dakota, Ohio, Pennsylvania, Tennessee.

[4]Alaska, Arizona, Arkansas, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nebraska, Nevada (repealed 1981), New Hampshire, New Jersey, New Mexico, New York, North Dakota (repealed 1981), Ohio, Pennsylvania, Rhode Island (repealed 1981), Tennessee (expired 1983), Virginia, Wisconsin.

APPENDICES

Appendix H Medical Society of Virginia Position Paper

Virginia Trial Lawyer's Association Position

Paper on the Limitation on Recovery

APPENDIX A

Requesting the House Committee for Courts of Justice and the Senate Committee for Courts of Justice to establish a joint subcommittee to study the medical malpractice laws of the Commonwealth.

Agreed to by the House of Delegates, March 10, 1984
Agreed to by the Senate, March 11, 1984

WHEREAS, the last major revision of the Commonwealth's statutory laws relating to medical malpractice occurred in 1976; and

WHEREAS, sufficient time has passed to evaluate the 1976 revision and to consider whether further changes in the Commonwealth's medical malpractice laws may be appropriate; and

WHEREAS, many questions have been raised in the legal field of medical malpractice, including the need for medical malpractice review panels, the limits on recovery amounts in medical malpractice cases, and the possible need for a method of reporting medical malpractice claims; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study the medical malpractice laws in the Commonwealth of Virginia. The joint subcommittee shall consist of seven members to be appointed as follows: two members of the House Committee for Courts of Justice to be appointed by the Speaker of the House and one member of the Senate Committee for Courts of Justice to be appointed by the Senate Committee on Privileges and Elections; one citizen member of the Virginia State Bar Association to be appointed by the Speaker of the House, one citizen member of the Virginia Bar Association to be appointed by the Senate Committee on Privileges and Elections, one citizen member of the Virginia Medical Society to be appointed by the Speaker of the House, and one citizen member of the Virginia Hospital Association to be appointed by the Senate Committee on Privileges and Elections. The joint subcommittee's study shall include, but shall not necessarily be limited to, the need to continue medical malpractice review panels, the limits on recovery amounts in medical malpractice cases, and the possible need for a method of reporting medical malpractice claims. The subcommittee shall complete its work in time to make recommendations to the 1985 Session of the General Assembly.

The direct and indirect costs of this study are estimated to be $18,500.

1984 SESSION

I.D0286474

HOUSE BILL NO. 668

Offered January 24, 1984

A BILL to amend the Code of Virginia by adding in Article 2 of Chapter 21.1 of Title 8.01 a section numbered 8.01-581.21, which provides for the use of standards of national boards or American colleges as evidence in certain medical malpractice cases.

Patrons—Slayton and Dicks

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 2 of Chapter 21.1 of Title 8.01 a section numbered 8.01-581.21 as follows:

§ 8.01-581.21. Use of standards of national boards and American colleges as evidence in certain medical malpractice cases.—If a health care provider holds himself out to be a specialist certified by a national board or an American college, then the standards promulgated by such board or college shall be evidence of the skill and diligence practiced by a reasonably prudent practitioner certified by the national board or American college in the field of practice or speciality in the locality where the medical malpractice is alleged to have occurred. A copy of the standards of a national board or American college, when attested to by its secretary and president, shall be admissible in evidence.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

LD0287474

HOUSE BILL NO. 669

Offered January 24, 1984

A BILL to amend and reenact § 8.01-581.20 of the Code of Virginia, relating to proof of the applicable standard of care in medical malpractice actions.

Patrons—Slayton and Dicks

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-581.20 of the Code of Virginia is amended and reenacted as follows:

§ 8.01-581.20. Standard of care in proceeding before medical malpractice review panel; expert testimony; determination of standard in action for damages.—A. In any proceeding before a medical malpractice review panel or in any action against a physician, dentist, nurse, hospital or other health care provider to recover damages alleged to have been caused by medical malpractice where the acts or omissions so complained of are alleged to have occurred in this Commonwealth, the standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth and the testimony of an expert witness, otherwise qualified, as to such standard of care, shall be admitted ; ~~provided,~~ However, ~~that~~ the standard of care in the locality or in similar localities in which the alleged act or omission occurred shall be applied if any party shall prove by a preponderance of the evidence that the health care services and health care facilities available in the locality and the customary practices in such locality or similar localities give rise to a standard of care which is more appropriate than a statewide standard. An expert witness who is familiar with the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in this Commonwealth.

In any such proceeding or action based upon the alleged negligent actions or omissions of a physician holding himself out as a specialist in a particular branch of medicine or surgery, upon a showing that the medical or surgical standards at issue are essentially uniform in character throughout the United States in the particular branch of medicine or surgery, the plaintiff or defendant may introduce on his behalf the expert testimony of any specialist certified by the recognized American Board of that particular specialty who practices in the same branch of medicine or surgery as the defendant and who is properly licensed as a physician in any state of the United States, or the District of Columbia.

B. In any action for damages resulting from medical malpractice, any issue as to the standard of care to be applied shall be determined by the jury, or the court trying the case without a jury.

1984 SESSION

LD1997566

HOUSE BILL NO. 664

Offered January 24, 1984

A BILL to repeal § 8.01-581.15 of the Code of Virginia, relating to limitation on recovery in certain medical malpractice actions.

Patron—Slayton

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-581.15 of the Code of Virginia is repealed.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
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Clerk of the House of Delegates	Clerk of the Senate

HP0301474

1984 SESSION
ENGROSSED

HOUSE BILL NO. 1011

House Amendments in [ ] - February 14, 1984

A BILL to amend and reenact § 8.01-581.15 of the Code of Virginia, relating to the limitation on malpractice recovery against a health care provider.

Patrons--Marks, Morrison, Dicks, Cohen, Almand, Putney, Hall, Jennings, Moss, McClanan, Miller, C., Ealey, and Anderson

---

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-581.15 of the Code of Virginia is amended and reenacted as follows:

§ 8.01-581.15. Limitation on recovery in certain medical malpractice actions.--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 October 1, 1983, 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 one million dollars *or the limits of the provider's insurance coverage, whichever is greater* . [*In order to receive the benefit of this limitation, a health care provider must have in effect with respect to the claim in question, liability insurance in the amount of at least one million dollars.*]

In interpreting this section, the definitions found in § 8.01-581.1 of the Code of Virginia shall be applicable.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
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Date: _____	Date: _____
Clerk of the House of Delegates	Clerk of the Senate

1984 SESSION

LD0623544

HOUSE BILL NO. 896

Offered January 24, 1984

A BILL to amend the Code of Virginia by adding in Article 4 of Chapter 8 of Title 38.1 a section numbered 38.1-389.3:1, relating to the reporting of certain medical malpractice claims.

Patrons--Dicks, Saunders, Forehand, Marks, Morrison, Rollins, Robinson, W. P., Cohen, Murphy, Moncure, Cranwell, Ackerman, Almand, Jennings, and Philpott; Senators: Joannou and Scott

---

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 4 of Chapter 8 of Title 38.1 a section numbered 38.1-389.3:1 as follows:

§ 38.1-389.3:1. Certain medical malpractice claims to be reported to Commissioner; duty of Commissioner; reviewing reasonableness of malpractice insurance rates; annual report and list of payments.--A. All medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing medical or health care or any claim closed without payment relating to such person, corporation, firm or entity providing medical or health care shall be reported to the Commissioner of Insurance by the claimant's attorney and by the health care provider or his insurer within sixty days following final disposition or close of the claim. The report to the Commissioner shall in a format prescribed by him state the following:

1. Nature of claim;

2. Damages asserted and alleged injury;

3. Attorney's fees and expenses incurred in connection with the claim or defense;

4. The amount of the settlement or judgment; and

5. Any other pertinent and relevant information which the Commissioner may require.

B. The Commissioner shall forward the reports required by subsection A hereof to the licensing board having jurisdiction over such health care provider. Such reports and information furnished pursuant to this section shall not be considered public or official documents and shall be exempt from the provisions of the Virginia Freedom of Information Act. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or his subordinates, any insurer, its authorized representative, agents or employees, or any firm, person or corporation furnishing to the insurer and the Commissioner such information, for any statement made by any of them in complying with this section or for the providing of information pertaining thereto.

C. The Commissioner shall prepare an annual report of statistical data based on the information collected pursuant to subsection A, and shall prepare also an annual list identifying all sums paid during the previous year by amount and date of injury, which report and list shall be made available to all interested persons upon request.

D. In reviewing the reasonableness of malpractice insurance premium rates, the State

Corporation Commission shall consider the impact of existing or prospective limitations on liability.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
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Clerk of the House of Delegates	Clerk of the Senate

Virginia Trial Lawyers Association

MEDICAL MALPRACTICE INSURANCE

INTRODUCTION

The insurance industry and the medical community argue that the cost of medical malpractice insurance is unreasonably high, especially for certain specialties, because too many unwarranted suits are brought by patients against health care providers, and because the size of damage awards to litigants in medical negligence suits is disproportionately high. The result, they say, is that physicians are refusing to enter practice in certain specialties and that the cost of medical care is increased as health care providers pass on insurance costs to patients.

The following materials demonstrate that physicians are entering medical specialties at a steady rate. They show that the incidence of medical negligence suits has increased, but not disproportionately to the growth in the number of practicing physicians or in the general population. They show that the size of awards is not increasing. The average size of damage awards is very modest and fewer large awards are being made to victims.

The most interesting data, however, are the cost of medical malpractice insurance premiums, and the profitability of the largest Virginia carrier. If premiums are too high, which is arguable, it is clear this is not a result of medical negligence lawsuits. Rather, the evidence suggests that the medical community should look to their insurance carriers and their profits.

[illegible] CHARLOTTESVILLE VIRGINIA 22905 TELEPHONE (804) 979-6479

TABLE OF CONTENTS

ACTUARIAL ANAYSIS

ST. PAUL FIRE AND MARINE

MEDICAL MALPRACTICE INSURANCE -- VIRGINIA

J. ROBERT HUNTER *

Summary: Mr. Hunter's report states categorically that:

"Not only is there no "crisis," there is no problem. If anything, current rates charged by St. Paul are high, vis-a-vis the experience presented in its recent filing."

"I anticipate that, because the profits that St. Paul will enjoy under current rates should prove excessive, that the Medical Society of Virginia will receive a refund . . . "

"St. Paul has, and appears to continue to be, overreserved extensively in Virginia and in the country."

* Mr. Hunter is currently President of the National Insurance Consumer Organization, a non-profit group formed to aid and educate insurance consumers. Prior to joining N.I.C.O., he served as a Federal Insurance Administrator for four years. He has served as a consultant to the White House, OMB, and other federal agencies.

202 North 24th Street
Arlington, Virginia 22207
December 12, 1983

Mr. Edward W. Taylor
Chairman
Legislation Committee
Virginia Trial Lawyers Association
661 North Courthouse Road
Richmond, Virginia 23236

Re: Medical Malpractice Insurance -- Virginia
Physicians and Surgeons Professional Liability

Dear Mr. Taylor:

I have completed a preliminary review of the experience of St. Paul Fire and Marine Insurance Company (Annual Statement data from 1980-1982 and rate filings made in May of 1983 and June of 1981); the data on profitability promulgated by the National Association of Insurance Commissioners (1977-1981; the 1982 data are not yet available), the Virginia Medical Malpractice Data: A Summary Analysis, by Mr. Allen; the Presentation of Virginia Medical Malpractice Data Frequency and Distributions by the Bureau of Insurance; the Deposition of Mr. Hazelwood of February, 1981 (albeit many of the pages were missing), Senate Document No.29 (1976), the 1976 legislative changes; and numerous other newspaper articles, etc., which you furnished to me.

As I understand your request, you are interested if I can see any emerging crisis in medical malpractice in Virginia, based upon actuarial analysis of all available relevant data; such analysis to include consideration of the higher risk classifications.

Not only is there no "crisis" there is no problem. If anything, current rates charged by St. Paul are high, vis-a-vis the experience presented in its recent filing. I anticipate that, because the profits that St. Paul will enjoy under current rates should prove excessive, the Medical Society of Virginia will receive a refund under these rates (it is my understanding that, if profits including investment income prove excessive, such refunds do occur). Absent this retrospective protection, a rate hearing should be sought to show cause as to why a sharp reduction in rates is not in order.

Not one shred of evidence exists to indicate a significant deterioration of results in Virginia. In fact, data shows that St. Paul asked for a rate increase of only 13.1% in mid-1983, and that increase was predicated upon a profit margin which, I roughly estimate, will give the company a

return on net worth of about 50%! This was the first increase in 2 years, so the annual change asked for was 1.064 compounded.

Further, as the 1983 filing points out at page 1 of the Filing Memorandum, rates for "limits in excess of $1,000,000 are being reduced," indicating a reduction in expected large claims, another sign of stabilization.

St. Paul has, and appears to continue to be, overreserved extensively in Virginia and in the country. A review of two-year-later data between the two rate filings shows this effect:

Virginia

Year	Old Loss Ratio	New Loss Ratio
1977	46.8%	38.0%
1978	69.8	59.8
1979	124.1	87.6
1980	154.7	98.7

Countrywide

Year	Old Loss Ratio	New Loss Ratio
1977	47.1%	42.1%
1978	79.4	72.8
1979	120.8	93.9
1980	134.8	106.0

This overreserving effect is captured and reflected in the loss development data used in the filing, where recently reported data are cut by half or more based on St. Paul's historical ultra-high reserves (see Exhibit 8A and 8B for a display of the loss development factors). St. Paul's Schedule P, Part 2C confirms this remarkable phenomenon:

Year	as of 1980	as of 1981	as of 1982
1976	25%	24%	--
1977	34	30	28
1978	59	51	47
1979	86	76	65
1980	106	106	91
1981	--	106	94

It is my belief that the State Corporation Commissions in other states must have undertaken an extensive examination of St. Paul's reserving practices, given these sharply overreserved histories. If such exists, you should acquire it: if by chance they have not done so, they should do so.

Another sign of stability in this line is the fact that only 4 doctors per 100 had a claim. (Exhibit C1 of filing -- frequency is 0.041575). According to page 19 of Senate Document No. 29, St. Paul estimated its 1975 first half claim frequency at 7.22. Countrywide, it estimated its 1974 claim frequency at 6.85 when Senate Document No. 29 was prepared in 1976; now its estimate is 4.9.

This tells us that: 1)Virginia doctors are now believed to have about 20% fewer claims than the country as a whole today, whereas in 1976 they were believed to have about 6% more; 2) the frequency estimated has fallen sharply in Virginia and in the country; and 3) the earlier, mid-70's "crisis" was one of poor information, not fact (this finding agrees with the findings of the federal government when they studied these problems).

The average claim incurred in Virginia was $14,255 in 1982, according to St. Paul's questionable estimates, compared with $16,583 for the country; about 14% less than the country.

In 1982, the average doctor insured by St. Paul in Virginia had an estimated loss potential of $593, compared with $813 in the nation. The expected loss potential was thus almost 40% higher in the nation than in Virginia.

The favorable results of writing medical malpractice in Virginia are evident when one reviews the profitability experience reported to the NAIC:

Operating Profit Margin (Related to Sales)

	Countrywide		Virginia	
Year	All P/C Lines	Med. Mal	All P/C Lines	Med. Mal.
1977	+8.0%	+24.1%	+7.9%	+23.6%
1978	+5.9	+12.7	+5.7	+23.1
1979	+4.7	+8.6	+7.0	+8.0
1980	+4.6	+6.8	+6.0	+20.3
1981	+6.3	+0.8	+7.6	+17.6
Average	+5.9%	+10.8%	+6.8%	+18.5%

You will note that, although the operating profit in the country has declined for medical malpractice it has remained very high (excessive) in Virginia. The above profit levels do not reflect income in the investment of net worth. If the 18.5% profit on sales is converted to a net worth basis and profits on the investment of net worth are included, the Virginia historic profit for this line has been about a 40% rate of return on net worth, after taxes.

It is also interesting to note that the 5.9% countrywide operating margin was sufficient to enable the industry to enjoy banner profit years and superb stock market performance during 1977-1981. 18.5%, by any test, is an outlandishly high return on sales for this industry.

The conclusion is that there is no emerging medical malpractice "crisis" in Virginia. By any test, the condition is stable and profitable for St. Paul. This finding has been confirmed by off-the-record discussions with technicians working for the Virginia Insurance Department.

You also wondered if conditions were deteriorating at a fast pace for the higher rates classes. The attached Exhibit E2 from the mid-1983 St. Paul filing, shows that the rates for the three highest rated classes went up less than the average increase for all classes and actually went down for 2 of the 3 highest rated classes. The highest manual rate in the state, Rating Class 8, is $13,192. The next highest is $7,574 and on down as the Exhibit shows.

These costs are, of course, passed on to the medical consumer. Assuming the Class 8 doctor works 220 days a year, his or her manual rate is $60 per day. Even if the doctor only average one patient a day, the pass-through cost of $60 is hardly a major factor in the high cost of medical care. Prior to the mid-1983 change, the Class 8 risk paid $12,047 or $55 a day, again assuming 220 working days. The change of $5 a day is hardly significant and below the double digit medical care price charges which have occurred over the last few years.

Again, no crisis and no problem exists or is emerging for the high rated classes.

I trust that this information is helpful to you.

Very truly yours,

J. Robert Hunter
Consulting Actuary

JRH/m
attachment

BIOGRAPHY
Advisory Committee
Task Force On Profitability And Investment Income

Mr. J. Robert Hunter
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National Insurance Consumer Organization
344 Commerce Street
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PREMIUMS PAID BY PHYSICIANS

FOR MEDICAL MALPRACTICE INSURANCE

IN VIRGINIA

1975 - 1984

Summary: The information provided is a breakdown of physicians by specialties (as listed in the AMA publication, Physician Characteristics and Distribution in the U.S.). The specialties are listed with the premiums paid by each for medical malpractice insurance in Virginia over the past several years.

The insurance information presented was gathered by the Bureau of Insurance. The Bureau requested data from the three major medical malpractice writers (St. Paul's, Virginia Reciprocal, and Pennsylvania Casualty) in Territory One for $1 Million/$1 Million Limits on mature claims made rates.

As you will note, the Virginia Reciprocal and Pennsylvania Casualty detailed in a comprehensive manner their premiums since they began writing business in Virginia. We regret that St. Paul's data was not more complete so that a clearer comparison might be shown.

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
GENERAL PRACTICE										
General Practice										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
MEDICAL SPECIALTIES										
Allergy										
St. Paul's	$1364				$1128	$1336	$1807	$2091	$2146	$2752
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Cardiovascular Diseases										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Dermatology										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Gastroenterology										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Internal Medicine										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Pediatrics										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Pediatric Allergy										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Pediatric Cardiology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Pulmonary Diseases										
St. Paul's	$1364									
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
SURGICAL SPECIALTIES										
General Surgery										
St. Paul's	$6540				$5272	$5790	$8424	$8999	$10878	$14197
Va. Reciprocal							$5577	$6373		$8861
Pa. Casualty							$7360	$6763	$6763	$7805
Neurological Surgery										
St. Paul's										
Va. Reciprocal							$8709	$13860	*	$3393
Pa. Casualty							$14720	$13526	$13526	$15610

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Obstetrics and Gynecology										
St. Paul's										
Va. Reciprocal							$6583	$7595		$12290
Pa. Casualty							$8832	$8116	$8116	$9366
Opthalmology										
St. Paul's	$2374				$1911	$2174	$3097	$3097	$4069	$5243
Va. Reciprocal							$2115	$2382		$3393
Pa. Casualty							$4416	$4058	$4058	$2498
Orthepedic Surgery										
St. Paul's	$10408				$8290	$9014	$11667	$12399	$12981	$16951
Va. Reciprocal							$8709	$8819		$10575
Pa. Casualty							$11776	$10821	$10821	$12488
Otolaryngology										
St. Paul's										
Va. Reciprocal							$5638	$6373		$8861
Pa. Casualty							$5152	$4734	$4734	$5464

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Plastic Surgery										
St. Paul's										
Va. Reciprocal							$6583	$7595		$8861
Pa. Casualty							$8832	$8116	$8116	$9366
Colon and Rectal Surgery										
St. Paul's										
Va. Reciprocal							$3465	$3682		$5333
Pa. Casualty							$7360	$6763	$6763	$7805
Thoracic Surgery										
St. Paul's										
Va. Reciprocal							$8709	$8819		$10575
Pa. Casualty							$8832	$8116	$8116	$9366
Urology										
St. Paul's										
Va. Reciprocal							$4551	$3926		$4300
Pa. Casualty							$5152	$4734	$4734	$5464

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
OTHER SPECIALTIES										
Aerospace Medicine										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Anesthesiology										
St. Paul's										
Va. Reciprocal							$6882	$6373		$8861
Pa. Casualty							$7360	$6763	$6763	$7805
Child Psychiatry										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Diagnostic Radiology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Forensic Pathology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Neurology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Occupational Medicine										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561
Psychiatry										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	$1561

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Pathology										
St. Paul's										
Va. Reciprocal (no surgery)							$1267	$1385		$1702
(minor surgery)							$2115	$2382		$3393
Pa. Casualty (no surgery)							$1472	$1353	$1353	$1561
(minor surgery)							$2355	$2166	$2166	$2498
Physical Medicine and Rehabilitation										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	
General Preventive Medicine										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	
Public Health										
St. Paul's										
Va Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Radiology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty							$1472	$1353	$1353	
Therapeutic Radiology										
St. Paul's										
Va. Reciprocal							$1267	$1385		$1702
Pa. Casualty										

(* While this is the information provided in the statistics received, it looks as though it may not be accurate, perhaps it should read $13,393)

MEDICAL MALPRACTICE CLOSED CLAIM DISTRIBUTION

BY SIZE OF PAYMENT

July 1976 - 1980

Amount	Frequency	Percent
ZERO	1,967	73.5
$1 - $25,000	568	21.2
$25K - $100K	110	4.1
$100,001 - $1Mill	31	1.2
	2,676	100 %

1981 - 1983

Amount	Frequency	Percent
ZERO	3,275	78.7
$1 - $25,000	678	16.3
$25K - $100K	180	4.3
$100,001 - $1Mill	27	.7
	4,160	100 %

THE STATISTICS ABOVE SPEAK FOR THEMSELVES, AND THEY ARE DOCUMENTED BY THE BUREAU OF INSURANCE. BRIEFLY, THE FOLLOWING CONCLUSIONS ARE RELEVANT:

1. THE NUMBERS OF SUITS BEING FILED IS INCREASING (BUT SO IS THE NUMBER OF PHYSICIANS.)

2. THE NUMBER AND PERCENTAGE OF PLAINTIFFS WHO RECEIVE NO AWARD HAS INCREASED.

3. THE NUMBER AND PERCENTAGE OF THOSE RECEIVING AWARDS FROM $100,000 - $1 MILLION IS ACTUALLY DECREASING, NOT INCREASING.

VIRGINIA PHYSICIANS

NUMERICAL DISTRIBUTION

1974 - 1980

Summary: There has been a significant amount of concern that due to fear of medical malpractice litigation some physicians are leaving the "high risk" categories of their professions. The data provided with this summary shows that these concerns are notfounded in fact. These statistics have been reproduced from the following publications:

1974 - 1978	Physician Distribution and Medical Licensure in the U. S.; Published by the Center for Health Services; American Medical Association
1979	Characteristics of Physicians: Virginia; U.S. Department of Health and Human Services
1980	Physician Characteristics and Distribution in the U.S.; 1981 Edition American Medical Association

	1974	1975	1976	1977	1978	1979	1980	1981	1982
GENERAL PRACTICE									
General Practice	1,121	1,140	1,224	1,254	1,316	1,410	1,357		
MEDICAL SPECIALTIES									
Allergy	20	22	19	24	25	25	25		
Cardiovascular Diseases	95	95	104	133	149	163	165		
Dermatology	82	93	103	107	117	127	119		
Gastroenterology	30	33	38	56	66	73	75		
Internal Medicine	891	952	1,170	1,169	1,279	1,419	1,371		

	1974	1975	1976	1977	1978	1979	1980	1981	1982
Pediatrics									
	453	451	544	545	601	660	627		
Pediatric Allergy									
	12	12	16	10	12	12	9		
Pediatric Cardiology									
	8	8	10	13	13	13	11		
Pulmonary Diseases									
	47	47	53	62	72	85	82		
SURGICAL SPECIALTIES									
General Surgery									
	581	658	624	604	613	691	662		
Neurological Surgery									
	71	70	75	80	80	89	89		

	1974	1975	1976	1977	1978	1979	1980	1981	1982
Obstetrics and Gynecology	434	453	518	528	586	626	631		
Opthalmology	211	217	238	249	266	282	264		
Orthopedic Surgery	229	235	263	277	311	334	312		
Otolaryngology	118	114	123	137	141	149	144		
Plastic Surgery	53	51	54	53	63	69	66		
Colon and Rectal Surgery	6	7	9	11	10	10	11		
Thoracic Surgery	28	29	36	31	36	38	36		
Urology	127	144	151	152	166	183	164		

	1974	1975	1976	1977	1978	1979	1980	1981	1982
Occupational Medicine	36	35	32	37	40	45	41		
Psychiatry	360	412	441	444	526	596	560		
Pathology	197	197	220	226	231	265	251		
Physical Medicine and Rehabilitation	14	19	21	22	23	32	24		
General Preventive Medicine	6	10	10	5	10	15	10		
Public Health	75	76	70	66	67	78	64		
Radiology	196	198	223	219	233	256	230		

	1974	1975	1976	1977	1978	1979	1980	1981	1982
Therapeutic Radiology	17	18	25	26	26	27	26		
Other Specialty	136	157	171	233	257	279	270		
Unspecified	127	64	160	192	111	121	210		
Total Physicians	7,188	7,541	8,240	8,653	9,226	10,030	9,682		

TOPICS

1. RATE REVIEW

2. RESERVING

3. INVESTMENT INCOME

4. SPECIFIC QUESTIONS

EXHIBIT E-2

MATURE RATE CHANGES BY RATING CLASS

STATE OF VIRGINIA

(TERRITORY 1)

Rating Class	Current Rate	Proposed Rate/Change
1	1,165	1,334 14.5%
2	2,036	2,582 26.8%
3 - E.R.	3,124	3,830 22.6%
3 - Other	3,124	3,206 2.6%
4	3,324	3,206 -3.5%
5	5,518	6,326 14.6%
6 - O.B.	6,606	8,822 33.5%
6 - Other	6,606	6,326 -4.2%
7	7,694	7,574 -1.6%
8	12,047	13,192 9.5%

Estimated overall rate level change is 13.1%#

Off balance in the new class plan creates a 1.4% change in the manual rates. The overall increase is 13.1% (a class 1 change ÷ class off-balance factor or 114.5 ÷ 101.2)

1. RATE REVIEW

ASSUMED YOU ARE FAMILIAR WITH HOW THE ST PAUL ESTIMATES FUTURE LOSSES FROM PAST LOSSES.

2. RESERVING

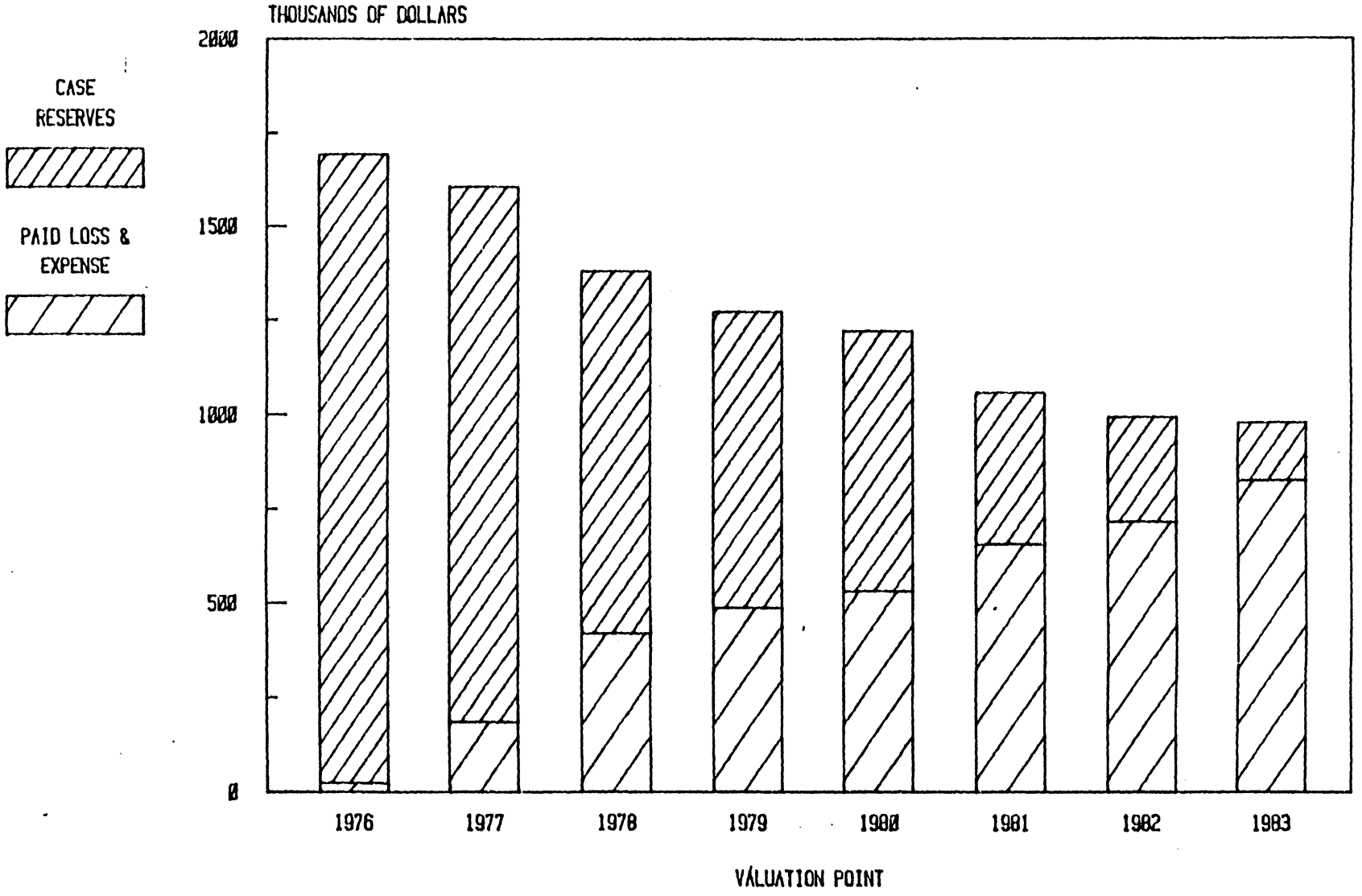
ARE THE ST PAUL MEDICAL RESERVES REDUNDANT?

LIFE CYCLE OF A CLAIM

1. RECEIVE NOTICE OF EVENT
2. IMMEDIATE INVESTIGATION
3. INITIAL RESERVE IS SET
4. IN DEPTH INVESTIGATION & FACT FINDING
5. RESERVE ADJUSTED FOR NEW FACTS
6. NEW INFORMATION MAY COME TO LIGHT
7. RESERVE ADJUSTED FOR NEW FACTS
8. SETTLEMENT

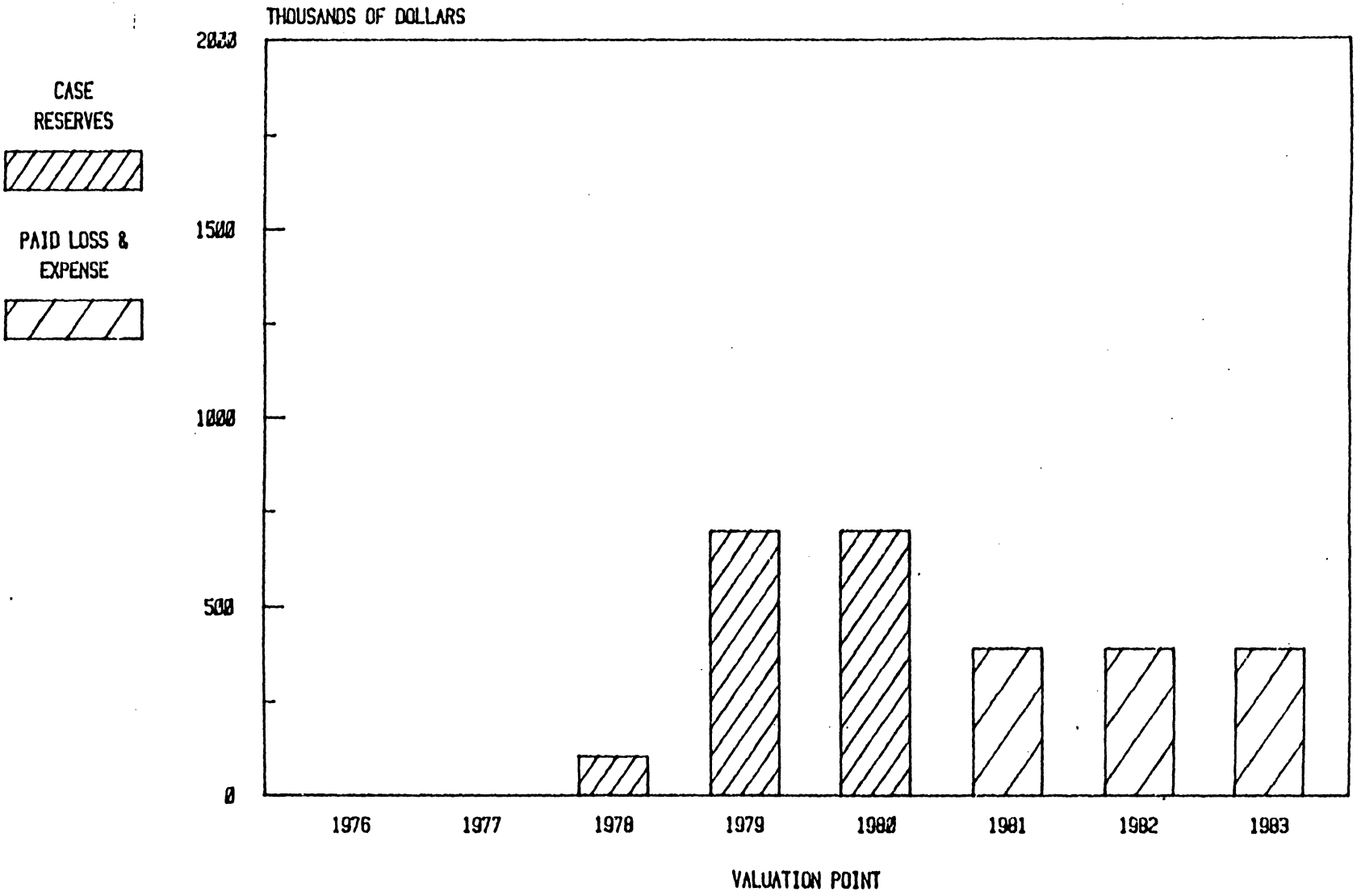
VIRGINIA CLAIMS MADE CASE DEVELOPMENT

REPORT YEAR 1976; PRIMARY LIMITS ONLY



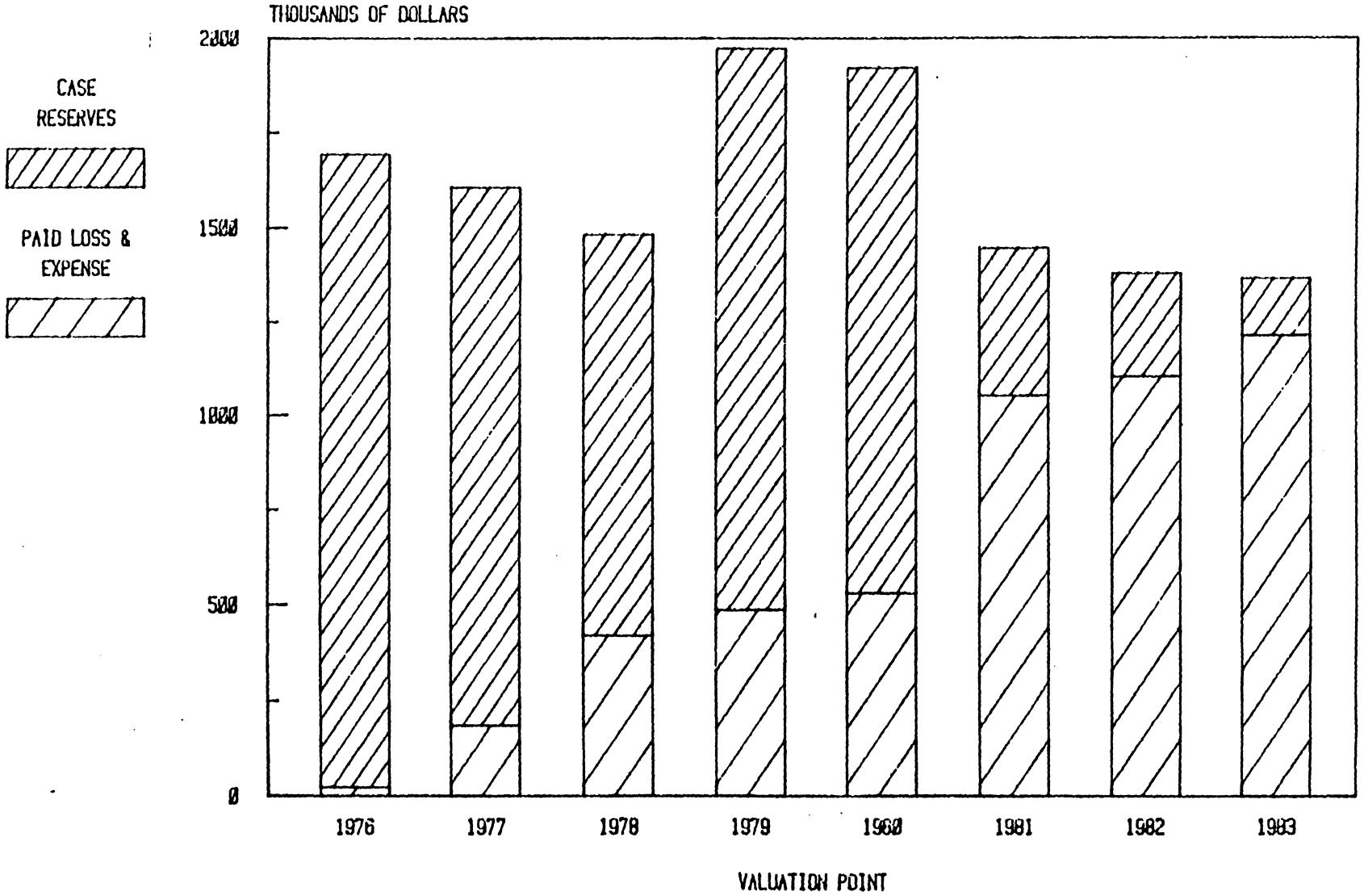
VIRGINIA CLAIMS MADE CASE DEVELOPMENT

REPORT YEAR 1976; HIGH LIMITS ONLY



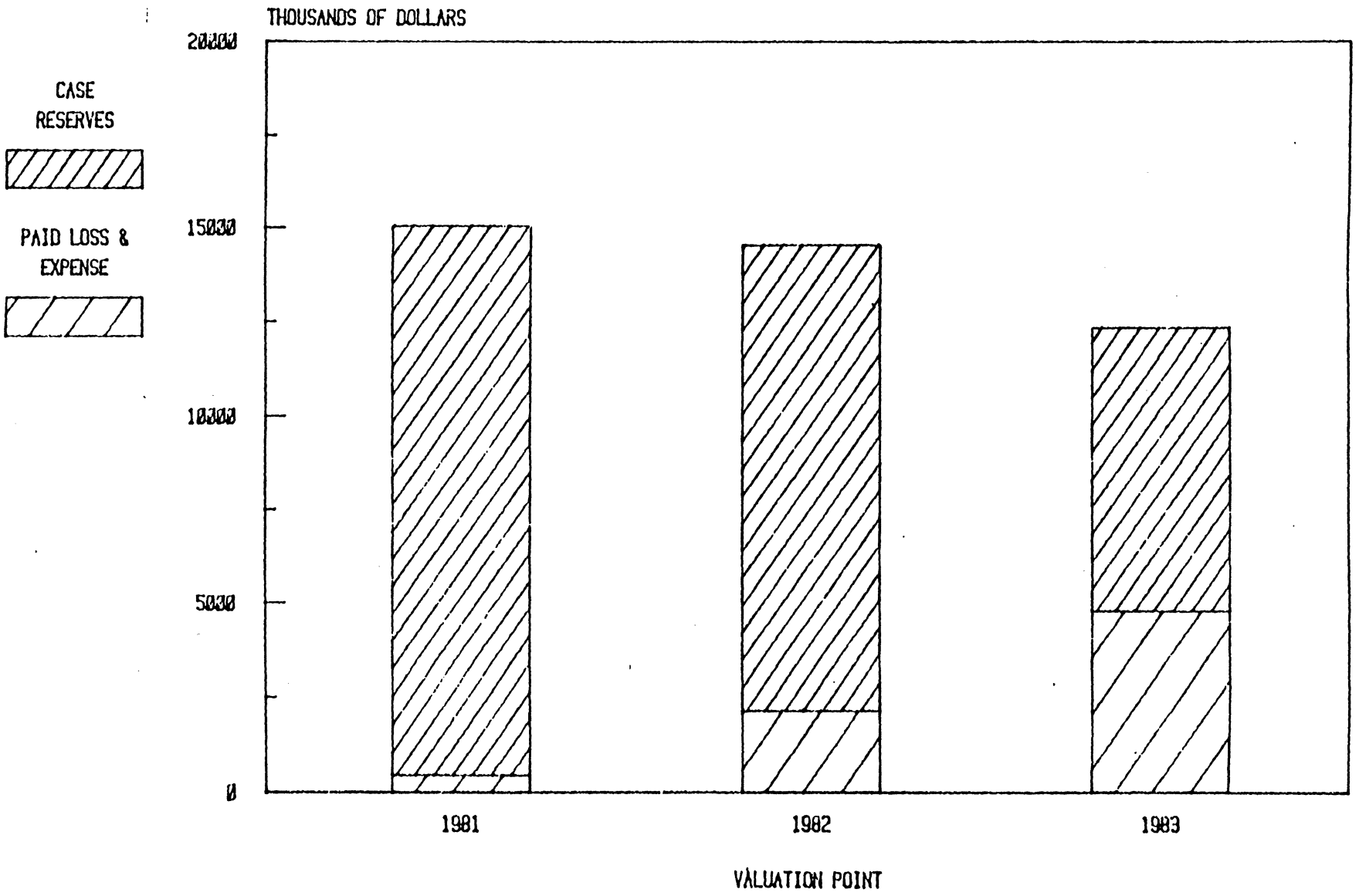
VIRGINIA CLAIMS MADE CASE DEVELOPMENT

REPORT YEAR 1976; TOTAL LIMITS ONLY



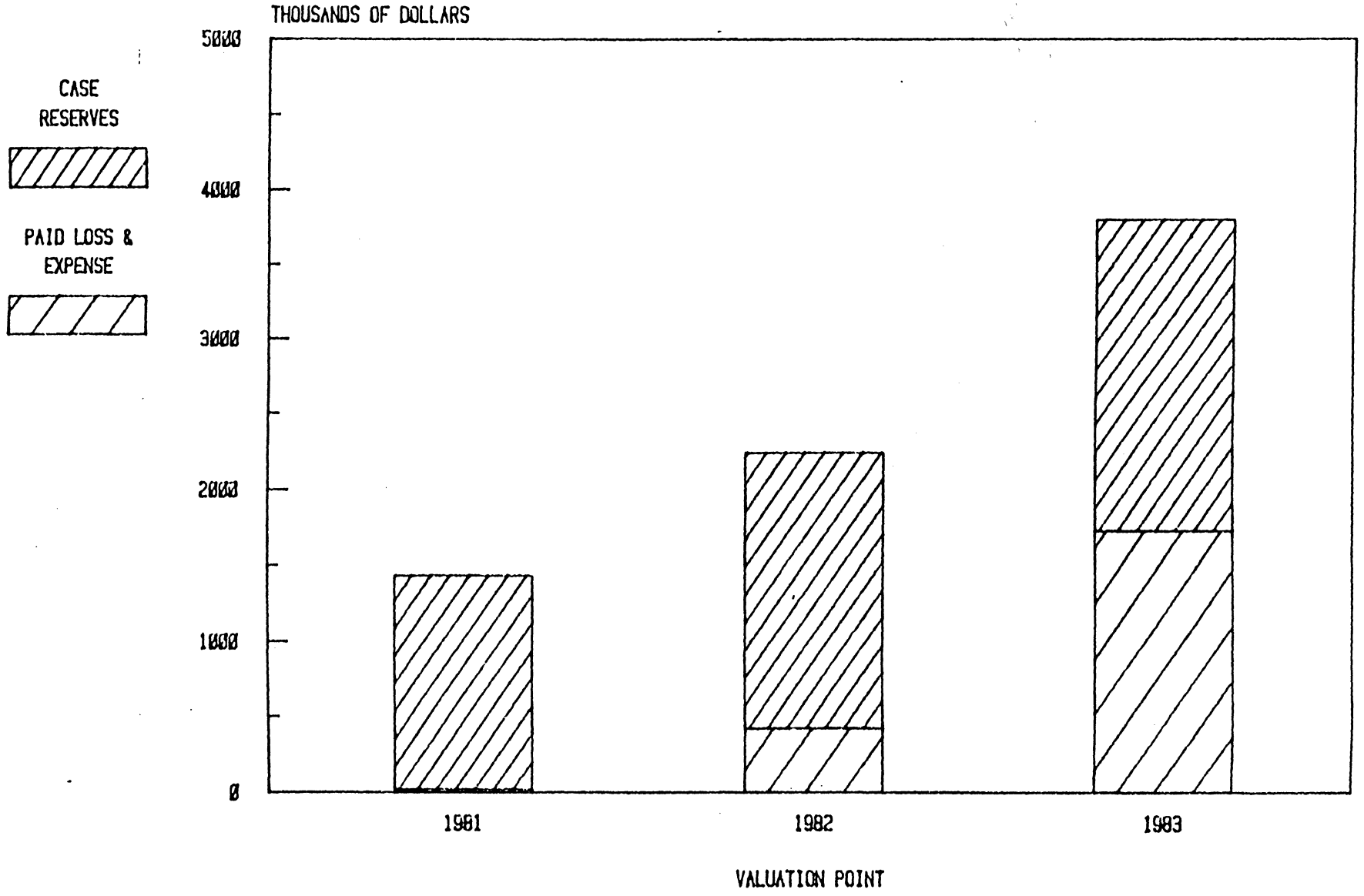
VIRGINIA CLAIMS MADE CASE DEVELOPMENT

REPORT YEAR 1981; PRIMARY LIMITS ONLY



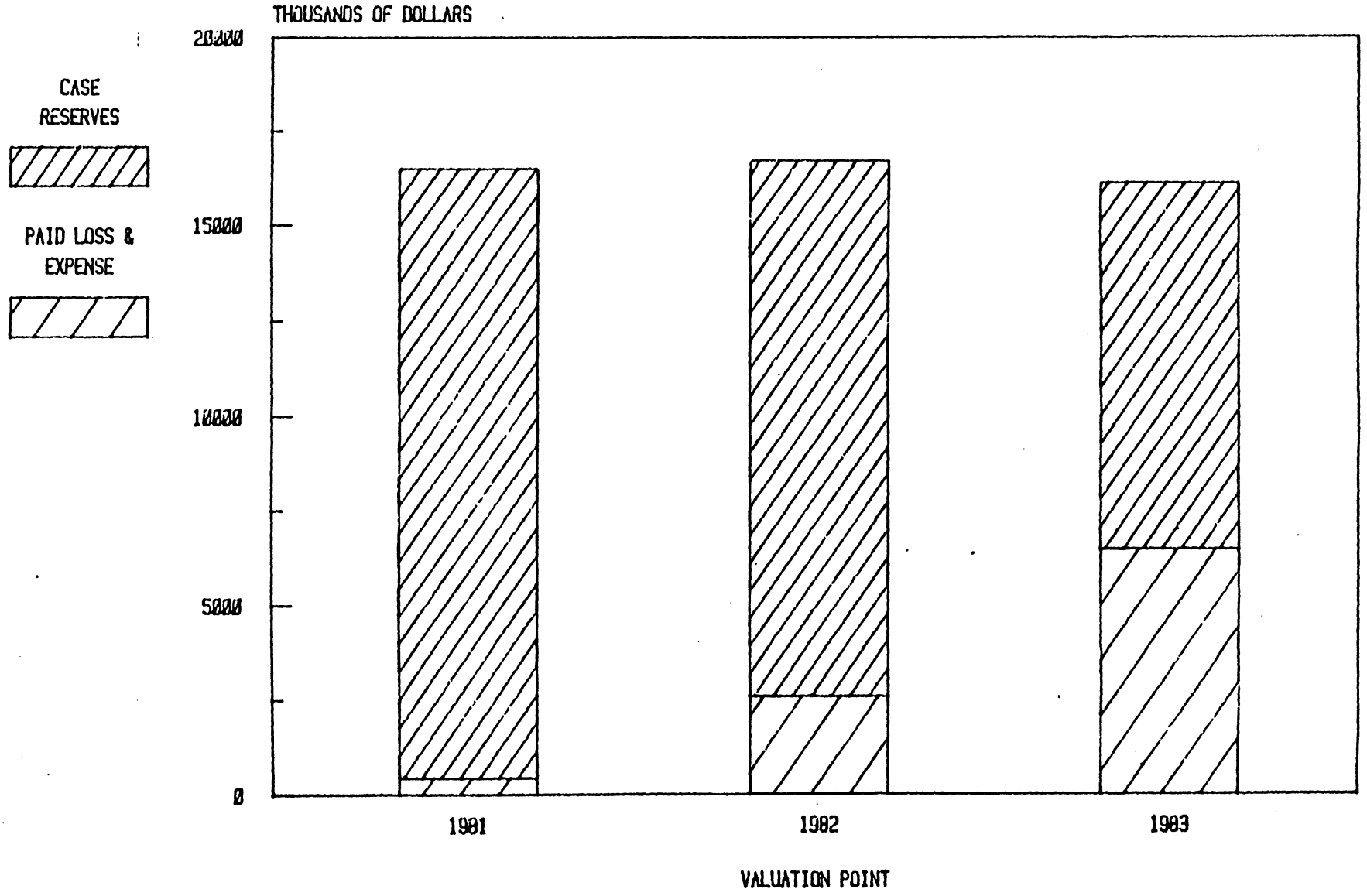
VIRGINIA CLAIMS MADE CASE DEVELOPMENT

REPORT YEAR 1981, HIGH LIMITS ONLY

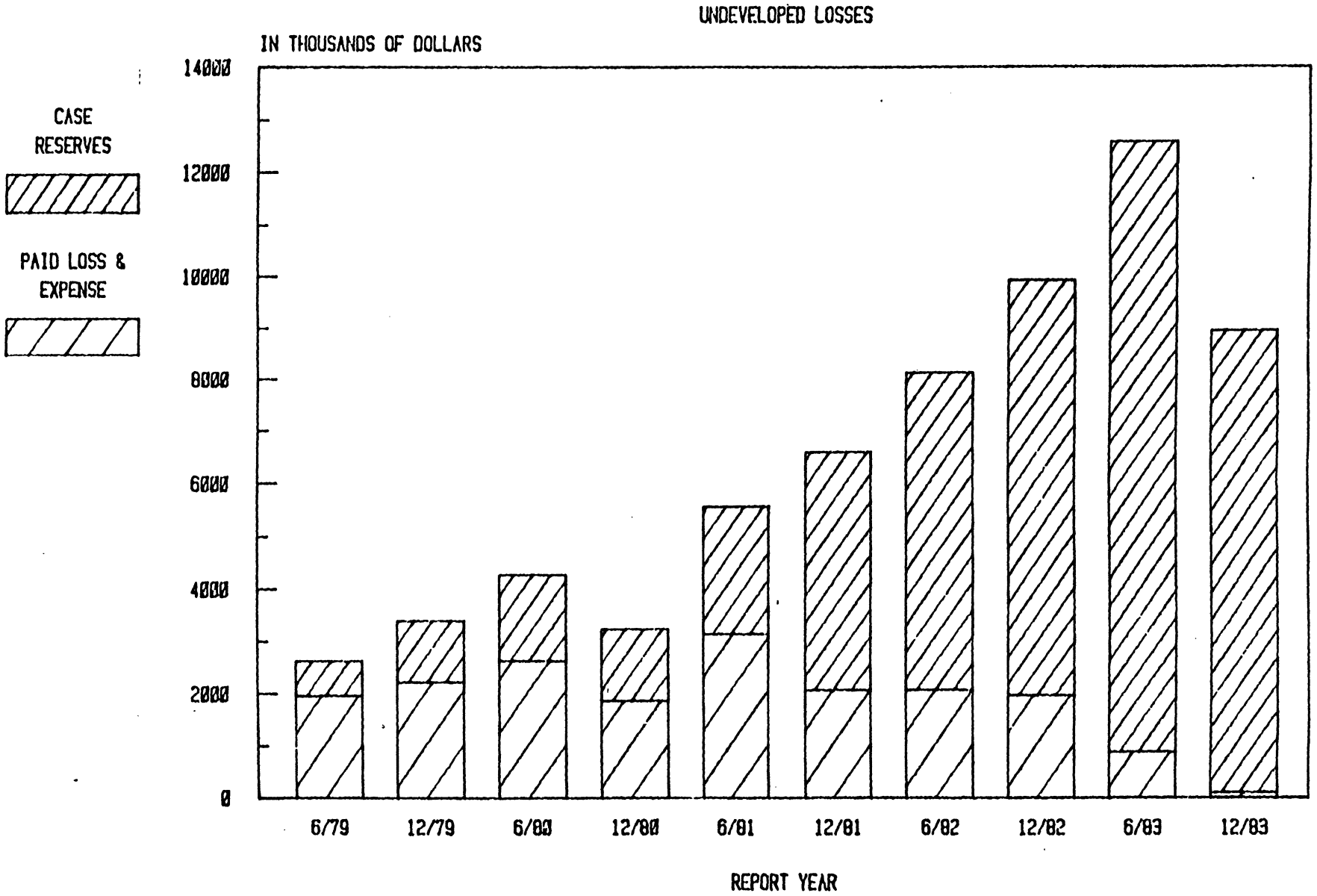


VIRGINIA CLAIMS MADE CASE DEVELOPMENT

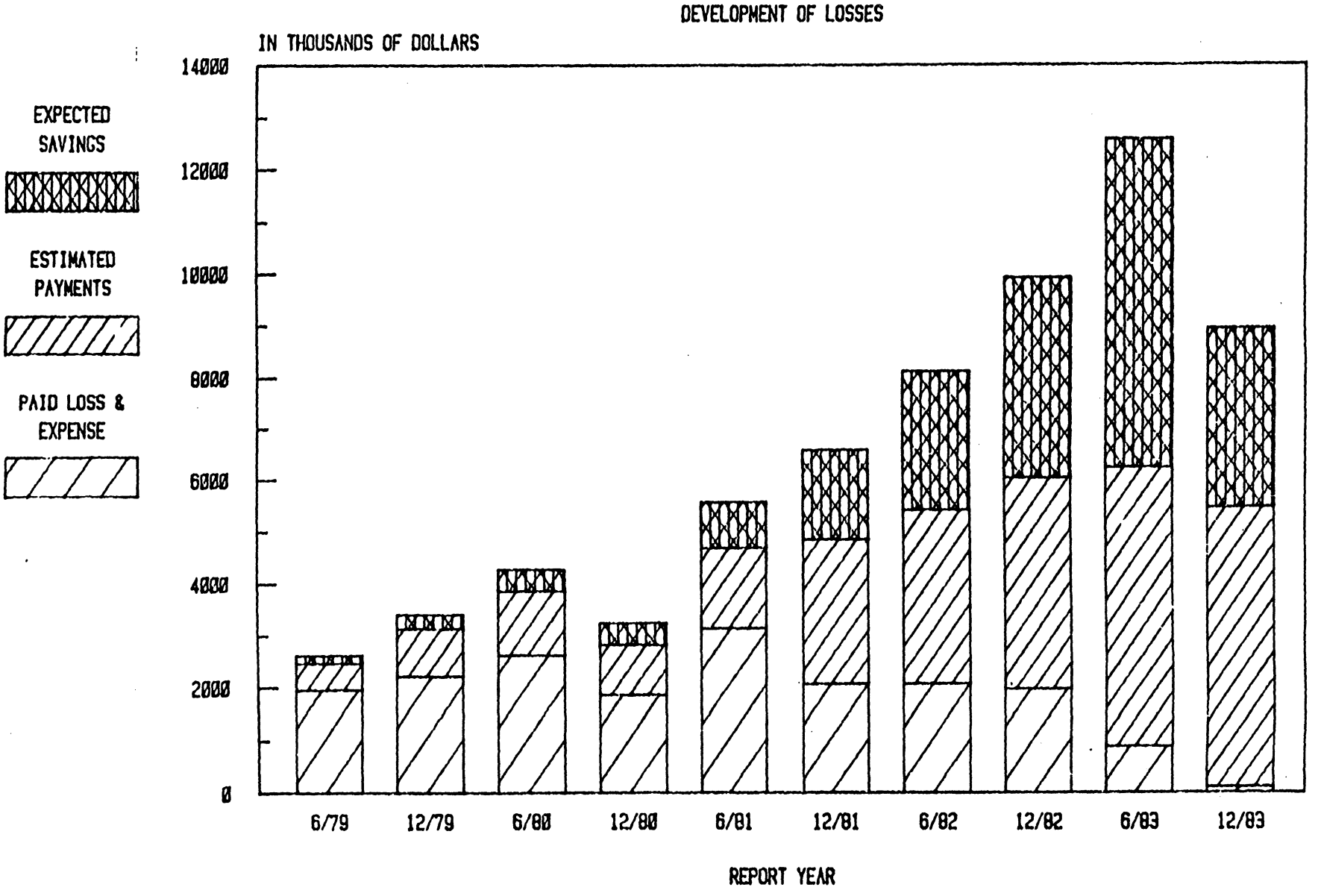
REPORT YEAR 1981; TOTAL LIMITS ONLY



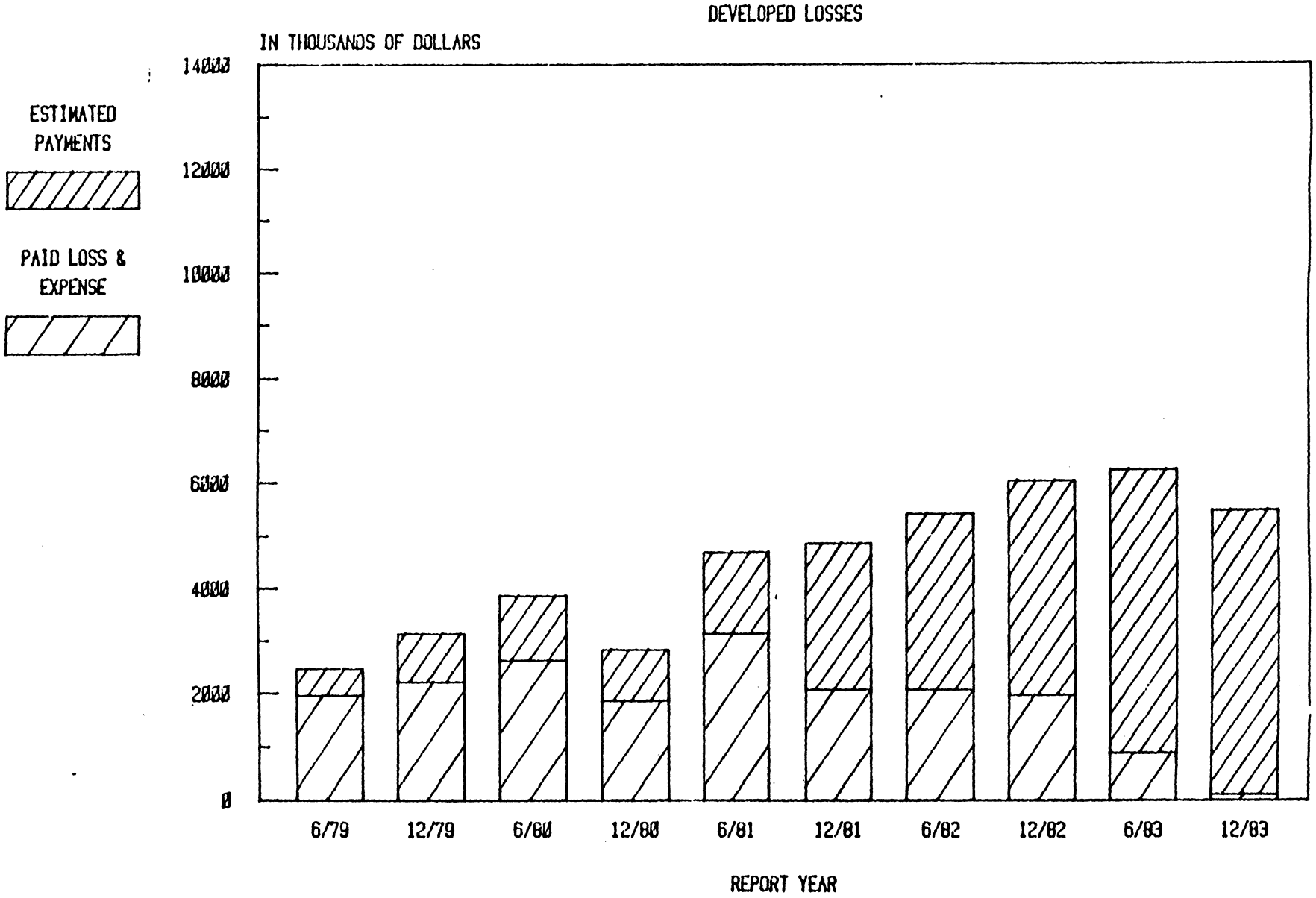
VIRGINIA FILING: CASE DEVELOPMENT



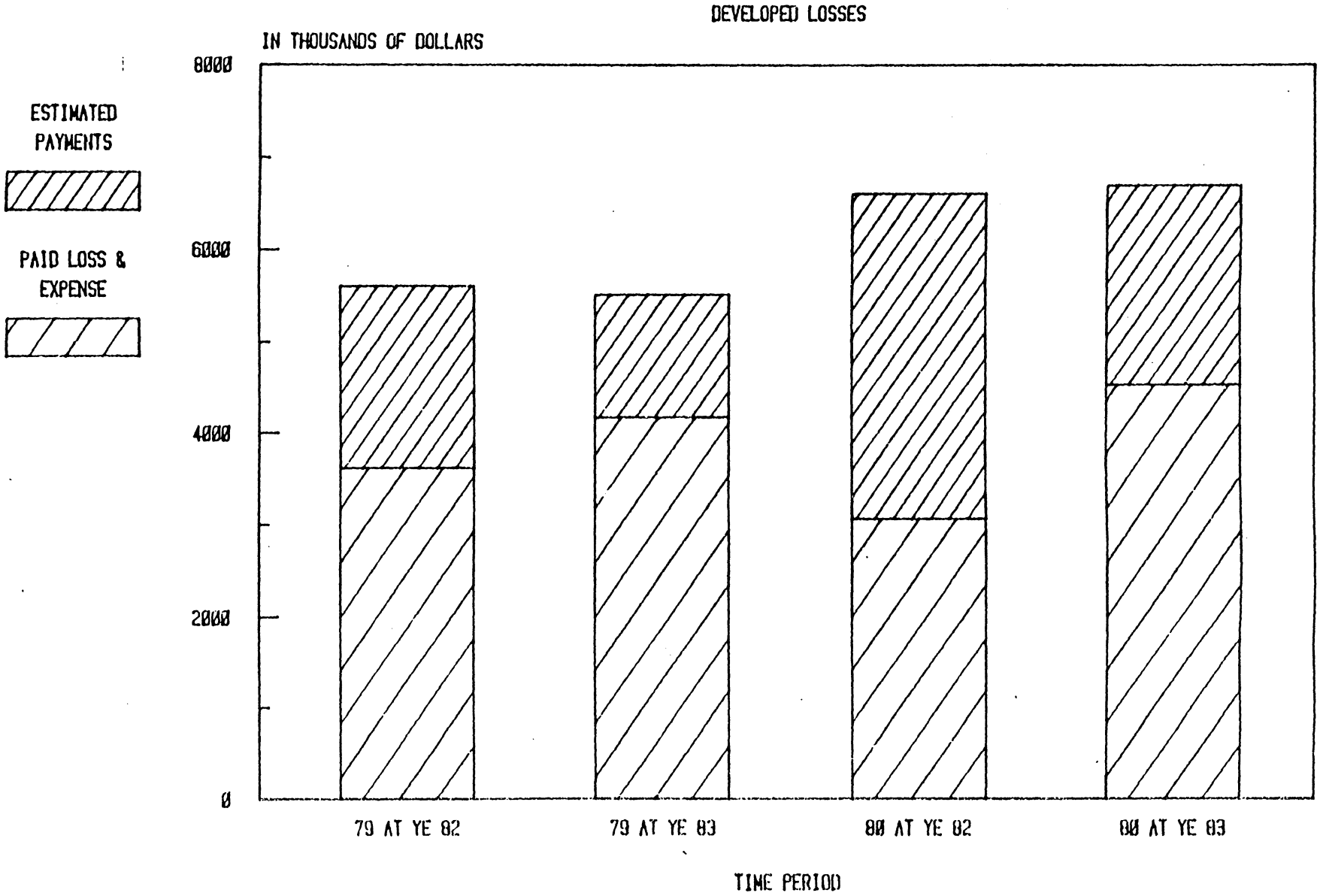
VIRGINIA FILING: CASE DEVELOPMENT



VIRGINIA FILING: CASE DEVELOPMENT



VIRGINIA DEVELOPMENT: COMPARISON



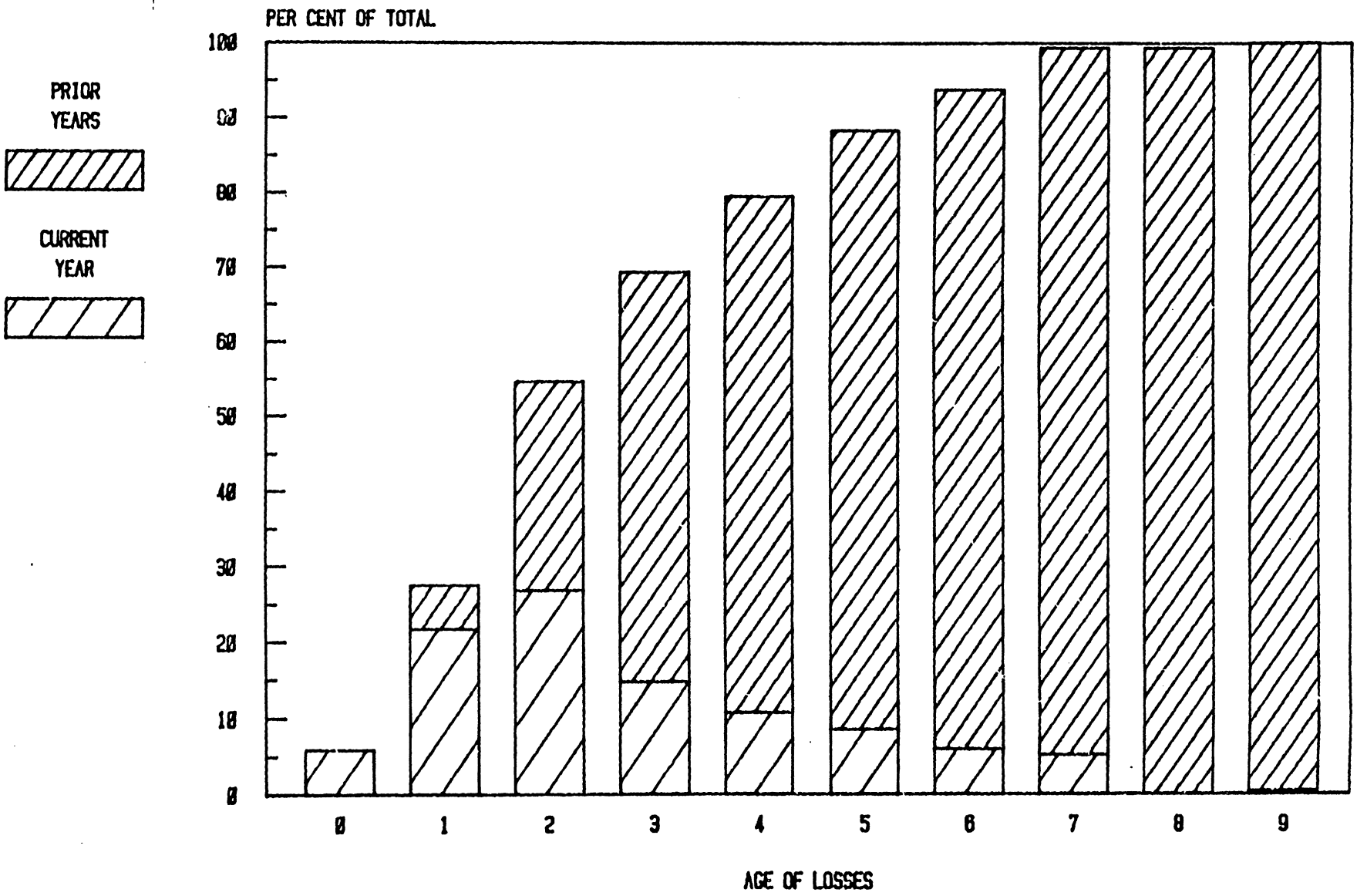
3. INVESTMENT INCOME

HOW DO WE ACCOUNT FOR

INVESTMENT INCOME?

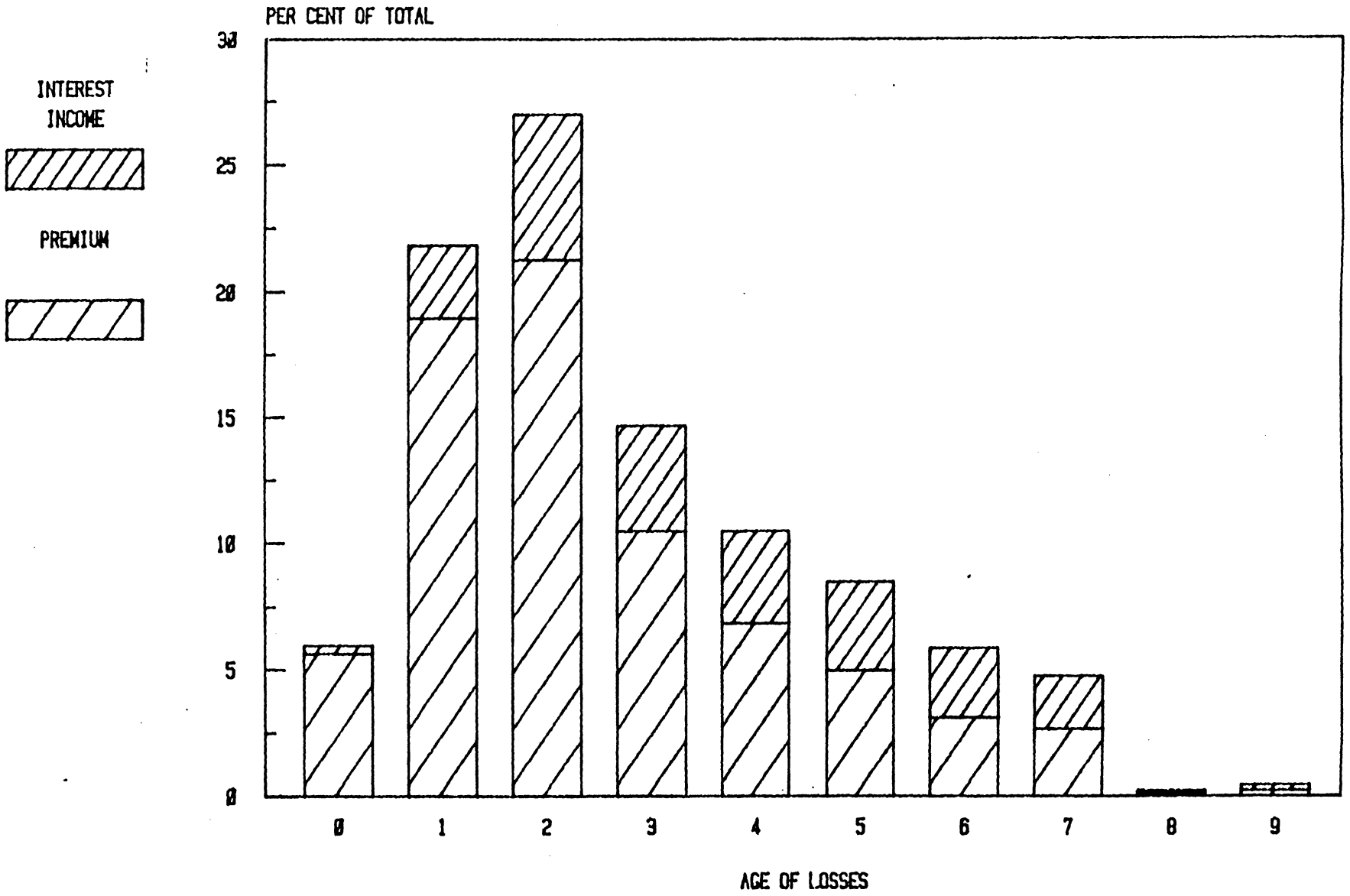
VIRGINIA P & S EXPERIENCE

ESTIMATED PAYOUT PATTERN



VIRGINIA P & S EXPERIENCE

SOURCE OF FUNDS, 10% YIELD RATE



SOURCES & USES OF CASH

SOURCES:		USES:	
PREMIUM	100	LOSSES	90.7
INTEREST		PREMIUM TAXES	2.8
INCOME	22.1	CO. EXPENSE	4.9
		FED. TAXES	3.7
		PROFIT	4.4
		ACQUISITION & PREMIUM DISC.	15.6
TOTAL	122.1	TOTAL	122.1

4. SPECIFIC QUESTIONS

A. RATE COMPARISON AMONG STATES

B. RESERVES FOR MEDICAL MALPRACTICE

C. PROFITABILITY: RETRO/DIVIDEND PLAN

APPENDIX D

The Virginia Medical Malpractice Review Panel - Present Status

By: Knloch Nelson, M.D.; R. Carter Scott, LL.B.; Richard Immel, M.A.

1. The Establishment of Medical Malpractice Review Panels in Virginia

In 1976 the General Assembly added sections 8-911 through 8-922 to Chapter 39 of Title 8 of the Virginia Code setting up Medical Malpractice Review Panels, with the objectives of reducing costs and speeding up the litigation process.

Section 8-913 states "The Medical Review Panel shall consist of (1) three impartial attorneys and three impartial health care providers licensed and actively practicing their professions in the state, and (2) one sitting judge of a circuit court who shall serve as chairman of the panel. The chairman shall have no vote except in the case of a tie vote. The medical review panel shall be selected by the Chief Justice of the Supreme Court of Virginia from a list of health care providers submitted to him by the State Board of Medicine and a list of attorneys submitted by the Virginia State Bar. In the selection of the health care provider members, the Chief Justice shall give due regard to the nature of the claim and the nature of the practice of the health care provider. The members of the medical review panel shall be sworn by the chairman to reach an opinion faithfully and fairly.

Section 8-917 defines the opinions to be rendered by such Panels.

A (i) "The evidence does not support a conclusion that the health care provider failed to comply with the appropriate standard of care;

(ii) "The evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is a proximate cause in the alleged damages;

(iii) "The evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is not a proximate cause in the alleged damages; or

(iv) "The evidence indicates that there is a material issue of fact, not requiring an expert opinion, bearing on liability for consideration by a court or jury."

B "If the review panel's finding is that set forth in subsection A(ii) of this section the panel may determine whether the claimant suffered any disability or impairment and the degree and extent thereof."

2. Number of Panels and who requested them between November 1976 and February 1982.

Five hundred (500) Panels were requested by plaintiffs and/or defendants. The styles* (Figure 1) of all but 24 of these are available.

*From the Office of the Supreme Court of Virginia, courtesy of Mr. Robert Baldwin and Mrs. Kathy Rice.

Of the remaining 476, 392 were for claims against physicians and/or hospitals; 60 against dentists; 14 against podiatrists; 4 against optometrists; 3 against pharmacists; 2 against chiropractors; and one against a nurse - a total of 84 against other than M.D.s and/or hospitals.

Between February 1982 and December 31, 1983 an additional 300 were requested. Of these we know only which side called for them.

Of this total of 776 the defendants requested 51 and the claimants 49 percent.

The rest of this study applies to physicians and/or hospitals and hospital personnel.

The number of opinions is greater than the number of styles because where there were several defendants there were several opinions a number of times.

3. Number of Defendants by Specialty

Obstetrics-Gynecology - 65; Hospital - 53; Internal Medicine - 40; Radiology - 6; Orthopedic Surgery - 55; Anesthesiology - 6; Psychiatry - 15; Emergency Room Physicians - 7; Urology - 13; General and Family Practice - 40; Neurosurgery - 14; General Surgery - 65; Plastic Surgery - 11; Pathology - 2; Neurology - 1; Dermatology - 8; Pediatrics - 6; Ophthalmology - 7; Otolaryngology - 3.

4. Nature of Claim

Failure to Diagnose - 91; Foreign Body left - 9; Lack of Informed Consent - 9; Medication Error - 47; Negligent or Improper Treatment - 131; Surgical Error - 103.

5. Action after Panels were requested*

a. Panel never met (appointed, not appointed, withdrawn, dismissed) Figure 2.

b. Panel requested by plaintiff gave opinion Figure 3.

c. Panel requested by defendant gave opinion Figure 4.

In thirteen of the 392 styles of claims against physicians and/or hospitals no further information is available.

6. Duration of Panels from request to conclusion

(Data applies to all 476 styles; several opinions in a number)

	Average in months	Range in months
Opinion given	10½	2 to 54
Settlement	9	1 to 30
Withdrawal	8½	2½ to 30
Dismissed	11	1 to 36

*Information supplied by the defense attorneys, the St. Paul Fire & Marine Insurance Companies, and the Virginia Insurance Reciprocal.

ACTION AFTER PANEL REQUESTED BUT NEVER MET
(Appointed - not appointed - withdrawn - dismissed)

	No. of Styles	Settled	No Further Action	Results of Cases Tried					No Information
				Non-* Suited	Decision for Defendant	Decision for Plaintiff	Appealed	Pending	
Requested by Defendant	62	23	33	2	1			1	2
Requested by Plaintiff	79	37	29	3		1		2	7
Total	141	60	62	5	1	1	0	3	9

*Case went to trial; one side withdrew with the option of resuming within six months.

Figure 2

ACTION AFTER PANEL HELD - REQUESTED BY PLAINTIFF
(Physicians and Hospitals only)

Panel Decision	No. of Opinions	Settled	No Further Action	Results of Cases Tried					No Further Information
				Non-Suited	Decision for Defendant	Decision for Plaintiff	Appealed	Pending	
Found for Defendant	120	26	65	6	12	2	2	5	2
Found for Plaintiff	24	16	3	0	1	3	0	1	0
Def. Failed to Comply but not prox. cause	4	4							
Need more Information	8	2	0	1	3	0	0	1	1
Total	156	48	68	7	16	5	2	7	3

Figure 3

ACTION AFTER PANEL HELD - REQUESTED BY DEFENDANT

Panel Decision	No. of Opinions	Settled	No Further Action	Results of Cases Tried					No further Information
				Non-Suited	Decision for Defendant	Decision for Plaintiff	Appealed	Pending	
Found for Defendant	92	9	60	8	11	0		3	1
Found for Plaintiff	13	7	3	1	1	1	1	1	0
Def. Failed to Comply but not prox. cause	5	2	1	1		1			
Need more Information	2	1	1						
Total	112	19	65	10	12	2	1	4	1

Figure 4

Summary

1. The finding that the plaintiffs called 49% and the defendants 51% of the panels indicates that neither group looks on them as particularly favorable to it.

2. The panel process favors the defendant, 63% of 396 requests (panels not held and those that gave an opinion).

3. The panel process avoids litigation

   127 claims were settled before trial.

   Only 73 (less than 20%) of the 396 dispositions of claims against physicians and/or hospitals went to court.

4. Significant Information not available

   a. The number of claims that would have gone to trial if the panel process had not existed:

      Out of 132 cases where a panel was requested but not held 60 were settled. Ten went to trial.

   b. The duration and costs of panels vs those of trials:

      Several defense attorneys and insurance company representatives estimate that trials last at least twice as long as panels.

MEDICAL MALPRACTICE REVIEW PANEL STATISTICS

July 1, 1976 - March 31, 1984

Number of Panels Withdrawn	215
Number of Panels Dismissed	53
Number of Panels Concluded	414
Number of Panels Outstanding	154
TOTAL	836

Panel Decisions Pursuant to the Following:

Section 8.01-581.7(1) (Decision for the Health Care Provider)	398
Section 8.01-581.7(2) (Decision for the Claimant)	56
Section 8.01-581.7(3) (See Attached)	23
Section 8.01-581.7(4) (See Attached)	18
TOTAL	495

MEDICAL MALPRACTICE REVIEW PANELS

Geographical Breakdown of Claims Against Specialties

July 1, 1976 - March 31, 1984

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6
Anesthesiology	3	8	2	2	5	-
Chiropractor	1	-	-	2	1	-
Clinical Psychologist	1	-	-	-	2	1
Colon and Rectal Surgery	1	-	-	-	-	-
Dentistry	7	54	1	23	54	9
Dermatology	1	-	3	3	3	1
Emergency Medicine	-	12	-	3	7	4
Family Practice	2	7	2	1	12	1
General Practice	7	21	4	15	33	8
General Surgery	8	34	15	17	39	31
Hospital Administrator	25	91	20	53	101	56
Internal Medicine	12	37	6	19	36	16
Neurology	2	5	-	1	-	1
Neurosurgery	1	11	3	7	17	4
Nurse	12	17	1	17	17	7
Nursing Home Administrators	-	4	-	3	1	1
Obstetrics and Gynecology	24	49	5	24	36	24
Ophthalmology	-	2	1	4	2	1
Optometrist	-	1	-	3	4	-
Orthopaedic Surgery	9	36	6	14	10	8
Otorhinolaryngology	-	8	-	-	2	4
Pathology	-	-	-	1	5	-
Pediatrics	2	3	1	2	16	1
Pharmacist	-	1	-	2	9	-
Physical Therapist	-	1	-	-	-	-
Plastic Surgery	2	5	-	3	5	2
Podiatrist	-	16	2	2	11	2
Psychiatry	6	12	-	4	28	4
Radiology	4	12	-	6	13	8
Thoracic Surgery	-	4	-	1	5	7
Urology	-	13	3	3	10	3
TOTAL	130	464	75	235	484	204

AREA 1 - CENTRAL VALLEY (CIRCUITS 16, 25 AND 26)
AREA 2 - NORTHERN VIRGINIA (CIRCUITS 17, 18, 19, 20 AND 31)
AREA 3 - PIEDMONT (CIRCUITS 10, 21, 22 AND 24)
AREA 4 - RICHMOND AREA (CIRCUITS 6, 9, 11, 12, 13, 14 AND 15)
AREA 5 - TIDEWATER (CIRCUITS 1, 2, 3, 4, 5, 7 AND 8)
AREA 6 - SOUTHWEST VIRGINIA (CIRCUITS 23, 27, 28, 29 AND 30)

HOUSE BILL NO. 896

AMENDMENT IN THE NATURE OF A SUBSTITUTE

A BILL to amend the Code of Virginia by adding in Article 4 of Chapter 8 of Title 38.1 a section numbered 38.1-389.3:1, relating to the reporting of certain medical malpractice claims.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 4 of Chapter 8 of Title 38.1 a section numbered 38.1-389.3:1 as follows:

§ 38.1-389.3:1. Certain medical malpractice claims to be reported to Commissioner; duty of Commissioner; annual report; statistical summary.--All medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing health care and any such claim closed without payment during each calendar year shall be reported annually to the Commissioner of Insurance by the insurer of the health care provider or, if there is no insurer, by the health care provider. The reports shall not identify the parties.

The report to the Commissioner shall state the

following in a format prescribed by him:

1. Nature of claim and damages asserted;

2. Principal medical and legal issues;

3. Attorneys' fees and expenses incurred in connection with the claim or defense to the extent these amounts are known;

4. The amount of the settlement or judgment;

5. The specialty of each health care provider and

6. Any other pertinent and relevant information which the Commissioner may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. Each annual report shall be a matter of public record.

#

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact §§ 8.01-581.1, 8.01-581.3 and 8.01-581.6 of the Code of Virginia, relating to medical malpractice review panels; impartiality of members; oath; conduct of proceedings.

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-581.1, 8.01-581.3 and 8.01-581.6 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-581.1. Definitions.--As used in this chapter:

~~1.~~ "Health care provider" means a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist or a nursing home as defined in § 54-900 of the Code of Virginia except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination, or an officer, employee or agent thereof acting in the course and scope of his employment.

~~2.~~ "Physician" means a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 12 (§ 54-273 et seq.) of Title 54.

~~3.~~ "Patient" means any natural person who receives or

should have received health care from a licensed health care provider except those persons who are given health care in an emergency situation which exempts the health care provider from liability for his emergency services in accordance with § ~~54-276.9~~ 8.01-225 of the Code of Virginia.

~~4.~~ "Hospital" means a public or private institution licensed pursuant to Chapter ~~16~~ 5 (§ ~~32-297~~ 32.1-123 et seq.) of Title ~~32~~ 32.1 or Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 ~~or subject to the provisions of Chapter 10 (§ 32-147 et seq.) of Title 32~~ .

~~5.~~ "Malpractice" means any tort based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

~~6.~~ "Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.

~~7.~~ "Impartial attorney" means an attorney who has not represented ~~,~~ ~~a.~~ (i) the claimant, his family, his partners, co-proprietors or his other business interests ~~,~~ or ~~b.~~ (ii) the health care provider, his family, his partners, co-proprietors or his other business interests.

~~8.~~ "Impartial health care provider" means a health care provider who has not ~~,~~ ~~a.~~ (i) examined ~~or~~ , treated or been consulted regarding or anticipates examining ~~or~~ , treating or being consulted regarding the claimant or his

family ~~;~~ or ~~b.~~ (ii) been an employee, partner or co-proprietor of the health care provider against whom the claim is asserted.

§ 8.01-581.3. Certificate of parties; composition, selection, oath, etc., of panel.--Upon certification by the parties that discovery has been completed, the Chief Justice of the Supreme Court shall appoint a medical review panel. Such certification shall not of itself preclude the taking of additional discovery in the event an action is subsequently filed. The medical review panel shall consist of (i) three impartial attorneys and three impartial health care providers, licensed and actively practicing their professions in the Commonwealth and (ii) one sitting or one retired judge of a circuit court who shall serve as chairman of the panel. The chairman shall have no vote except in the case of a tie vote. The medical review panel shall be selected by the Chief Justice from a list of health care providers submitted to him by the State Board of Medicine and a list of attorneys submitted by the Virginia State Bar. In the selection of the health care provider members, the Chief Justice shall give due regard to the nature of the claim and the nature of the practice of the health care provider. ~~The members of the medical review panel shall be sworn by the chairman to render an opinion faithfully and fairly.~~

The written notification to the panel members of selection by the Chief Justice shall include the definitions of "impartial attorney" and "impartial health care provider"

as contained in § 8.01-581.1 and a copy of the oath to which the panel members will be required to subscribe when the panel convenes. The oath shall be as follows:

"I do solemnly swear (or affirm) that I am aware of nothing which prevents me from being impartial. I further swear (or affirm) that I will render an opinion faithfully and fairly on the basis of the evidence presented, applying any professional expertise I may have, giving due regard to the nature of the claim and the nature of the practice of the health care provider."

§ 8.01-581.6. Conduct of proceedings.--In the conduct of its proceedings:

1. The testimony of the witnesses shall be given under oath. Members of the medical review panel, once sworn, shall have the power to administer oaths.

2. In the event a hearing is held, the parties are entitled to be heard, to present relevant evidence, and to cross-examine witnesses to the extent necessary to enable the panel to render an opinion as specified in § 8.01-581.7. The rules of evidence need not be observed. The medical review panel may proceed with the hearing and render an opinion upon the evidence produced, notwithstanding the failure of a party duly notified to appear.

3. The medical review panel may issue or cause to be issued, on its own motion or on application of any party, subpoenas for the attendance of witnesses and for the production of books, records, documents, and other evidence. Subpoenas so issued shall be served and, upon application by

a party or the panel to a court of proper venue having jurisdiction over a motion for judgment based on such claim, enforced in the manner provided for the service and enforcement of subpoenas in a civil action. All provisions of law compelling a person under subpoena to testify are applicable.

4. [Repealed.]

5. The hearing shall be conducted by all members of the medical review panel unless the parties otherwise agree. A majority of the members present may determine any question and may render an opinion.

6. The medical review panel members may apply their expertise in evaluating the evidence giving due regard to the nature of the claim and the nature of the practice of the health care provider, whether expert medical opinions are presented by the parties or not.

#

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact § 8.01-38 of the Code of Virginia, relating to tort liability of hospitals; limitations.

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-38 of the Code of Virginia is amended and reenacted as follows:

§ 8.01-38. Tort liability of hospitals; limitations.--Hospital as referred to in this section shall include any institution within the definition of hospital in § 32.1-123 of the Code of Virginia.

No hospital, as defined in this section, shall be immune from liability for negligence or any other tort on the ground that it is a charitable institution unless (i) such hospital renders exclusively charitable medical services for which service no bill for service is rendered to, nor any charge is ever made to the patient, or ~~unless~~ (ii) the party alleging such negligence or other tort was accepted as a patient by such institution under an express written agreement executed by the hospital and delivered at the time of admission to the patient or the person admitting such patient providing that all medical services furnished such patient are to be supplied on a charitable basis without financial liability to the patient ~~; provided,~~ .

However, ~~that~~ notwithstanding the provisions of § 8.01-581.15 a hospital which is exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States Code (Internal Revenue Code of 1954) and which is insured against liability for negligence or other tort in an amount not less than $500,000 for each occurrence shall not be liable for damage in excess of the limits of such insurance.

#

HOUSE JOINT RESOLUTION NO.....

Continuing the joint subcommittee studying Virginia's medical malpractice laws.

WHEREAS, House Joint Resolution No. 20, passed during the 1984 Session of the General Assembly, created a joint subcommittee to study and evaluate the laws of the Commonwealth as they pertain to medical malpractice; and

WHEREAS, the joint subcommittee identified several areas of the law on which to focus the study, including a review of the insurance rate-making process, the need for reinstitution of a closed-claim data reporting requirement, the effect of the use of malpractice review panels and the need for their continuation, the desirability of modifying certain practices and procedures before the panel and at trial, the effect of the law governing the standard of care to be applied in malpractice actions and the qualification of expert witnesses, an evaluation of the effect of the limitation on recovery and application of the collateral source rule and the desirability of modifying the law pertaining to the statute of limitations in malpractice actions; and

WHEREAS, the joint subcommittee met on several occasions to hear testimony from interested persons including representatives of the insurance industry,

actuaries, attorneys, physicians, nurses and other health care providers and from consumers of health care services; and

WHEREAS, the joint subcommittee was able to formulate recommendations regarding certain of these issues for consideration by the 1985 Session of the General Assembly; and

WHEREAS, because of the complexity of the issues and interests involved and the vast amount of relevant information available, the joint subcommittee was not able to formulate recommendations on all of the issues; and

WHEREAS, substantial progress was made by the joint subcommittee toward making these recommendations and solidifying the necessary working relationship among the affected interest groups; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the joint study of Virginia's medical malpractice laws is continued. The membership of the joint subcommittee shall remain the same, with any vacancy being filled in the same manner as the original appointment. The joint subcommittee shall complete its study in time to submit its recommendations to the 1986 Session of the General Assembly.

The direct and indirect costs of this study are estimated to be $12,035.

#

Endorsed

APPENDIX F

MEMORAND

DATE: August 28, 1984

TO: PCC PRODUCERS

FROM: GENE O. SMITH, ASSISTANT VICE PRESIDENT - MARKETING

SUBJECT: OB/GYN PHYSICIANS

Effective immediately there will be some changes in our underwriting procedures on new business for the above class of physicians written under our Individual Physicians Professional Liability Program. This is due to adverse loss experience and the extremely long tail associated with claims on this class. These changes are:

1. Claims made coverage only will be considered.
2. No prior acts coverage will be written.
3. For Ob/Gyn's with prior claims history, coverage will be declined.

In addition, the following criteria will be applied to renewals:

1. Ob/Gyn's with a claims history while an insured of our company will be reviewed for non-renewal.
2. Occurrence policies will not be renewed but if the Ob/Gyn is otherwise acceptable, claims made coverage may be offered.

I apologize for any inconvenience that these changes may cause. I am sure though that you recognize this as another indication that the market is firming up.

GOS/sa

APPENDIX F

MEMORANDUM

DATE: October 26, 1984

TO: PHICO/PCC PRODUCERS

FROM: GENE O. SMITH, ASSISTANT VICE PRESIDENT-MARKETING

SUBJECT: PHYSICIAN AND INSTITUTIONAL UNDERWRITING CHANGES

Based upon the deterioration of our experience in our Professional Liability line of business, our Company has found it necessary to implement certain changes. These steps are being taken to preserve a viable market for your use and to allow our company to continue to aggressively seek good business as well as retain our established renewal business within the program changes listed below.

Physicians' Professional Liability

1. Effective November 1, 1984, we will not accept any Prior Acts' coverage over four years. During 1985 our Company will seek on a state-by-state basis approval for an adequate rate charge for Prior Acts' beyond four years. This position on Prior Acts' coverage will remain until such time as we receive approval for this additional charge for Prior Acts.'
2. Our company will consider claims-made coverage only on a new business and will begin converting occurrence renewal policies to a claims-made basis beginning with January 1, 1985, renewals. Our company will continue to accept submissions for occurrence coverage which are received in our office prior to November 1, 1984.
3. Beginning with policy year 1985, we will discontinue all physician dividend programs in all states, with the exceptions of Delaware and Vermont. We will continue to honor the prior policy year plans that were in effect for those prior policy years, but we will not continue any additional plan years beyond year-end 1984.
4. Our company has noted an alarming difference in the experience of hospital based & group physicians as opposed to the self-standing doctor. Therefore we will no longer write new self-standing independent physicians. We will, however, continue to consider Physician groups under the following criteria;
   (a) Contact or employed physicians of an institutional client.
   (b) Staff physician programs subject to controlled risk management of an insured institution. (Consult your Marketing Representative for futher details on this program.)
   (c) Organized physician groups consisting of five or more physician members subject to a Risk Managment Program.

   Our Company will, however, continue to accept self-standing independent physician submissions which are received in our office prior to November 1, 1984, regardless of the policy effective date.

5. Effective 1/1/85 all physician groups (other than full-time equivalency-rated groups or where General Liability is provided) will be converted to the PPL master policy. Previous groups written under a CHL policy form required a replacing physician in certain cases, to pay the tail costs for a departing doctor by charging the mature (or policy year) claims-made rate. Under the PPL Master, each departing physician will be charged a tail premium in much the same manner as if an individual policy was purchased. Newly added physicians will take a first year claims-made rate under the PPL Master.

Institutional Malpractice

1. Effective immediately, claims-made coverage only will be offered.

We view these changes as both positive and consistant with our prior committments. Our company objectives remain unchanged; namely to provide for long term financial stability and growth. Any questions regarding these changes may be referred either to your Marketing Representative or the Home Office.

MALPRACTICE REVIEW PANELS
(NATIONAL DATA FROM THE AMERICAN TRIAL LAWYERS ASSOCIATION)

Voluntary, Binding (4)

- Alabama
- Alaska
- Arkansas (binding only if parties agree in advance)
- * Illinois (binding only if parties agree in advance)

Voluntary, Non-Binding (9)

- Connecticut
- Kansas
- Maine
- Michigan
- Nebraska
- Pennsylvania
- Vermont
- Virginia

Mandatory (15)

- Arizona (waivable)
- * Florida
- Hawaii (non-binding)
- Idaho (non-binding)
- Indiana
- Louisianna
- Maryland (non-binding)
- Missouri
- Montana (non-binding)
- Nevada - Repealed 1981
- New Jersey
- New Mexico
- Ohio
- Tennessee (waivable)
- Wisconsin (binding if parties agree)

California and Michigan require an arbitration agreement to be offered to a patient.

* State provision held unconstitutional.

STATUTE OF LIMITATIONS[1]

(NATIONAL DATA FROM THE AMERICAN TRIAL LAWYERS ASSOCIATION)

Date of Discovery, With Limitation

Alabama	- 6 months from discovery; maximum 4 years from act
Arkansas	- Foreign object only; 1 year from discovery
California	- 1 year from discovery; maximum 3 years from act, unless concealment, fraud or foreign object
Colorado	- 2 years from discovery; maximum 3 years from act unless concealment or foreign object - 2 years from discovery
Connecticut	- 2 years from discovery; maximum 3 years from act except concealment - 3 years from discovery
Florida	- 2 years from act or discovery; maximum 4 years from act unless fraud, concealment or misrepresentation - 2 years from discovery; maximum 7 years from act
Hawaii	- 2 years from discovery; maximum 6 years from act
Idaho	- Foreign object; and concealment only - 1 year from discovery; maximum 2 years from act
Illinois	- 2 years from discovery; maximum 4 years from act
Iowa	- 2 years from discovery; maximum 6 years from act unless foreign object
Kansas	- 2 years from act; maximum of 4 years (contract) or 10 years (other) from discoverability
Kentucky	- 1 year from discovery; maximum 5 years from act
Louisiana	- 1 year from act or discovery; maximum 3 years from act
Maryland	- Shorter of 5 years from act, 3 years from discovery
Montana	- 3 years from act or discovery; maximum 5 years from act unless act not disclosed
Nebraska	- 2 years from act, 1 year from discovery; maximum 10 years from act

North Carolina - 3 years from act, 1 year from discovery; maximum 10 years from act

North Dakota - 2 years from discovery; maximum 6 years from act unless fraud

Oklahoma - 2 years from discovery; if brought more than 3 years after act, damages limited to actual medical/surgical expenses

Oregon - 2 years from discovery; maximum 5 years from act unless fraud

South Carolina - 3 years from discovery; maximum 6 years from act

Tennessee - 1 year from discovery; maximum 3 years from act unless fraud or foreign object

Utah - 2 years from discovery; maximum 4 years from act unless foreign object or fraud - 1 year from discovery

Vermont - 3 years from act, 2 years from discovery; maximum 7 years unless fraud or foreign object

Washington - 3 years from act, 1 year from discovery; maximum 8 years from act

Wisconsin - 3 years from act, 1 year from injury; maximum 5 years unless concealment or foreign object

Date of Discovery, No Limitation

Arizona - Foreign object and intentional fraud only; 3 years

Georgia - Foreign object only; 1 year

Maine - 2 years

Michigan - 6 months

Mississippi - 2 years

Missouri - Foreign object only; 2 years

Nevada - 2 years

*New Hampshire	- Foreign object only; 2 years
New York	- Foreign object only; 1 year
Rhode Island	- 1 year
(W. Virginia	- Judicial application of discovery rule)
Wyoming	- 2 years

Special Provision for Minors

Alabama	- Under 4, by 8th birthday
Arizona	- Tolled until 7th birthday
Arkansas	- By 19th birthday
California	- Under 6, by longer of 3 years or by 8th birthday
Colorado	- Under 6, by 8th birthday
Delaware	- By 6th birthday
Indiana	- Under 6, tolled until 8th birthday
Maryland	- Under 16, tolled until 16th birthday
Massachusetts	- Under 6, tolled until 9th birthday
Mississippi	- Tolled until 18th birthday
Missouri	- Under 10, by 12th birthday or maximum of 10 years from act
Nevada	- Tolled until 10th birthday if brain damsage or birth defect; 2 years from discovery for sterility
*New Hampshire	- Under 8, until 10th birthday
*New Mexico	- Under 6, until 9th birthday
Ohio	- Under 10, until 14th birthday
Rhode Island	- By 19th birthday
Texas	- Under 12, until 14th birthday

[1]Includes only those states having special limitations provisions for medical malpractice cases.

*State provision held unconstitutional

STANDARD OF CARE IN MEDICAL MALPRACTICE ACTIONS[1]

(National Data from the American Trial Lawyers Association)

National Standard
- Alabama[2]

Same Specialty
- Alaska
- Arkansas
- Florida
- Idaho
- Louisiana
- Massachussetts
- Nebraska
- *New Hampshire
- Tennessee

Statewide Standard
- Arizona
- Virginia[3]
- Washington

Same/Similar Community (Locality)
- Arkansas
- Delaware
- Florida
- Idaho
- Indiana
- Louisiana
- Massachussetts
- Nebraska
- Nevada
- North Carolina
- Tennessee
- Virginia[3]

[1]Includes only those states with a special statute governing medical malpractice claims.

[2]Judicial construction. Drs. Lane, et el v. Otis, 412 So.2d 254 (1982).

[3]Unless locality rule shown, by preponderance, to be more appropriate §8.01-581.2.

*State provision held unconstitutional.

LIMITATION ON RECOVERY
(NATIONAL DATA FROM THE AMERICAN TRIAL LAWYERS ASSOCIATION)

Periodic Payments Required (9)

Alabama
Alaska
Arkansas
California
Delaware
Kansas
Maryland
* New Hampshire
Washington

Limitation on Attorneys Fees (16)

Arizona
Delaware
Florida
Hawaii
Indiana
Iowa
Kansas
Maryland
Nebraska
* New Hampshire
New York
Oregon
Pennsylvania
Tennessee
Washington
Wisconsin

Limitation on Non-Ecomonic Losses (3)

California ($250,000)
* New Hampshire ($250,000)
New Mexico ($500,000)

Limitation on Recovery (16)

* Florida ($200,000/$500,000 + fund to $10 million)
* Idaho ($150,000/$300,000; common law negligence only)
* Illinois ($500,000; excess fund for $100,000 to $500,000)
Indiana ($100,000/$300,000 + fund to $500,000)
Kentucky ($100,000 + fund with no limit)
Louisianna ($100,000/$500,000 + fund with no limit)
Nebraska ($1 million + fund to $6 million)
New Mexico ($100,000 + fund to $500,000)
* North Dakota ($300,000 per occurance + fund for $100,000 to $300,000)
* Ohio ($200,000 for general damages, non-death cases)
Oregon ($100,000/$300,000 + fund with no limit)
South Carolina ($100,000/$300,000 + fund with no limit)
Virginia ($1 million)
Wisconsin ($200,000 or insurance + fund)
Wyoming ($50,000 + fund to $1 million)

* State provision held unconstitutional.

COLLATERAL SOURCE RULE

(National Data from the American Trial Lawyers Association)

Abolished

*Idaho
Iowa
*North Dakota

Modified

Alaska	-	Recovery limited to excess; evidence admissible after award
Arizona	-	Subrogation precluded
California	-	Subrogation precluded
Delaware	-	Evidence of public collateral sources admissible
Florida	-	Court reduces award by amount of payments receive unless payor has right of subrogation
*Kansas		
Nebraska	-	Evidence not admissible; amounts received credited against award
*New Hampshire	-	Jury reduces award by payments received less amounts paid to ensure compensation
*New York	-	Court reduces award by payments received less amounts paid to ensure compensation
*Ohio		
Pennsylvania	-	Subrogation precluded
Rhode Island	-	evidence admissible at trial
South Dakota	-	Evidence of public collateral sources and those not subject to subrogation admissible
Tennessee	-	Award reduced by collateral sources not purchased privately and individually.
Washington	-	Evidence of privately obtained insurance not admissible.

THE MEDICAL SOCIETY OF VIRGINIA

Position Paper Regarding the Current Medical Malpractice Situation in the State of Virginia

The Medical Society of Virginia would like to take this opportunity to commend the General Assembly's special study committee that has been reviewing the State's medical malpractice laws. The Society applauds the committee members for the diligence with which the committee has conducted its study. Since the medical malpractice situation is extremely complex, it is to the advantage to all concerned parties that a highly qualified group has conducted such an in-depth study.

The Society hopes that this position paper will be of help to the study committee in its deliberations. While the positions hereinafter set forth obviously cannot be completely objective, a conscious effort has been made to look at the overall situation in a realistic way. More specifically, the Society wants to emphasize that it is not trying to effect changes in the law that will deny fair compensation to any patient who has been injured as a result of a tort committed by a health care provider.[1]

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[1]Nor is the Society's goal to protect any licensed physician who is not qualified to have a license to practice medicine. We hasten to add, however, that the malpractice case involving the marginal practitioner is the exception. Most malpractice cases involve physicians who are fully qualified to practice. Even the best often are accused of malpractice.

By way of introduction, we would emphasize that all patients bear the burden of malpractice costs incurred by physicians and hospitals. The cost of malpractice insurance flows to the patient in the form of increased fees. More significantly, defensive medicine costs -- a much greater cost -- also are passed through to the patient. Finally, in a growing number of instances the fear of exposure to a malpractice claim is adversely impacting on quality of patient care. Simply put, providers in high risk specialties are becoming increasingly reluctant to perform certain procedures that admittedly involve significant risk to the patient.

We also note that while the availability of malpractice insurance is not at a crisis level today, there have been recent adverse developments regarding coverage for some physicians, especially obstetricians. And there are clear and troublesome indications that from a cost point of view the malpractice insurance situation is deteriorating rapidly. Rates have doubled in the last five years. Current trends suggest that rates will double again in the next 2-1/2 years. A summary of the actual cost in Virginia today for $1 million of coverage from St. Paul Insurance Company is attached as Exhibit A.

While the situation in our State obviously is not as troublesome as in New York, Florida or California, the Society believes that the situation here is just as fragile as it appears to be in most other states. See, for example, the recent article on the situation in Wisconsin attached as Exhibit B.

We suspect that without fundamental changes in our basic tort system, little can be done to change significantly the cost to providers and patients associated with exposure to malpractice claims. The near crisis is, in our view, founded on three basic facts that remain unchanged so long as our existing tort system is kept intact. First, the subject matter -- health care services -- inherently involves significant risks to the patient. Adverse results will be experienced by patients on a regular basis. Second, the pool of payers of insurance premiums, namely physicians and hospitals, is small, as contrasted with purchasers of homeowners or automobile liability insurance, for example.[2] Third, with scientific advancement, the practice of medicine is becoming increasingly complex. It is not possible for the typical juror to comprehend much of the information that is relevant to the question whether a particular course of treatment was or was not appropriate.

Because we believe the existing system is teetering on the brink, we intend to spend significant time and effort in the coming year trying to look in a creative way at other alternatives. We would hope that the General Assembly study committee might be continued in order to be able to evaluate any recommendations that might evolve from our efforts. Continuation of the study makes sense if, as we suspect, the increase in

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[2]A recent $1,000,000 malpractice verdict in Richmond can be looked upon as a premium cost of about $1,000 for every practicing physician in the City.

malpractice insurance premiums that will be effected in July, 1985, may even exceed the 30% increase implemented in July, 1984.

With this introduction, the Society would make the following summary assessment of the various issues considered by the study committee:

1. Is the high cost of malpractice insurance a result of excessive profits generated by malpractice carriers? There is sufficient competition among malpractice insurance carriers, and other checks and balances, to insure that the rates currently charged for malpractice insurance in the Commonwealth do not provide excessive profit to the carrier.[3] While St. Paul Insurance Company is the only commercial carrier writing significant coverage in the State, it has been facing intense competition from two non-profit provider controlled entities. In addition, annual review of rate filings by the actuary retained by the Commissioner of Insurance as well as by the national actuarial firm retained by The Medical Society of Virginia prevents improper rate setting. Further, any over-reserving by St. Paul no longer can inure to its benefit under the terms of the rate adjustment plan that has been in effect between the Society and St. Paul for the last several years.

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[3]When St. Paul switched from occurrence to claims made coverage in 1976, the premium levels underestimated the positive effect of this change. As a result of this switch, and perhaps other changes, such as the adoption of screening panels, St. Paul did extremely well in 1976, 1977 and 1978.
(Footnote Continued)

2. Malpractice screening panels. While a number of the more significant malpractice cases in the State never go before medical malpractice screening panels, there now is statistical evidence that at least in the more marginal malpractice cases, the screening panels have performed a very valuable function. The Society's study of screening panel results establishes that in most instances the panel's decision, whether pro-plaintiff or pro-defendant, leads to the disposition of the case without a subsequent trial. The responses to the Society's questionnaire to physicians who have been before panels make clear that panels are a source of psychological comfort to physician-defendants, primarily because they believe that the panel gives them an opportunity to be judged by their peers. Further, physicians appreciate that less publicity is associated with a panel proceeding than is often the case with a full-blown court trial. In short, retention of the panels is one key to maintaining some level of provider confidence in our existing tort system.

The Society is happy to consider possible changes in the operations of the panel, but it does not appear that wholesale changes are needed. More specifically, it appears that any advantages in reducing the number of panel members are outweighed by the disadvantages.

(Footnote Continued)
Its profit and loss experience since then has been bad and is getting worse.

While it appears that the vast majority of providers and attorneys who have served on panels have fulfilled their responsibility objectively and fairly, there has been a question from time to time as to the impartiality of a particular panel member. The Society would be receptive to any suggested change that would permit either side to raise objection to an alleged lack of impartiality of any particular panel member.

The Society is concerned about the burden imposed on panel members that results when they are called as witnesses in a subsequent trial. We believe that no panel member should have to testify without his consent as to any matter other than the findings of the panel as a whole. More specifically, a panel member should not have to testify without his consent as to his own views of the case in question. If such a limitation was imposed, there should be a reduction in the number of instances in which panel members are called to testify at trial.

There also is a growing concern that panel decisions are not given sufficient weight in a subsequent trial. The Society would support any legislative change that would make the panel finding presumptively correct.

3. Ceiling on awards. The Society believes that retention of the $1 million ceiling on any award to a patient is absolutely essential. If physicians believed that the risk of claims cannot be adequately covered by insurance, and that all of their personal assets are exposed, the adverse ripple effect on the cost and quality of health care would be immense -- in addition to the direct cost of acquiring increased coverage.

The increase in coverage alone would force a significant increase in premium costs. For example, today a $3 million policy costs roughly 50% more than a $1 million policy. In addition, we believe that the existing cap on awards has a positive effect on the level of claims and demands for settlement, the loss of which would produce adverse impacts on the cost of coverage at all levels, including coverage limits of $1 million or lower.

The evidence presented to the study committee also confirms that the existence of the cap should not be a disadvantage even to a severely injured patient if the patient is willing to accept a structured settlement. The evidence presented to the committee made clear that even in the case of the most extreme injury, an annuity can be acquired for less than $1 million that will compensate the injured person fully for all economic losses for the balance of his life.

4. Collateral sources. The Society believes that the State's current prohibition against introduction of evidence of payments by collateral sources is unfair. Physicians cannot understand why a jury in awarding damages should not have before it all or the relevant facts. If one injured person is going to have all hospital bills paid by a third source while another injured person will not, shouldn't the jury know this? The objective is to make the injured person whole. Under the existing system some injured persons are made more than whole, which simply makes no sense.

The Society finds especially troublesome the fact that collateral source payments are not admissible even if the

injured person did not contribute, by way of premium or otherwise, in obtaining the benefits in question. For example, if an injured person will be paid a monthly sum under a federal or state rehabilitation law for the cost of rehabilitation treatment, it seems unfair to allow a jury to order a physician to pay the patient a second time for the same cost.

5. Closed claims reporting. The Society has no objection to any arrangement, including legislation, if necessary, that would require carriers to provide to the Commissioner of Insurance annual data on closed malpractice claims. The Society believes that the use of a system in which counsel for plaintiff and defendant must report after each malpractice case is impractical and should not be reinstituted. But the Society does not object to any reasonable requirement for reporting of annual data on closed medical malpractice claims.

6. Statute of limitations. The Society believes that the existing statute of limitations for all tort claims in Virginia is fair, especially in light of decisions of the Virginia Supreme Court over the last decade that make clear that the statute begins to run at the time of injury rather than at the time of the occurrence that causes the injury. The malpractice insurance rate implications of a change to a discovery rule militate strongly against adoption of such a rule. Actuaries have made clear that the unpredictability that results from a discovery rule will force a significant upward adjustment of malpractice rates. For this reason, the Society strongly opposes any change in the existing statute of limitations.

We hope that the Committee members have become sensitive to the sense of frustration being experienced by obstetricians in the State. That specialty has experienced the most alarming adverse trend in malpractice experience in the last five years. In the present environment we would hope that the study committee would consider following the lead of other states in adjusting the statute of limitations for minors from the current rule (up to 20 years from the date of occurrence) to a fixed age (perhaps age six or age eight) plus two years.

7. Expert witnesses and standard of care. The Society believes that the local standard of care is the only logical standard. What is appropriate in Grundy Memorial Hospital may not be appropriate at The Medical College of Virginia. The shift to a statewide standard in 1980 was intended to make sure that screening panel members were familiar with the applicable standard -- a rationale that seems suspect today.

The shift to a statewide standard, and to an even greater extent, to a national standard is a denial of the reality that what is appropriate treatment is tied inevitably to the circumstances then prevailing.

Concerns have been raised that a local standard will make it impossible to obtain qualified experts. Since the locality rule is not limited to the locality in which the incident occurred -- but rather the same or any similar locality -- retention of experts should not be a problem. Keep in mind that similar locality need not necessarily be in the State of Virginia.

The Society also believes that a physician should not be qualified as an expert if he does not spend a substantial part of his time (perhaps 50%) engaged in the practice of the same specialty as the defendant-physician. The circumstances that confronted the defendant-physician cannot be appreciated fully by an expert who does not practice his specialty and, therefore, can only theorize about the situation at hand.

In summary, the Society believes that the standards for qualifying expert witnesses should be tightened rather than loosened. This does not mean that the Society is trying to make it more difficult for the plaintiff attorneys to find experts, but rather to improve the quality of those experts. In this connection the Medical Society would be happy to undertake to organize a list of physicians in each specialty who would agree to review malpractice cases for both plaintiffs and defendants. We believe we could develop a list of physicians of high quality.

We hope the foregoing is of help to the study committee.

Respectfully submitted,

Ronald K. Davis
Chairman, Special Malpractice
Committee of The Medical
Society of Virginia

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Exhibit A

VIRGINIA MEDICAL MALPRACTICE PREMIUMS

St. Paul Fire and Marine*
Effective July 1, 1984

(Coverage: $1 million/$1 million)

	Territory 1 (No. Va.)	Territory 2 (Tidewater)	Territory 3 (Remainder)	Territory (Richmond
Family Practice	$ 2,940	$ 2,723	$ 2,179	$ 1,851
Emergency Medicine	8,436	7,814	6,249	5,310
General Surgery	15,750	14,589	11,667	9,915
Ob/Gyn	21,963	20,347	16,270	13,828
Neurosurgery	32,835	30,418	24,324	20,673

*Mature, Claims Made, Annual Premium, $1 million per occurrence/$1 million aggregate

$48-million deficit seen

Exhibit B

Wisconsin facing new liability crisis, official says

Wisconsin is "facing a medical malpractice crisis" that could surpass the crisis of the mid-1970s, the state's insurance commissioner recently told a legislative committee on medical malpractice.

Wisconsin's novel plan of providing unlimited medical liability coverage to physicians, after they have paid out $200,000 in a malpractice award, is too costly, Commissioner Thomas P. Fox said. The Patient Compensation Fund is projected to have a deficit of $48 million in 1985.

"The deficit facing the fund is not manageable and should be dealt with now," Fox said. "With the possible exception of Lloyd's of London, I know of no insurance company that will write an unlimited liability policy."

Last year, the fund paid out a record $10 million in awards to patients. The previous record was $4.3 million.

Fox also cited a "sharp increase" in the number of claims filed, skyrocketing amounts of the awards to plaintiff-patients, and the increasing costs of medical liability insurance as compounding the problem in the state.

William Listwan, MD, a member of the State Medical Society of Wisconsin Committee on Medical Liability, told the legislative committee that the burgeoning malpractice dilemma had forced many physicians out of the market. Less obstetrical care is available in the state, according to a medical society survey, "because of high malpractice pressures associated with obstetrical practice," a society bulletin disclosed.

THE STUDY showed that 31% of general practitioners, 19% of family physicians, and 6% of obstetricians/gynecologists no longer deliver babies because of liability pressures.

The survey also showed that 90% of Wisconsin physicians surveyed had passed their high insurance costs on to the patients. The cost of the liability insurance alone adds $3 to the cost of visiting a physician, $5 a day to the cost of a hospital bill, and $300 to the cost of some births, Dr. Listwan said.

To alleviate some liability woes in the state, the Madison-based medical society recommended placing caps on awards made to patients for pain and suffering. Further, no more than $1 million would be paid by the Patient's Compensation Fund for any one award, the society suggests, and any money paid out of the fund should be done so in installments of $100,000 per year.

Insurance Commissioner Fox suggested that the legislative committee strengthen the authority of the malpractice examining boards and provide stricter reporting requirements to these boards. "I do not believe we can continue to expect the total health care industry to continue to do penance for the sins of a few providers," he said.

APPENDIX H

THE GENERAL ASSEMBLY OF VIRGINIA SHOULD REPEAL THE CAP ON RECOVERY IN MEDICAL AND HOSPITAL NEGLIGENCE CASES - THE COURTS OF VIRGINIA SHOULD DECLARE THE CAP UNCONSTITUTIONAL

I. The limitation unfairly discriminates against those most seriously injured.

Virginia Code Section 8.01-581.15 unfairly discriminates between victims of medical negligence who are severely injured with damages in excess of $1,000,000 and those victims with smaller damage claims; it distinguishes between victims who are egregiously injured as a result of medical negligence and those egregiously injured by other tortfeasors; it treats health care providers differently from other tortfeasors, e.g., manufacturers of defective products or negligent operators of automobiles.

It is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured. These seriously injured victims are less able to help themselves and therefore most in need of compensation. The limitation on recovery does not provide adequate compensation to patients with meritorious claims; on the contrary, it does the opposite for the most seriously injured victims of medical negligence.

II. The limitation provides no quid pro quo.

The limitation imposed by Section 8.01-581.15 provides no quid pro quo societal or otherwise to medical malpractice victims and is thereby distinguished from those cases upholding the constitutionality of the Workmen's Compensation Acts and the limitations imposed by some legislatures on the amount of recovery for wrongful death.

III. The limitation has not reduced health care costs.

The limitation does nothing toward the elimination of nonmeritorious claims. If anything, the reduction of medical accountability may be followed by relaxation of medical standards of care to the public's detriment. The cap has done nothing to reduce health care costs. In fact, these costs since 1976 have continued to escalate. The Virginia Health Care Cost Review Commission has attributed the increase in hospital costs to the failure of many Virginia hospitals to follow Commission recommendations.

The 1976 Virginia Legislature's premise that it would reduce health care costs was false, and its intended goal enacted at the expense of seriously injured victims is not

being achieved. The limitation constitutes nothing more than special class legislation enacted solely for the benefit of specially defined health care providers.

IV. There was and is no crisis in 1976, and there is none today.

Certainly there was no crisis in Virginia in 1976 with respect to the availability of liability insurance for physicians prior to the imposition of the cap, and none exists today. There were no damage awards in excess of $750,000 prior to the enactment of the law in 1976. Nor does any such crisis exist today. Paid out damage awards constitute a very small fraction of total insurance premium costs. Furthermore, the statutory creation of Virginia's Joint Underwriting Association in 1976 has resulted in a stable medical liability insurance market. See "The Limitation on Recovery in Medical Negligence Cases," 16 U. of Richmond Law Review, Summer 1982, No. 4, p. 799; letter to Edward W. Taylor from J. Robert Hunter, consulting actuary, dated December 12, 1983.

V. The limitation serves no important governmental objective.

The limitation on recovery in negligence cases against health care providers serves no important governmental objective in 1984. It served no important governmental objective in 1976. It has no relationship to the number of persons entering or leaving the allied health professions. There is no evidence the number of health care providers has done anything but increase in the last 14 years. There has never been a time Virginia physicians could not obtain medical malpractice insurance at affordable rates. The cap has done nothing to contain hospital costs which have continued to rise. There is simply no problem related to the amount of recovery by victims of medical negligence adversely affecting the public health, safety and welfare necessitating the imposition of such a limitation.

A. Number of physicians in Virginia have doubled

There is no reasonable relationship between the imposition of the cap and the number of physicians or other health care professionals entering or leaving the professions. Their numbers steadily increased over the fourteen year period 1970-1984 and was rapidly increasing before 1976. The number of physicians has more than doubled in the past fourteen years.

B. There is no reasonable relationship between the imposition of the cap and health care costs.

(1) In a full page ad published in Virginia newspapers in October of 1983, Blue Cross/Blue Shield of Virginia stated:

> Everyone involved with our health care system -- hospitals, doctors, patients, employers, and insurance companies -- have all contributed to rising costs.

(2) The Virginia Health Services Cost Review Commission, in its most recent Report for the period July 1, 1982 - June 30, 1983, reported:

> The continuing escalation of hospital costs remains the primary concern of the Commission as well as citizens of the Commonwealth. It is believed that significant reductions in hospital costs could be effected through increased voluntary compliance with Virginia Health Cost Review Commission recommendations.

(3) In its 1984 position paper prepared for the Virginia legislature in support of a reduction of the cap, the Richmond Academy of Medicine illogically boasted:

> Physician incomes are legendary. They always live in the best neighborhoods, drive expensive cars, and take expensive vacations.
>
> Health care costs have gone up. Doctors make a lot of money. It would only seem to follow that the cause of the problem is the one who is making the money. From the health care consumer's standpoint, it is a fairly logical assumption. And, as can be seen from the quotes that preceded this section, the image of the physician is changing.

VI. The classificaiton of health care providers is purely arbitrary and capricious

The classification of health care providers under Section 8.01-581.1(1) to include physicians, hospitals, dentists, pharmacists, nurses, optometrists, podiatrists, chiropractors, physical therapists, psychologists and nursing homes is purely arbitrary and capricious, irrational and not founded on reason or judgment. For example, between the years July 1976 and presumably July 1981 when the closed-claims reporting law was in effect, there is reported to have been some 2,676 medical malpractice claims closed in Virginia. Only 6 claims (0.3%) reported under former Virginia Code Section 38.1-389.3 involved physical therapists. There were no reported claims against psychologists during this period. Furthermore, claims in Virginia against these and similar health care professionals were almost non-existent before 1976, and while a few may exist, there are no reported cases of a claim against a podiatrist or psychologist. It was purely arbitrary for the legislature to so broadly define "health care provider" so as to include classifications of persons against whom there have been few, if any, claims.

VII. The 1976 limitation of $750,000 was purely arbitrary and was picked out of the sky.

It was purely arbitrary to set a $750,000 limitation when there had never been an award that high in Virginia in the two centuries before 1976.

(1) There had been only one physician award between 1970 and 1975 which fell in the range between $250,000 to $499,999.

(2) Over the five year period between 1969 and 1974, St. Paul paid out or reserved only $1,307,243 for some 102 claims against physicians. This amounts only to about $12,816 per claim.

(3) St. Paul admitted that the severity of each of its 264 physician claims in 1974 was only $9,649.09.

(4) The average value of a 1975 claim against a physician was reported to be $10,190.66.

(5) With respect to Virginia hospitals over the same five year period, St. Paul had paid out or reserved only $136,786 for some 84 claims which amounts to approximately $1,628 per hospital claim. This information was available to the Virginia Legislature in a Report to the Senate from the Insurance Commission. Yet, the 1976 Legislature apparently ignored this information and the Bill

before the Legislature imposing a limitation vacillated arbitrarily back and forth jumping from $100,000 to $750,000 with increments in between. See 16 U. Richmond Law Review at 809, 818-822.

VIII. The $1,000,000 cap imposed in 1983 is purely arbitrary

During the three year period 1981 through 1983, there is reported to have been 4,160 medical malpractice claims closed by insurance carriers in Virginia. In only 27 of these claims (0.7%) was there a sum paid greater than $100,000. No payment was reported by an insurance carrier to be in excess of $559,625. The median value of these 27 payments was $200,000 -- the mean value was $203,332. Only one payment was reported to be over $500,000 and that was $559,625. There were no payments reported in the $400,000 range. Only three of the payments fell into the $300,000 range. Eleven of the 27 payments were between $100,000 and $126,634; twelve of the 27 payments were in the $200,000 range.*

IX. More than 78% of the claimants received nothing.

Between 1981 and 1983, 3,275 of the 4,160 claimants (78.7% of the total) received nothing. 16.3% received $25,000 or less, and only 4.3% received between $25,000 and $100,000.*

(* The writer acknowledges personal thanks to the Honorable Bernard S. Cohen, D-Alexandria, for obtaining and furnishing this valuable information.)

X. Virginia has a competitive medical malpractice insurance market

While St. Paul Fire & Marine Insurance Company in years past has written most of the medical malpractice insurance policies in Virginia, its ranking in Virginia has steadily fallen in recent years. Due to healthy competition in the marketplace, St. Paul now writes only about 65% rather than 90% of the policies for Virginia health care providers. The Virginia Insurance Reciprocal is now writing about 25% of the business with the rest going to others such as the Chubb Group, Phico, Prudential, USF&G, Travelers and Aetna Casualty & Surety. The business is profitable and much sought after by insurance companies.

XI. Insurance companies have given no premium discounts to physicians because of the cap.

Between 1976 and 1983 when there was a $750,000 limitation, St. Paul wrote policies for a majority of Virginia doctors. Most of the St. Paul policies were written with $1,000,000 limits at regular premium rates despite the $750,000 limitation. Many policies are written today with $3,000,000 limits but no discount is given by reason of the $1,000,000 cap.

XII. St. Paul has made such a profit on Virginia doctors that it said it was going to give them a refund, yet now they ask for a 30% rate increase.

(1) Richard Immel, the Assistant Executive Vice President of the Virginia Medical Society, was quoted as saying in March, 1983:

> Commenting on some of the points raised in the article, a Medical Society of Virginia official said St. Paul recently agreed to repay company profits in excess of 11 percent to doctors and hospitals insured by the company.
>
> Richard Immel, the society's assistant executive vice president, conceded that insurance premiums are eventually passed on to medical consumers, but said the agreement -- on which the first payments are to be made later this year -- will eliminate profiteering.
>
> The payments will be returned to doctors in the form of dividends and will include investment income earned by the insurance company, Immel said.

(2) A consulting actuary employed by the Virginia Trial Lawyers Association reported in December 1983:

> Not only is there no "crisis", there is no problem. If anything, current rates charged by St. Paul are high, vis-a-vis the experience presented in its recent filing. I anticipate that, because the profits that St. Paul will enjoy under current rates should prove excessive, that the Medical Society of Virginia will receive a refund under these rates (it is my understanding that, if profits including investment income provie excessive, such refunds do occur). Absent this retrospective protection, a rate hearing should be sought to show cause as to why a sharp reduction in rates is not in order.

Not one shred of evidence exists to indicate a significant deterioration of results in Virginia. In fact, data shows that St. Paul asked for a rate increase of only 13.1% in mid-1983, and that increase was predicated upon a profit margin which, I roughly estimate, will give the company a return on net worth of about 50%! This was the first increase in 2 years, so the annual change asked for was 1,064, compounded.

Further, as the 1983 filing points out at page 1 of the Filing Memoandum, rates for "limits in excess of $1,000,000 are being reduced", indicating a reduction in expected large claims, another sign of stabilization.

St. Paul has, and appears to continue to be, overreserved extensively in Virginia and in the country. However, in June 1984 the lobbyist for the Virginia Medical Society told a joint House/Senate Committee that St. Paul had asked for a thirty percent (30%) rate increase in Virginia.

(3) The Virginia Insurance Reciprocal, which now has about 25% of the business, writes physician policies at 75% of the St. Paul rate, i.e., 25% less than what St. Paul charges for the same coverage. They are able to do this by eliminating the costs of middlemen, such as agents, and by careful risk assessment. On the other hand, St. Paul, in an agreement with the Medical Society, will write a policy for any member, however poor the risk. Thus, many doctors pay higher premiums for the few doctors who have a large claim or many suits against them.

XIII. Standards should be tightened, not relaxed.

A legitimate governmental objective is accountability of health care providers for their negligence; standards of care should be tightened, not relaxed. A limitation on recovery tends to breed irresponsibility, not accountability, to the public's detriment. As recently as 1980 in James v. Jane, 211 Va. 43, 54, the Virginia Supreme Court recognized that a legitimate state interest is that patients receive proper medical care. Furthermore, in James the Court rejected as a compelling state interest the possibility that the cost of medical malpractice insurance might increase. In Schilling v. Bedford County Memorial Hospital, Inc., 225 Va. 539, (1983), the Court pronounced prompt and "efficient" medical services was recognized as a legitimate state concern.

XIV. The limitation on Recovery is Unconstitutional

The limitation imposed by Section 8.01-581.15

(1) violates the equal protection clause of the Fourteenth Amendment to the United States Constitution because it does not serve any important governmental objective and because it is not substantially related to the achievement of any important governmental objective,

(2) violates the equal protection clause of the Fourteenth Amendment to the United States Constitution because it violates the fundamental right of trial by jury and violates the guarantee of trial by jury on the issue of damages as provided by Article I, Section 11 of the Virginia Constitution,

(3) violates the equal protection clause of the Fourteenth Amendment to the United States Constitution because the classification has no reasonable basis and bears no reasonable or substantial relationship to the legislative objective,

(4) constitutes special legislation in violation of Article IV, Section 14 and Article I, Section 4 of the Virginia Constitution,

(5) violates the separation of powers clause of Article IV, Section 1 of the Virginia Constitution and

(6) violates Article IV, Section 12 of the Virginia Constitution because it embraces more than one object, i.e., a total limitation on recovery, which is not expressed in the title of the law and is in conflict with its title which imposes a limitation on pain and suffering only.

XV. Most Courts have held limits unconstitutional.

A majority of the Courts of other states considering the constitutional issue has struck down similar limitations on recovery on equal protection grounds. These Court have applied an intermediate standard of scrutiny. Jones v. State Board of Medicine, 97 Idaho 859, 555 P.2d 399 (1976), Cert. denied, 431 U.S. 914; Wright v. Central DuPage Hospital Asso., 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Simon v. St. Elizabeth Medical Center, 3 Ohio Ops 3d 164, 355 N.E.2d 903 (1976, CP); Arneson v. Olson, 270 N.W.2d 125 (1978 N.D.); Carson v. Maurer, 424 A.2d 825 (1980 N.H.). See 80 A.L.R.3d 583, Section 3.

Courts of other states have also decided limitations on recovery unconstitutional by resort to their states' constitution. Wright v. Central DuPage Hospital Assoc., Jones v. State Board of Medicine, supra.

XVI. Section 8.01.15 constitutes special legislation in violation of the Virginia Constitution.

(1) The cap constitutes special legislation.

The General Assembly does not have constitutional authority to grant relief by special legislation in cases of which the courts have jurisdiction. Article IV, Section 14 of the Virginia Constitution provides that the General Assembly shall confer on the courts certain powers and "shall not, by special legislation, grant relief in these or other cases of which the courts or other tribunals may have jurisdiction". The Courts of Virginia always have had jurisdiction over medical negligence cases.

(2) The cap is a private law, changes the rules of evidence and the method of collecting debts against health care providers.

Article IV, Section 14, furthermore, provides "The General Assembly shall not enact any local, special, or private law" in cases "(3) Regulating the practice in, or the jurisdiction of, or changing the rules of evidence in any judicial proceedings or inquiry before the courts or other tribunals, or providing or changing the methods of collecting debts or enforcing judgments...". Virginia Code Section 8.01-581.15 unconstitutionally removes malpractice claims for damages over $1,000,000 from the jurisdiction of the courts and changes the rules of evidence as they relate to damages over $1,000,000. It changes the method of collecting debts by victims of medical negligence from health care providers by prohibiting collection of tort debts in excess of $1,000,000 and changes the methods of enforcing judgments against health care providers by eliminating the right to enforce judgments for amounts in excess of $1,000,000.

(3) The cap grants an exclusive right, privilege or immunity to health care providers.

Article IV, Section 14(18) provides, in pertinent part, that the General Assembly shall not enact any local, special or private law "Granting to any private corporation, association, or individual any special or exclusive right, privilege, or immunity". All health care providers as

defined by Section 8.01-581.1 are granted the special right or privilege not to be liable for damages in excess of $1,000,000 or to have immunity from payment of damages to injured patients in excess of $1,000,000. Victims with claims for less than $1,000,000 are given a complete remedy while those most seriously injured are not granted the same right or privilege. This is patently unconstitutional because the statue arbitrarily separates some persons from those upon whom, but for the separation, it would operate. See Martin's Ex'rs v. Commonwealth, 126 Va. 603, 610 (1920).

(4) The cap which grants an exclusive privilege to health care providers is not in consideration of a public service.

Furthermore, the grant of an exclusive privilege for the medical community is not given in consideration of public service, as required by Virginia Constitution Article I, Section 4, which further provides "That no man, or set of men, is entitled to exclusive or separate emoluments or privileges from the community, but in consideration of public services...". There can be no doubt that private Virginia health care providers are given an exclusive or separate privilege that no one else in the community has.

(5) Section 8.01-581.15 violates the separation of powers clause of the Virginia Constitution.

Article IV, Section 1 of the Virginia Constitution vests the judicial power of the Commonwealth in the courts. Legislative, executive and judicial departments shall be separate and distinct. Article VI, Section 1 mandates none can "exercise the powers properly belonging to the others". An attempt on the part of the Legislature to exercise judicial power is void. The legislative department can no more exercise judicial power than the judicial department can exercise legislative power. Each is supreme in the exercise of its own proper functions, when acting within the limits of its authority. An act of the legislature which would direct a court to rehear a case or to grant a new trial or an appeal, for example, is an invasion of judicial power which is unconstitutional. A legislature has no power to set aside a judgment or decree of a judicial court. Griffin's Ex'or v. Cunningham, 61 Va. 31, 50-52 (1870).

Section 8.01-581.15 provides that in "any judgment...in such an action which is tried without a jury, the total amount recoverable...shall not exceed one million dollars". The statute grants the judge, whether or not he

is the trier of fact, the power to enter the judgment for a sum greater than $1,000,000, however, he has no power to enforce it. "The total amount recoverable...shall not exceed" $1,000,000. To "recover" means "to collect". This is clearly an attempt on the part of the Legislature to set aside or prevent the entry of a judgment of a judicial court in violation of Article VI, Section 1.

(6) Section 8.01-581.15 violates Article IV, Section 12 of the Virginia Constitution because it embraces more than one object which is not expressed in the title of the law.

Article IV, Section of the Virginia Constitution provides:

> No law shall embrace more than one object, which shall be expressed in its title. Nor shall any law be revised or amended with reference to its title, but the act revised or the section amended shall be reenacted and published at length.

The title to the original 1976 Act reads as follows:

Chapter 611

An act to amend the Code of Virginia by adding sections numbered 8-654.8, 8-654.9, 8-654.10 and numbered 39, consisting of sections numbered 8-911 through 8-922, relating respectively to limitations on recovery for pain and suffering in certain actions; civil immunity and privileged communications of certain boards or committees; establishment of medical review panels; and reporting of certain settlements and judgments to Commissioner of Insurance. (emphasis added)

The law imposed by Section 8-654.8 of Chapter 611 (now Section 8.01-581.15) made no mention of a "limitation on recovery for pain and suffering". It provided "the total amount recoverable...shall not exceed seven hundred fifty thousand dollars". Clearly, a review of the legislative history shows the 1976 General Assembly was confused as to whether the cap applied just to damages for pain and suffering when it passed Chapter 611 of the Acts of Assembly. See 16 U. of Richmond Law Review at 818-819.

The purpose of Article IV, Section 12 is "to prevent the members of the legislature and the people from being misled by the title as a cover for vicious legislation...and to prevent surprise and fraud in legislation by means of

provisions in bills of which the titles give no intimation." Commonwealth v. Brown, 91 Va. 762, 771-772; 21 S.E. 357 (1895). The title to an act sets the bounds of the act; and to the extent that its provisions exceed those bounds they are void. Irvine v. Com., 124 Va. 817, 97 S.E. 769 (1919); Wooding v. Leigh, 163 Va. 785, 199 S.E. 310, 317 (1934).

The fact that Chapter 611 was recodified in 1977 and 1983 does not cure the defect existing in the original act. While the adoption of a Code by general reference is broad enough to cover any lawful enactment, it does not cover an enactment originally unlawful. Mache v. Commonwealth, 156 Va. 1015, 1020, 159 S.E. 148, 149 (1931).

(7) Virginia Courts should first rely on the Virginia Constitution in declaring the limit unconstitutional.

The Virginia Supreme Court has ruled that where possible it will rely on our own Constitution rather than resorting to that of the United States. Richmond Newspapers v. Comm., 222 Va. 574, 588, 281 S.E.2d 915, 922-23 (1981). However, we rest our decision on Article I, Section 12, for, as the Commission on Constitutional Revision stated:

> [t]hat most of the provision of the Virginia Bill of Rights have their parallel in the Federal Bill of Rights is...no good reason not to look first to Virginia's Constitution for the safeguards of the fundamental rights of Virginians. The Commission believes that the Virginia Bill of Rights should be a living and operating instrument of government and should, by stating the basic safeguards of the people's liberties, minimize the occasion for Virginians to resort to the Federal Constitution and the federal courts. Report of the Commission on Constitutional Revision, p. 86 (1969).

Other courts have decided this issue by resort to their state's constitutions.

Indeed, other courts have decided limitations on recovery unconstitutional by resort to their states' constitutions. Wright v. Central DuPage Hospital Assoc., Jones v. State Board of Medicine, supra.

XVII. Section 8.01-581.15 violates the equal protection clause of the Fourteenth Amendment of the United

States Constitution because the classification has no reasonable basis and bears no reasonable or substantial relationship to the legislative objective.

While most Courts have applied an intermediate or strict scrutiny standard to review malpractice limitations or recovery, Section 8.01-581.15 does not pass muster even under the lowest level of scrutiny. The so-called "rational basis" test has been applied when the classification is not suspect or does not involve a fundamental right. Under this test, if the "classification is not suspect it is permissible if the governmental objective is 'legitimate' and the classification bears a 'reasonable' or substantial relation thereto.... If the classification has some reasonable basis and bears a reasonable relationship to the legislative objective, the governmental authority may treat different classes in different ways.... The classification will not be held to be unconstitutional merely because it results in some inequality or some discrimination." Duke v. County of Pulaski, 219 Va. at 432-433.

However:

(1) How does the classification between various victims of malpractice (those egregiously injured versus those with minor injuries) relate to the asserted purpose of assuring medical care to the people of Virginia?

(2) What is the reasonable basis for classifying podiatrists, physical therapists or psychologists among the definition of "health care providers"? There have been almost no claims in Virginia against these professionals.

(3) What was the reasonable basis in 1976 for classifying hospitals when the major insurer had paid out or reserved only $136,786 over the preceding five years for 84 separate claims?

(4) Furthermore, what is the reasonable basis for so classifying hospitals today when the Virginia Insurance Reciprocal, since 1977, has written policies for most hospitals at a discount and claims to be financially sound and approximately 80% of Virginia's some 112 hospitals claim the benefit of charitable immunity?

(5) What was the reasonable basis for classifying physicians in 1976 when the average value of a claim the year before was only $10,190.66, no claim had ever been paid over $500,000, and only one claim in the preceding five year period ranging between $250,000 and $499,999 had been paid?

(6) What is the reasonable basis for classifying health care providers today when less than 1% of some 4,160 claims between 1981 and 1983 involved payments over $100,000, none exceeded $559,625, and the median of the 1% was $200,000 and 78% of the total number of claimants received nothing?

XVIII. Section 8.01-581.15 violates the equal protection clause of the Unites States Constitution because it violates the fundamental right of trial by jury; the Statute violates Article I, Section 11 of the Virginia Constitution.

Clearly the right to jury trial is granted explicitly by Article I, Section 11 of the Constitution of Virginia:

> That in controversies respecting property, and in suits between man and man, trial by jury is preferable to any other, and ought to be held sacred.

The Virginia Supreme Court has said it is elementary that a plaintiff is entitled to a trial by jury on a punitive damage claim. O'Brien v. Snow, 215 Va. 403, 405, 210 S.E.2d 165 (1974). It stands to reason the same right exists on the underlying compensatory damage claim. Trial by jury is a sacred right, and should be sedulously guarded. Buntin v. Danville, 93 Va. 200, 212, 24 S.E. 830 (1896). The plaintiffs' constitutionally guaranteed right to demand a jury to determine their damages has been taken away without amendment to the Constitution as proscribed by Article XII, Section 1. To deprive a person of trial by jury where the facts are in conflict is a denial of a substantive right. Quick v. Southern Churchman Co., 171 Va. 403, 199 S.E. 489, 494 (1938). It has been said the right to have a trial by jury is a fundamental right in our democratic system. It was recognized as such in the Magna Carta and the Declaration of Independence. Trial by jury was brought to this country from England and has become a birthright of every free man. Any seeming curtailment of this right should be scrutinized with the utmost care. Where the constitutional right to jury trial exists, it cannot be made a nullity, destroyed, annulled, obstructed, impaired, or restricted by legislative action. It cannot be invaded under the guise of legislation for another purpose. 47 Am. Jur. 2d, "Jury" Sections 7 and 12.

Section 8.01-581.15 states "in any verdict...which is tried by a jury...the total amount recoverable...shall not

exceed one million dollars." The Section does not say a jury cannot return a verdict for more than $1,000,000, but it limits the plaintiff's recovery to $1,000,000. The statute, in effect, declares any jury's verdict in excess of $1,000,000 to be a nullity and uncollectible. Thus, it deprives plaintiffs of their right to have trial by jury on the issue of damages.

Strict scrutiny is the appropriate standard of review under equal protection where the challenged classification violates a fundamental right.

CONCLUSION

The Legislature of Virginia should repeal the cap at the 1985 session. Courts construing the cap should declare the cap unconstitutional under both the Virginia and United States Constitutions.

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