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Pulliam v. Coastal Emergency Services of Richmond, Inc.: Reconsidering the Standard of Review and Constitutionality of Virginia's Medical Malpractice

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**PULLIAM v. COASTAL EMERGENCY SERVICES OF
RICHMOND, INC.: RECONSIDERING THE STANDARD OF
REVIEW AND CONSTITUTIONALITY OF VIRGINIA'S
MEDICAL MALPRACTICE CAP**

INTRODUCTION

Consider the following scenario. A plaintiff is injured in a devastating automobile accident and a jury finds the other driver negligent. As a result of that driver's negligence, the plaintiff is now a quadriplegic. The jury, after careful deliberation and calculation, awards \$4.5 million to the plaintiff consisting of both economic damages for past and future medical expenses, as well as non-economic damages for pain and suffering and loss of enjoyment of life. Now consider a similar scenario. The plaintiff is a patient who is injured during a low-risk surgical procedure and a jury finds the surgeon negligent. As a result of the surgeon's negligence, the plaintiff is now a quadriplegic. Although negligence caused each plaintiff's injuries, under Virginia's Medical Malpractice statute,¹ the plaintiff in the second scenario finds his damages limited to a maximum of \$1.5 million dollars for both economic and non-economic damages.

In the 1970s, numerous state legislatures believed that a statutory limitation or "cap," on medical malpractice damages would prove to be an effective mechanism for ensuring future affordability and availability of medical malpractice insurance for health care providers.² However, the perceived threat of an economic crisis in medical malpractice insurance rates and availability in the 1970s did not correspond with existing insurance statistics at the time. For instance, one study found that the average hospital only spent approximately one percent of its annual revenues on malpractice insurance during the period immediately before and after most

¹ VA. CODE ANN. § 8.01-581.15 (Michie 1992). The Virginia statute provides that: [i]n 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 judgement 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.

Id. Effective August 1, 1999, the maximum amount recoverable in medical malpractice actions increased to \$1.5 million, with annual increases of \$50,000 effective after each July 1 until the years 2007 and 2008, where the annual increase will be \$75,000. VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 1999).

² See generally Patricia Chupkovich, Comment, *Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for Obtaining Affordable Health Care?*, 9 J. CONTEMP. HEALTH L. & POL'Y 337 (1993); Carol A. Crocca, Annotation, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R. 5th 245 (1999).

states imposed a cap on medical malpractice damages.³ By 1985, the American Medical Association (AMA) estimated that the average physician spent only four percent of her income on malpractice insurance.⁴ Furthermore, the overall probability of a serious medical malpractice mistake resulting in damages exceeding \$1 million was estimated at roughly one in 100,000 in hospitals, with an even lower injury probability occurring within a physician's private office.⁵ Despite these statistics, state legislatures quickly passed statutory caps on total damages recoverable in a medical malpractice action to deal with a perceived "crisis" in the malpractice insurance industry.⁶ The Commonwealth of Virginia is among those states with a medical malpractice cap and it continues to support the cap as the most effective means for keeping malpractice premiums under control.

In *Pulliam v. Coastal Emergency Services of Richmond, Inc.*, the Virginia Supreme Court upheld the federal and state constitutionality of Virginia's statutory medical malpractice cap for the third time.⁷ While this Note follows much scholarly analysis on the constitutional debate over medical malpractice caps,⁸ this Note focuses on the state constitutional challenges that may provide the most viable arguments for striking down medical malpractice caps as invalid tort reform in Virginia.⁹ Although *Pulliam* should come as no surprise given Virginia's conservative rulings upholding the constitutionality of its medical malpractice cap,¹⁰ the Virginia Supreme Court made two egregious errors in its most recent constitutional analysis. First, the court incorrectly applied the standard of review with respect to the Commonwealth's prohibition against special legislation. Second, the court applied the wrong standard of review with respect to challenges against state equal protection guarantees. Consequently, Vir-

³ See James R. Posner, *Trends in Medical Malpractice Insurance 1970-1985*, 49 LAW & CONTEMP. PROBS. 37, 50 (1986).

⁴ *Id.* This estimate involved pre-tax gross income dollars of the average physician in 1984. The AMA also noted that some surgical specialists might spend around 15%-20% of their gross income on malpractice insurance. *Id.*

⁵ *Id.* at 53.

⁶ See discussion *infra* Part II.

⁷ 509 S.E.2d 307, 310 (Va. 1999); see also *Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990); *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525 (Va. 1989).

⁸ See generally Kenneth O. O'Connor, Comment, *Funeral for a Friend: Will the Seventh Amendment Succumb to a Federal Cap on Non-Economic Damages in Medical Malpractice Actions?*, 4 SETON HALL CONST. L.J. 97 (1993); M. Margaret Branham Kimmel, Comment, *The Constitutional Attack on Virginia's Medical Malpractice Cap: Equal Protection and the Right to Jury Trial*, 22 U. RICH. L. REV. 95 (1987); Ronald E. Wagner & Jesse M. Reiter, *Damage Caps in Medical Malpractice: Standards of Constitutional Review*, 1987 DET. C.L. REV. 1005.

⁹ See generally Jacqueline Ross, *Will States Protect Us, Equally, From Damage Caps in Medical Malpractice Legislation?*, 30 IND. L. REV. 575 (1997) (arguing that independent state challenges, particularly equal protection challenges, to medical malpractice caps are the most viable solution in striking down such legislation as unconstitutional).

¹⁰ See *Bulala*, 389 S.E.2d 670; *Etheridge*, 376 S.E.2d 525.

ginia's medical malpractice cap continues to violate the Commonwealth's constitution, leaving those most severely injured by medical malpractice negligence unable to pursue full compensation for their injuries—a legal right that Virginia affords any other tort plaintiff.¹¹

Part I of this Note focuses on the legislative and legal history surrounding Virginia's medical malpractice cap. In Part II, this Note provides a brief overview of how other state courts have interpreted similar caps in the face of state constitutional challenges. Part III presents the majority's rationale in *Pulliam*, as well as the two concurring opinions. In Part IV, this Note examines the Medical Malpractice Act under Virginia's constitution, paying particular attention to the "special legislation" prohibition and implicit equal protection guarantees in Virginia's constitution and the corresponding standards of review for each. This part also considers alternative solutions that may more effectively ensure the affordability and availability of medical malpractice insurance without creating the inequities that have resulted under the current damage cap. Finally, this Note concludes that the Virginia cap on total damages recoverable in medical malpractice cases is unconstitutional and should not survive the next constitutional challenge brought before the Virginia Supreme Court.

I. HISTORICAL BACKGROUND

In a remarkably cyclical pattern, the health care industry experienced a perceived medical malpractice "crisis" in terms of increased medical malpractice claims and damage awards during the mid-1970s, mid-1980s, and mid-1990s.¹² The first "crisis" of the 1970s resulted in various types of tort reform purported to remedy the two-fold dilemma surrounding the medical malpractice insurance industry: 1) affordability, as demonstrated through a sudden and substantial increase in medical malpractice insurance premium rates; and 2) availability, as health care providers feared that medical malpractice liability coverage would soon become unavailable as insurance carriers subsequently withdrew from the field.¹³ In Virginia, however, neither of these two dilemmas specifically burdened the state's health care providers to an extent that would justify the initial \$750,000 limitation on

¹¹ See Michael L. Goodman, Kathryn Freeman-Jones & Kathleen M. Mccauley, *Damages for Medical Malpractice in Virginia*, 33 U. RICH. L. REV. 919 (1999) (noting that "Virginia has chosen . . . to regulate damages in medical malpractice cases in ways it has not applied to other personal injury actions").

¹² See Glen O. Robinson, *The Medical Malpractice Crisis Of The 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5 (1986) (comparing the potential causes of the health care "crisis" of the mid-1970s with that of the mid-1980s); Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093, 1114-15 (1996) (citing one study that attributed the increase in dollar awards from 1960-1994 to the cyclical patterns of inflation, increases in real income, medical costs and increased life expectancy).

¹³ Robinson, *supra* note 12, at 6.

total plaintiff recovery in 1976.¹⁴

A. Legislative History

1. Overview of Virginia's Medical Malpractice Cap

According to the Virginia General Assembly, the Medical Malpractice Act¹⁵ (the Act) was the necessary response to a perceived medical malpractice insurance crisis that plagued health care providers who currently practiced or desired to practice medicine in Virginia.¹⁶ In addition to concerns about the impact of malpractice insurance affordability and availability for Virginia's health care providers, the General Assembly was also concerned that Virginia's patient population would experience reduced health care services and potentially higher health care insurance premiums.¹⁷ In an "unusually explicit statement of [its] legislative purpose,"¹⁸ the General Assembly attached a preamble to the Act that read:

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

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

Whereas these factors constitute a significant problem adversely affecting the public health, safety and welfare which necessitates the imposition of a limitation on the liability of health care providers in tort actions commonly referred to as medical malpractice cases . . .¹⁹

Based on this rationale, the Virginia General Assembly passed the Medical

¹⁴ See *infra* Part I.A.2; see also Judy Tyrrell, Comment, *Interpretation of Virginia's Medical Malpractice Act*: Boyd v. Bulala, 12 GEO. MASON L. REV. 361, 363 (1990); Edward W. Taylor & William G. Shields, *The Limitation on Recovery in Medical Negligence Cases in Virginia*, 16 U. RICH. L. REV. 799, 809-810, 815-818 (1982).

¹⁵ See VA. CODE ANN. § 8.01-581.1-581.20 (Repl. Vol. 1992 & Cum. Supp. 1999). Other provisions of the Medical Malpractice Act include a grant of immunity in civil liability to individuals who "review, evaluate, or make recommendations" on matters that could result in a medical malpractice claim, *id.* at § 8.01-581.16, and protection for reports, proceedings, and all oral and written communications by medical staff committees and review boards from legal discovery. *Id.* § 8.01-581.17. In addition, medical malpractice review panels were created and authorized to provide voluntary arbitration in medical malpractice actions pursuant to an article added to the Act in 1977. *Id.* at § 8.01-581.1-581.12.

¹⁶ See 1976 Va. Acts ch. 611, pmbl.; *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 527-28 (Va. 1989).

¹⁷ See 1976 Va. Acts ch. 611, pmbl.

¹⁸ *Bulala v. Boyd*, 389 S.E.2d 670, 674 (Va. 1990).

¹⁹ 1976 Va. Acts ch. 611, pmbl.

Malpractice Act on April 9, 1976.²⁰

This Note focuses on section 8.01-581.15, which imposes a cap on the amount of total damages recoverable in a medical malpractice action. This section provides the following:

In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after April one, nineteen hundred seventy-seven, which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed seven hundred fifty thousand dollars.²¹

Although the total amount recoverable has increased incrementally over the past twenty years from \$750,000 in 1976, to \$1,000,000 in 1983, and most recently to \$1,500,000 as of August 1, 1999,²² the disparate impact of the cap on Virginia's most seriously injured medical malpractice plaintiffs unfortunately has remained the same.

In addition to increasing the limitation of the cap, the General Assembly amended another section of the Act in 1994 to include a more expansive definition of "health care provider."²³ The new definition includes "a corporation, partnership, limited liability company or any other entity, except a state-operated facility, which employs or engages a licensed health care provider and which primarily renders health care services."²⁴ These relatively minor modifications and clarifications to the Act over the past twenty years indicate that Virginia's legislature remains convinced that the Act is a necessary instrument to preserve the affordability and availability of medical malpractice insurance in Virginia for years to come.

2. Conditions Leading to the Passage of Virginia's Medical Malpractice Act

Despite the eloquent rationale presented in the preamble to the Act,

²⁰ See 1976 Va. Acts ch. 611 at 784.

²¹ VA. CODE § 8-654.8 (1976). This section was later recodified as VA. CODE ANN. § 8.01-581.15 (Michie 1992).

²² VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 1999). The Act provides that the existing maximum recovery limit of \$1.5 million:

shall increase on July 1, 2000, and each July 1 thereafter by \$50,000 per year; however, the annual increase of July 1, 2007, and the annual increase on July 1, 2008, shall be \$75,000 per year. Each annual increase shall apply to the act or acts of malpractice occurring on or after the effective date of the increase. The July 1, 2008, increase shall be the final annual increase.

Id.

²³ VA. CODE ANN. § 8.01-581.1 (Cum. Supp. 1999).

²⁴ *Id.* This section of the statute is particularly important for *Pulliam v. Coastal Emergency Services of Richmond, Inc.* Although Coastal Emergency Services is technically a physician-staffing agency that contracted emergency physicians to local hospitals, it was nonetheless liable under the broad applicability of section 8.01-581.1 as a "health care provider" and under the theory of respondeat superior. 509 S.E.2d 307, 320 (1999).

the General Assembly's generalized conclusions were largely unsubstantiated. Statistics offered by the General Assembly in support of the assumption that Virginia's health care industry was in the midst of a malpractice insurance crisis were either taken out of context or extracted from the national experience. Prior to the General Assembly's enactment of the Medical Malpractice Act in 1976, there had been a 178% increase in the frequency of medical malpractice claims and a 144% increase in the severity, or cost, of claims adjudicated in the Commonwealth from 1969 to 1975.²⁵ While statistics such as these were similar to those experienced around the nation in the 1970s,²⁶ the primary concern of legislators and health care professionals focused on the exorbitant increases in malpractice premium rates, which had increased more than 1000% nationwide since 1960.²⁷ Meanwhile, the continued availability of medical malpractice insurance became a national concern as insurance providers became "increasingly reluctant to continue writing malpractice insurance."²⁸ The General Assembly, however, did not provide any statistics indicating that the malpractice insurance affordability or availability concerns that faced most of the nation were of imminent concern to the Commonwealth of Virginia.²⁹

The State Corporation Commission's Bureau of Insurance (Bureau of Insurance) first addressed the scope and severity of the presumed health care crisis in Virginia in 1975.³⁰ While the Bureau of Insurance noted the positive impact that St. Paul Fire and Marine Insurance Company, a medical malpractice insurance program sponsored by the Medical Society of Virginia, had on malpractice premium rates in the Commonwealth,³¹ it

²⁵ See COMMONWEALTH OF VA., INTERIM REPORT OF THE COMM'N TO STUDY THE COSTS AND ADMIN. OF HEALTH CARE SERVICES TO THE GOVERNOR AND GEN. ASSEMBLY OF VA., S. DOC. NO. 29, at 4 (1976) [hereinafter S. DOC. NO. 29].

²⁶ See generally, PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985) (offering a comprehensive economic analysis of the malpractice insurance experience in the 1970s and the attempts used to remedy the unusually high rates of malpractice claim frequency and severity through tort reform).

²⁷ BUREAU OF INS., STATE CORP. COMM'N, MEDICAL MALPRACTICE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS, at 1 (November, 1975), reprinted in S. DOC. NO. 29 *supra* note 25.

²⁸ *Id.* at 1-2. From 1965 to 1975, the number of new companies seeking to underwrite medical malpractice insurance declined roughly 75%. *Id.* at 2, n.1. Similarly, a majority of those companies already in the medical malpractice insurance business had expressed their desire to discontinue coverage with regulators. *Id.*

²⁹ See *id.* at 93. Although the Bureau of Insurance Report stated that the *national scope* of the health care crisis was supported by data; however, there was not sufficient data to conclude the same in Virginia. See also Taylor & Shields, *supra* note 14.

³⁰ See BUREAU OF INS., *supra* note 27, at 12.

³¹ See *id.* The Medical Society of Virginia sponsored a medical malpractice insurance program in 1956, underwritten and administered by St. Paul Fire and Marine Insurance Company. *Id.* at 12. As of 1975, St. Paul provided coverage for 80% of practicing physicians in Virginia and offered premium rates 25% to 35% lower than those charged by other insurers in Virginia who used standard Insurance Service Office rates. *Id.* Rates with respect to Virginia's hospitals were in a unique situation because the General Assembly repealed the "charitable immunity" exception to non-profit hospitals in 1974.

concluded in its report to the General Assembly that Virginia's health care situation "ha[d] not reached crisis proportions."³² The Bureau of Insurance did, however, recommend the creation of a Joint Underwriting Association to deal with the ex ante concerns of continued medical malpractice insurance availability—the most prominent concern facing Virginia's health care providers at the time.³³ The Bureau of Insurance also listed three solutions "to assure the continued availability of malpractice insurance."³⁴

In briefly addressing concerns regarding the recent increases in damage awards for medical malpractice claims, the Bureau of Insurance recommended that the legislature focus on strengthening medical disciplinary proceedings and increasing the practice of defensive medicine.³⁵ Limiting tort recovery in medical malpractice actions was not recommended anywhere in the continued availability solution, and was in fact explicitly cautioned against in light of Virginia's "conservative legal climate."³⁶

Damage caps were discussed in the section addressing future affordability of malpractice insurance, along with several other proposals designed to reduce malpractice premiums.³⁷ However, the Bureau of Insurance was very skeptical that limiting recovery in medical malpractice actions would achieve the desired effect of reducing insurance premium payments for health care providers.³⁸ In fact, the Bureau of Insurance specifically noted the absence of any medical malpractice claims paid from Virginia-licensed physicians, surgeons or hospitals in excess of \$500,000 from the years 1970-1975.³⁹ During the same five-year period, there was

This imposed a requirement upon 70% to 80% of the state's hospitals that were previously immune as non-profit institutions, to purchase liability insurance. *Id.* at 5. Arguably, this resulting increase in the distribution base should have reduced hospital-based malpractice premiums.

³² *Id.* at 93.

³³ *Id.*

³⁴ *Id.* at 36. These included specifically:

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

Id.

³⁵ *Id.* at 94. The Bureau of Insurance further recommended that "all malpractice claims should be reported to appropriate state agencies for review and individuals who provide information to any state or private disciplinary or risk management committee or board should be immune from civil liability." *Id.* at 94-95.

³⁶ *Id.* at 95. Specifically, the Bureau of Insurance noted that "many of the proposed changes in the legal system would adversely affect the existing remedies of injured patients. This coupled with the fact that there is considerable doubt as to whether any of the proposed changes would have their intended impact argues strongly for restraint." *Id.*

³⁷ *Id.* at 60-73. Among these were suggestions of shortening the statute of limitations, precluding the use of the "breach of warranty" doctrine, eliminating the collateral source rule, increased use of arbitration and regulation of contingent fee contracts in medical malpractice cases. *Id.*

³⁸ *Id.* at 64-66.

³⁹ *Id.* at 28. The Bureau of Insurance reports insurance coverage rates in increments, not specific

only one award ranging from \$250,000 to \$499,999, and one award ranging from \$150,000 to \$249,999.⁴⁰ Based on these statistics, it is difficult to understand exactly where the General Assembly derived the \$750,000 limit, which was significantly more than any prior medical malpractice judgments in Virginia at the time.⁴¹

The Bureau of Insurance also raised "serious questions" regarding the constitutional validity of a cap on medical malpractice recovery, including the absence of a "quid pro quo,"⁴² which had been recognized in other jurisdictions as "essential" to the determination "between the law being declared constitutional or unconstitutional."⁴³ As this Note illustrates, the Bureau of Insurance was correct in not recommending a damage cap, given the absence of any empirical data showing that this type of recovery limitation would have a "beneficial cost impact in [sic] Virginia where settlements in excess of \$200,000 are a rarity," as well as the fact that constitutional challenges to such a cap would be inevitable.⁴⁴ Nonetheless, the Virginia General Assembly ultimately decided to place a \$750,000 limit on damages in medical malpractice actions and passed the Act less than a year after the Bureau of Insurance's report.⁴⁵

Ten years after the Act was passed, the General Assembly authorized another joint subcommittee to evaluate the effectiveness of the Act, including the continued need for the limitation on recovery in section 8.01-581.15.⁴⁶ The subcommittee determined that the medical malpractice cap

dollar amounts.

⁴⁰ *Id.*

⁴¹ See *id.*; see also Taylor & Shields, *supra* note 14, at 810 (noting that no known insurance policies were ever written for \$750,000, which further supports the analysis that the original limitation on recovery was "pulled out of the air by the 1976 legislature and is completely unrelated to any actual examinations, studies, insurance policies, statistics or figures.").

⁴² Most states analyzing the constitutionality of medical malpractice caps look to see if there is a "quid pro quo"—a positive correlation between the limitation imposed on the recovery of medical malpractice plaintiffs and lower medical malpractice premiums for physicians coupled with continued availability. See *infra* note 83. The Virginia Supreme Court has addressed this argument and concluded that "Virginia law does not impose such a quid-pro-quo requirement." Pulliam v. Coastal Emergency Servs. of Richmond, Inc., 509 S.E.2d 307, 314 (Va. 1999).

⁴³ BUREAU OF INS., *supra* note 27, at 65-66. But see Jones v. State Bd. of Med., 555 P.2d 399, 406 (Idaho 1976) (holding that those most severely injured medical malpractice victims lacked an adequate quid pro quo to uphold the constitutionality of a limitation on medical malpractice recovery under a due process challenge); Smith v. Department of Ins., 507 So. 2d 1080, 1088 (Fla. 1987) (declaring a medical malpractice cap unconstitutional under Florida law's quid-pro-quo requirement prohibiting the legislature from taking away a common law right without simultaneously providing a "reasonable alternative").

⁴⁴ BUREAU OF INS., *supra* note 27, at 66.

⁴⁵ See 1976 Va. Acts ch. 611 at 784.

⁴⁶ See COMMONWEALTH OF VA., REPORT OF THE JOINT SUBCOMM. STUDYING VIRGINIA'S MEDICAL MALPRACTICE LAWS TO THE GOVERNOR AND THE GEN. ASSEMBLY OF VA., H. DOC. NO. 12, at 3 (1986) [hereinafter H. DOC. NO. 12]. Other areas discussed in the report were the issues of continuing malpractice review panels, attorneys' fees, the legal standard of care for physicians, qualification of expert medical witnesses and the statute of limitations in medical malpractice actions. See *id.* at

did not require any modifications, in part because of their recommendation to retain the collateral source rule as a "mitigating factor against the harshness of the limitation on recovery."⁴⁷ However, the subcommittee did acknowledge the unfair disparity between those medical malpractice plaintiffs most severely injured and those not affected by the imposition of the damage cap, but ultimately recommended that the Act remain in effect.⁴⁸

In 1987, a third joint subcommittee was formed to investigate the need for overall tort reform in Virginia in response to impending fears of a comprehensive insurance crisis that extended beyond the realm of medical malpractice.⁴⁹ With respect to the area of medical malpractice insurance, the subcommittee noted that Virginia had the third best "loss ratio" in the country and provided statistics showing that the average medical malpractice claim paid statewide in 1984 was still only \$17,000.⁵⁰ Despite these statistics, which were obviously offered to show the positive impact of legislative tort reform measures in the area of medical malpractice, the subcommittee was hesitant to suggest that the General Assembly become involved in comprehensive tort reform.⁵¹ However, the joint subcommittee report did indicate that Virginia's health care providers were still subject to malpractice premium rate increases—a problem that was theoretically alleviated by the damage cap.⁵²

The Attorney General responded, in a supplement to the subcommittee's report, that the relationship between tort reform and lower premiums was tenuous at best, and "may result in insurance companies paying less in claims; but it does not guarantee that insurance companies will allow policyholders in Virginia to share in their savings or that rates charged will reflect the actual loss experience in Virginia."⁵³ In addition, the Attorney General explicitly stated that "[t]ort reform alone will not guarantee [t]hat

3-9.

⁴⁷ *Id.* at 5-6. At common law, the collateral source rule provided that full compensation to the injured party should be borne by the party at fault, and not be offset by any collateral payments to the injured party from insurance or third parties. *See* RICHARD A. EPSTEIN, *CASES AND MATERIALS ON TORTS*, 907-14 (6th ed. 1995).

⁴⁸ *See* H. DOC. NO. 12, *supra* note 46, at 5.

⁴⁹ *See* COMMONWEALTH OF VA., REPORT OF THE JOINT SUBCOMM. STUDYING THE LIABILITY INSURANCE CRISIS AND THE NEED FOR TORT REFORM TO THE GOVERNOR AND THE GEN. ASSEMBLY OF VA., S. DOC. NO. 11, at 5-6 (1987) [hereinafter S. Doc. No. 11].

⁵⁰ *Id.* at 11. The Circuit Court Report publishing these statistics focused on jury awards in state courts around the Richmond metropolitan area; however, even in this—the state capital area—the average medical malpractice award during 1982-1984 was \$302,000. *Id.* at 8.

⁵¹ *Id.* at 18 (stating that "the joint subcommittee is satisfied that the insurance regulatory system and the civil justice system in the Commonwealth are functioning in an equitable manner").

⁵² *Id.* at 12-13. In particular, the subcommittee discussed the impact of rising insurance premium rates on obstetricians. *Id.* *See generally*, Galanter, *supra* note 12, at 1144-45 (finding that OB/GYN and family practice physicians experienced higher premium increases in medical malpractice insurance compared to other non-obstetric specialties, but that this increase was not associated with a corresponding increase in physician withdrawal from obstetrics-based practice).

⁵³ *See* S. DOC. NO. 11, *supra* note 49, at APPENDIX D.

liability insurance will be more available or affordable.”⁵⁴ However, the Attorney General’s warning to the General Assembly that tort reform alone would not solve the problems created by the liability insurance industry was ten years too late. While the warning temporarily spared Virginia from massive tort reform legislation, the health care industry remains the only public service provider in the Commonwealth specifically impacted by legislative tort reform. There has been no further review of the effectiveness of the Medical Malpractice Act since 1986.

In short, the preamble to the Act has served for over twenty years as a “bootstrap” for the Virginia Supreme Court to cling to when asked whether there exists any “rational relation” between the Act and the goals the General Assembly sought to achieve through such means. Given the lack of an immediate medical malpractice insurance crisis prior to the passage of the Act and the questionable effectiveness of the cap on reducing premiums or ensuring continued availability of malpractice insurance, the preamble emerges as an unsubstantiated impetus based on national fears and concerns that, as a matter of public policy, cannot necessitate such harsh tort reform in Virginia.

B. *Virginia’s Legal History*

The Virginia Supreme Court has a strong history of upholding the constitutionality of the Act, even though lower courts have found otherwise.⁵⁵ Under Virginia’s rules of statutory construction, the Virginia Supreme Court presumes that all actions by the General Assembly are constitutional and will find any “reasonable doubt” as to an act’s constitutionality in favor of validity.⁵⁶ In cases challenging the constitutionality of the medical malpractice cap, the court has identified the cap as “economic legislation,” and therefore applies a rational basis test to substantive due process and equal protection challenges.⁵⁷ Two important challenges to the medical malpractice cap as a valid form of tort reform in the Common-

⁵⁴ *Id.*

⁵⁵ See, e.g., *Boyd v. Bulala*, 647 F. Supp. 781 (W.D. Va. 1986), *aff’d in part, rev’d in part*, 877 F.2d 1191 (4th Cir. 1989). The Western District Court of Virginia held that the statutory cap on medical malpractice damages was unconstitutional as violative of the right to a trial by jury under the state and federal constitution, but on appeal the Fourth Circuit deemed the cap was constitutional and neither violative of the right to a jury trial under the state or federal constitution nor the Fourteenth Amendment guarantees of federal equal protection and due process. See *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir. 1989). The Fourth Circuit certified six questions of state law to the Virginia Supreme Court and the court upheld the cap’s constitutionality on state constitutional grounds. See *Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990).

⁵⁶ See *Supinger v. Stakes*, 495 S.E.2d 813, 815 (Va. 1998); *Blue Cross of Va. v. Commonwealth*, 269 S.E.2d 827, 832 (Va. 1980).

⁵⁷ The rational basis test is satisfied if “the legislation has a reasonable relation to a proper purpose and is neither arbitrary nor discriminatory.” *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 530 (Va. 1989) (citing *Duke v. County of Pulaski*, 247 S.E.2d 824, 829 (Va. 1978)).

wealth of Virginia preceded *Pulliam v. Coastal Emergency Services of Richmond: Etheridge v. Medical Center Hospitals*⁵⁸ and *Bulala v. Boyd*.⁵⁹

In *Etheridge*, the Virginia Supreme Court held that the state's medical malpractice cap did not violate the right to a jury trial,⁶⁰ satisfied the rational basis test with respect to both due process and equal protection challenges⁶¹ and did not violate Virginia's doctrine of separation of powers.⁶² The *Etheridge* court also rejected the claim that the malpractice limitation was a clear example of "special legislation" in violation of article IV, section 14 of Virginia's constitution.⁶³

This "special legislation" section provides 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."⁶⁴ The Virginia Supreme Court reasoned that the General Assembly has the power to make laws that create certain classifications "provided the classification itself [is] a reasonable and not arbitrary one, and the law [is] made to apply to all of the persons belonging to the class without distinction."⁶⁵ The court also noted that if a classification bears "a reasonable and substantial relation to the object sought to be accomplished by the legislation," then any special legislation challenge would fail.⁶⁶ By reasoning that the medical malpractice cap applies to all medical malpractice plaintiffs and that the preamble to the Act provides the "reasonable and substantial relation" to the desired goals of the legislature, the *Etheridge* court held that the cap did not violate the prohibition against special legislation.⁶⁷

⁵⁸ 376 S.E.2d 525 (Va. 1989).

⁵⁹ 389 S.E.2d 670 (Va. 1990).

⁶⁰ *Etheridge*, 376 S.E.2d at 529 (noting that the cap simply "establish[es] the outer limits of a remedy [and a] court applies the remedy's limitation only after the jury . . . fulfill[s] its fact-finding function. [Therefore,] section 8.01-581.15 does not infringe upon the right to a jury trial because the section does not apply until after a jury . . . complete[s] its assigned function").

⁶¹ *Id.* at 529-31, 533-34. The due process challenge covered both procedural and substantive due process claims under the Federal and Virginia constitutions. The equal protection challenge was a federal claim because Virginia does not have an equivalent "equal protection" provision in its constitution. The closest provision in the Virginia constitution to the Fourteenth Amendment is its anti-discrimination clause in art. I, § 11. *See* VA. CONST. art. I, § II.

⁶² *Etheridge*, 376 S.E.2d at 531-32 (explaining that legislative "modification of the common law" was a "proper exercise of legislative power").

⁶³ *Id.* at 532-33. A second argument made by the *Etheridge* court was that the cap violated art. I, § 4, which states in part that that "no man, or set of men, is entitled to exclusive or separate emoluments or privileges from the community." *Id.* The court dismissed this claim noting "[w]e have held that 'this clause was intended to shield against heredity in office and has no reference to the . . . action of the legislature in passing laws regulating the domestic policy and business affairs of the people.'" *Id.* (citing *O'Neil v. City of Richmond*, 126 S.E. 56, 59 (Va. 1925)).

⁶⁴ VA. CONST. art. IV, § 14.

⁶⁵ *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 533 (Va. 1989) (citing *Ex Parte Settle*, 77 S.E. 496, 497 (Va. 1913)).

⁶⁶ *Id.* (citing *Mandell v. Haddon*, 121 S.E.2d 516, 525 (Va. 1961)).

⁶⁷ *Id.*

The Virginia Supreme Court made two additional decisions regarding the appropriate interpretation of the statutory cap. First, the court held that the plain meaning of the term "total recovery" applied to a plaintiff's indivisible injury, not to each defendant.⁶⁸ Second, the court held that, although Virginia's charitable hospital provision limits liability in negligence actions to an amount not in excess of its liability insurance coverage, the medical malpractice cap specifically limits damages recoverable against any "health care provider," and thus, is the applicable statutory provision to apply in medical malpractice actions.⁶⁹

Etheridge was decided while *Boyd v. Bulala*⁷⁰ was on appeal in the Fourth Circuit. The United States District Court for the Western District of Virginia had held a year earlier that Virginia's medical malpractice cap violated the plaintiff's right to a jury trial.⁷¹ However, the United States Court of Appeals for the Fourth Circuit concluded that Virginia's medical malpractice cap did not violate any federal or state constitutional provisions, in light of the *Etheridge* decision.⁷² To aid in applying Virginia law, the Fourth Circuit certified six questions of state law to the Virginia Supreme Court regarding the scope of the Act.⁷³ Again, relying on the explicit language in the preamble to the Act, the state supreme court held that "the total damages recoverable for injury to a 'patient' are limited to the statutory amount, regardless of the number of legal theories upon which the claims are based."⁷⁴ The court also held that punitive damages are subject to the maximum cap.⁷⁵ Today, the Virginia Supreme Court continues to support the constitutionality of the Act, and the malpractice cap, in particular.

⁶⁸ *Id.* at 534-35.

⁶⁹ *Id.* at 535-36. Section 8.01-38 governs the tort liability of Virginia's hospitals. The code provides in part that no hospital shall be immune from liability unless (1) the hospital renders exclusively charitable medical care and treatment, or (2) if the hospital entered into an "express written agreement" with the patient at the time of admission "providing that all medical services furnished . . . are to be supplied on a charitable basis without financial liability to the patient." VA. CODE ANN. § 8.01-38 (Repl. Vol. 1992 & Cum. Supp. 1999).

⁷⁰ 647 F.Supp. 781 (W.D. Va. 1986), *aff'd in part, rev'd in part*, 877 F.2d 1191 (4th Cir. 1989).

⁷¹ *Id.*

⁷² *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir. 1989).

⁷³ *Id.* The certified questions regarding § 8.01-581.15 included: 1) whether the statute applied individually to each plaintiff or overall to two or more plaintiffs; 2) whether the statute applies to damages arising from the infliction of emotional distress; 3) whether the statute applies to punitive damages; 4) whether Virginia law allows recovery for loss of enjoyment of life resulting from medical malpractice; 5) whether Virginia law allows recovery for damages to plaintiff's lost earning capacity; and, 6) what the effect is of death after verdict, but before judgement, under VA. CODE ANN. §§ 8.01-21, 8.01-5, and 8.01-56. *Bulala v. Boyd*, 389 S.E.2d 670, 671-72 (Va. 1990).

⁷⁴ *Bulala v. Boyd*, 389 S.E.2d 670, 675 (Va. 1990).

⁷⁵ *Id.* at 676. *But see* VA. CODE ANN. § 8.01-38.1 (Cum. Supp. 1999), which caps punitive damages in civil cases to \$250,000 with the explicit language "including actions in medical malpractice."

II. OTHER STATE COURT INTERPRETATIONS OF MEDICAL MALPRACTICE CAPS

While the highest state court in Virginia consistently upholds the constitutionality of the limitation on medical malpractice damages,⁷⁶ other state court decisions have varied throughout the rest of the nation. According to one study, the notion of "state constitutionalism" has essentially nullified state tort law legislation over sixty times in the past decade.⁷⁷ The Association of Trial Lawyers of America (ATLA) embraces this notion as one of the "positive consequences" of the tort reform campaign given the long history of "disuse and disfavor" of state constitutional law.⁷⁸ However, the particular response of each state's legislature varies, as does the specific rulings of state courts on the constitutionality of tort reform measures. A brief look into how other state courts have addressed constitutional challenges to medical malpractice caps is instructive to comparatively analyze the situation in Virginia.

The Illinois and Ohio supreme courts are staunch opponents of legislative tort reform in many areas, including medical malpractice. The Illinois General Assembly enacted broad legislation in the fall of 1975 to deal with the presumed medical malpractice insurance crisis that was sweeping the nation.⁷⁹ One section of this act capped the total amount recoverable in medical malpractice actions to \$500,000.⁸⁰ In a swift challenge brought before the Illinois Supreme Court in 1976, the court held that the statutory cap constituted "special legislation" in violation of the Illinois state constitution.⁸¹ The court noted that the right to recover damages for medical malpractice existed at common law, and thus, any legislative limit imposed on medical malpractice damages was subject to judicial scrutiny when the constitutionality of such limitation was challenged.⁸² The court ultimately held that while the General Assembly can modify or abolish a common law action, legislation that limits recovery in medical malpractice actions

⁷⁶ See Part I.B *supra* and corresponding notes.

⁷⁷ VICTOR E. SCHWARTZ ET AL., WHO SHOULD MAKE AMERICA'S TORT LAW: COURTS OR LEGISLATURES? (WASHINGTON LEGAL FOUNDATION 1997).

⁷⁸ Jeffrey R. White, *Top 10 In Torts: Evolution In The Common Law*, TRIAL, July 1996, 50, 51. Although traditionally tort law was state common law modified by judges, recent decades have witnessed an "organized campaign" of legislative tort law, leaving judges with the task of striking it down on constitutional grounds. *Id.* at 51. The article further notes that many state courts have recognized that state constitutions "afford greater legal protections than the minimum provided by the US Constitution." *Id.*

⁷⁹ Pub. Act 79-960, *An Act to Revise the Law in Relation to Medical Malpractice*, was approved on September 12, 1975, and became effective on November 11, 1975.

⁸⁰ Ill. Rev. Stat. 1975, ch. 70, par. 101.

⁸¹ *Wright v. Central Du Page Hosp. Ass'n*, 347 N.E.2d 736, 743 (Ill. 1976).

⁸² *Id.* at 742. The court stated that in wrongful death actions the court had no authority to question statutory limitations placed on wrongful death damages because the right and remedy for wrongful death were both created by the General Assembly. *Id.*

at an arbitrary amount without a "concomitant quid pro quo"⁸³ constitutes "a special privilege . . . in violation of the Illinois constitution."⁸⁴

Most recently, the Illinois Supreme Court struck down another statutory provision enacted by its General Assembly that capped recovery of non-economic damages at \$500,000 per plaintiff.⁸⁵ This particular provision applied to "all common law, statutory or other actions that seek damages on account of death, bodily injury, or physical damage to property based on negligence, or product liability based on any theory or doctrine," and included non-economic damages arising out of medical malpractice actions.⁸⁶ Once again, the Illinois Supreme Court held that the statutory \$500,000 cap on non-economic damages was unconstitutional special legislation.⁸⁷ The court stated that "the arbitrary and automatic cap on compensatory damages for non-economic injuries in only certain tort cases parallels the harm of the arbitrary classifications [previously] stricken by this court."⁸⁸ Furthermore, the court noted that the cap operated as a "legislative remittitur" in practice and therefore violated the state's doctrine of separation of powers.⁸⁹

The General Assembly of Ohio passed similar legislation in its Medical Malpractice Act in July 1975. This legislation came in response to the "turmoil that swept the nation in the early 1970s with the medical fraternity predicting dislocation of medical care as the result of soaring malpractice rates."⁹⁰ The Ohio Medical Malpractice Act amended ten sections of the Ohio Revised Code and established twenty-six new statutes, including a \$200,000 cap on non-economic damages awarded in medical malpractice actions.⁹¹

The Ohio Supreme Court reviewed the constitutionality of this statutory cap in 1991, and held that the \$200,000 comprehensive limitation on recovery in medical malpractice actions violated the state's constitutional

⁸³ The court described an adequate "quid pro quo" by analogy to the Workmen's Compensation Act of 1975 in Illinois. See ILL. REV. STAT. 1975, ch. 48, § 138.1. In this example, employers "assumed a new liability without fault but was relieved of the prospect of large damage judgements" while employees agreed to accept limits on recovery in return for swift compensation without a determination of the employer's negligence. *Id.* at 742.

⁸⁴ *Id.* at 743. See ILL. CONST. art. IV, § 13 (prohibiting special legislation).

⁸⁵ See 735 ILL. COMP. STAT. 5/2-1115.1 (West 1996). This is one particular provision of Pub. Act 89-7, "An Act to Amend Certain Acts in Relation to Civil Actions, the Civil Justice Reform Amendments of 1995," which became effective on March 9, 1995. Arguably, this legislation was an attempt by the General Assembly to get around the court's previous ruling in *Wright*, 347 N.E.2d at 743, which held the \$500,000 cap on medical malpractice damages was unconstitutional special legislation.

⁸⁶ See 735 ILL. COMP. STAT. 5/2-1115.1 (West 1996).

⁸⁷ *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1078 (Ill. 1997).

⁸⁸ *Id.* at 1076.

⁸⁹ *Id.* at 1080.

⁹⁰ *Morris v. Savoy*, 576 N.E.2d 765, 768 (Ohio 1991). See 1975 Ohio Laws 136.

⁹¹ *Morris*, 576 N.E.2d at 768. See Ohio Rev. Code § 2307.43.

due process provisions.⁹² The court noted the absence of any conclusive evidence indicating a rational connection between the statutory cap and an effect on malpractice insurance rates in the amici briefs filed with the court or in other state supreme court opinions on the issue.⁹³ Furthermore, the court noted that Ohio's Medical Malpractice Act required annual reports on the Act's "effectiveness" from the State Superintendent of Insurance.⁹⁴ In particular, the court observed the absence of the \$200,000 cap on medical malpractice recovery from those sections requiring annual review. Based on these factors, the court ultimately concluded that the \$200,000 cap on non-economic damages was "unreasonable and arbitrary" and did not "bear a real and substantial relation to public health or welfare."⁹⁵

Unlike the tort reform legislation of Illinois and Ohio in 1975, the Kansas General Assembly did not include a limiting cap on medical malpractice damages in its first attempt to remedy the perceived "availability" malpractice insurance crisis.⁹⁶ However, as medical malpractice premiums continued to increase, an "affordability" crisis arose in the mid-1980s and the General Assembly subsequently enacted a \$250,000 cap on non-economic damages in medical malpractice actions.⁹⁷ In 1988, the constitu-

⁹² *Morris*, 576 N.E.2d at 771. Although the court found the cap unconstitutional under the state's due process provision, it did not find that it violated the state's equal protection provision. *Id.* at 772. However, Justice Sweeney's dissent in *Morris* convincingly argued that Ohio's damage cap is unconstitutional for additional reasons, including that the cap violates the right to a jury trial, equal protection and the open courts doctrine, and conveys special privileges in violation of the Ohio Constitution. *Id.* at 777-88 (Sweeney, J., concurring in part, dissenting in part). Justice Sweeney concluded that "[t]his court is the last bastion upon which most citizens can depend to protect their constitutional rights." *Id.* at 787.

⁹³ *Morris*, 576 N.E.2d at 770-71. The court noted that the Texas Supreme Court cited one independent study showing that less than 0.6 percent of all claims brought were for more than \$100,000. *Id.* (citing *Lucas v. United States*, 757 S.W.2d 687, 691 (Tex. 1988)). The court also noted that a 1987 study by the Insurance Service Organization (ISO) found the savings from various states' tort reforms, including caps on non-economic damages, "marginal to nonexistent." *Id.* (citing the amici curiae brief of ATLA, Consumer Federation of America, and Dissatisfied Parents Together).

⁹⁴ *Id.* at 770.

⁹⁵ *Id.* at 771. This standard of review is higher than the "rational basis" standard typically used for economic regulations such as recovery limitations. The New Hampshire Supreme Court also struck down a broad tort reform statute using a "fair and substantial relation" heightened scrutiny standard. In *Carson v. Maurer*, the New Hampshire Supreme Court held that a \$250,000 statutory cap on non-economic damages violated equal protection and that the right to recover for personal injuries was a "substantial" right. 424 A.2d 825, 836-37 (N.H. 1980). Moreover, the New Hampshire Supreme Court determined that it could afford individuals more rights than those conferred under federal constitutional standards when interpreting its state constitutional provisions. *Id.* at 831. See also *infra* Part IV.A.

⁹⁶ See KAN. STAT. ANN. § 40-3401 (1976). The "Health Care Provider Insurance Availability Act" required mandatory malpractice coverage for all practicing health care providers within the state. *Id.* To achieve this, the legislation called for the establishment of a Joint Underwriting Association to provide malpractice insurance to those health care providers who could not otherwise obtain malpractice insurance in the outside market. *Id.* In addition, it created "the Fund" to provide additional liability coverage above the primary coverage limits to all providers. *Id.*

⁹⁷ See KAN. STAT. ANN. § 60-3407 (1987 Supp.). In addition to the cap on non-economic damages, a \$1 million limitation was imposed on total damages recoverable, including both economic and

tionality of this statutory provision was challenged before the Kansas Supreme Court.⁹⁸ Ultimately, the court struck down the statute as unconstitutional and violative of both the section 5 guarantee of the right to a jury trial⁹⁹ and the section 18 guarantee to "remedy by due course of law"¹⁰⁰ within the bill of rights of the Kansas Constitution. Because the court found the statute unconstitutional under these two provisions, it did not consider the equal protection challenge also before the court.¹⁰¹

In contrast to the Illinois, Ohio, and Kansas approaches to tort reform, Indiana's Medical Malpractice Act of 1975¹⁰² is one of the "most comprehensive and severe set of insurance and tort reforms in the nation."¹⁰³ Indiana's Act contains three reform provisions: a \$500,000¹⁰⁴ cap on total damages recoverable in a medical malpractice action; mandated review by a medical review panel prior to trial; and a state-run insurance fund for large claims.¹⁰⁵ Although the Indiana state courts consistently uphold the medical malpractice cap against constitutional challenges, the effectiveness of the cap is questionable.¹⁰⁶ Two characteristics of claims affecting affordability and availability of medical malpractice insurance are frequency and severity, or cost, of the claims.¹⁰⁷ From 1977-1988, both claim severity and claim frequency in Indiana increased, reaching a highpoint in the mid-1980s.¹⁰⁸ As a result, the courts resorted to using "creatively structured" settlements¹⁰⁹ to provide claimants with damage awards that circumvented the strict statutory cap.¹¹⁰

While numerous state supreme courts have addressed the validity of

non-economic damages. *Id.* However, to offset this in severe cases where \$1 million is insufficient to cover future medical costs, the plaintiff may petition for supplemental benefits (which can be in the form of an annuity) to pay for future medical care and related benefits up to a total of \$3 million. *Id.* at § 60-3411. This section is known as the "pinhole provision." *Id.*

⁹⁸ Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988).

⁹⁹ *Id.* at 260.

¹⁰⁰ *Id.* at 260-64. The court noted that the absence of an adequate quid pro quo with respect to this modification of a medical malpractice victim's right to a remedy by "due course of law" was important in its decision to hold the cap unconstitutional as a violation of § 18 of the Kansas Bill of Rights. *Id.* at 264.

¹⁰¹ *Id.* at 264.

¹⁰² 1975 Ind. Acts 854, codified as amended at IND. CODE §§ 16-9.5-1-1 to -10-5 (1988).

¹⁰³ Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 IND. L. REV. 1275, 1302 (1991).

¹⁰⁴ IND. CODE § 16-9.5-2-2. This amount was subsequently increased to \$750,000 as of January 1, 1990.

¹⁰⁵ See Kinney, *supra* note 103, at 1278.

¹⁰⁶ *Id.* at 1281-82.

¹⁰⁷ *Id.* at 1285.

¹⁰⁸ *Id.* at 1287.

¹⁰⁹ Periodic payments and structured settlements are designed to ensure that damage awards will remain available to claimants throughout the course of their need for compensation, while eliminating the guess-work that comes with determining life expectancy and length of injury that is associated with lump-sum awards. *Id.* at 1299.

¹¹⁰ *Id.*

caps on medical malpractice damages, the United States Supreme Court has yet to entertain the issue of whether statutory medical malpractice liability caps violate the U.S. Constitution. In 1985, the California Supreme Court held that a \$250,000 limit on non-economic damages in medical malpractice cases did not violate the plaintiff's due process or equal protection rights under the Fourteenth Amendment.¹¹¹ The plaintiff appealed to the United States Supreme Court, and the court subsequently dismissed the case for "want of a substantial federal question," offering no opinion in support of its dismissal.¹¹² Thus, the lack of guidance resulted in widespread debate among state supreme courts and legal scholars alike as to whether medical malpractice caps violate the Federal Constitution, individual state constitutions, or both.¹¹³ Overall, the result is divided across the country on the constitutionality of statutory caps in medical malpractice suits.¹¹⁴ In addition to those states already mentioned, the following state courts have found legislative tort reform in the medical malpractice area to be unconstitutional: Alabama,¹¹⁵ New Hampshire,¹¹⁶ South Dakota,¹¹⁷ and Texas.¹¹⁸ On the other hand, state courts in California,¹¹⁹ Colorado,¹²⁰ Louisiana,¹²¹ Missouri,¹²² and West Virginia¹²³ have all up-

¹¹¹ Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985), *appeal dismissed* 474 U.S. 892 (1985).

¹¹² Fein v. Permanente Med. Group, 474 U.S. 892 (1985).

¹¹³ The federal constitutional debate on medical malpractice statutory caps is beyond the scope of this Note. See *supra* note 8 for articles on this topic.

¹¹⁴ See SCHWARTZ, *supra* note 76, at Appendices A & B.

¹¹⁵ Smith v. Schulte, 671 So. 2d 1334 (Ala. 1995), *cert. denied*, 517 U.S. 1220 (1996). Alabama is the only state where "recovery for wrongful death has been judicially restricted to punitive damages." *Id.* at 1338 (citing Breed v. Atlanta, B. & C.R.R., 4 So. 2d 315, 316 (Ala. 1941)). The Smith court held that the \$1,000,000 cap on total medical malpractice damages violated the equal protection and jury trial provisions in Alabama's constitution. *Id.* at 1337-1344.

¹¹⁶ Carson v. Maurer, 424 A.2d 825 (N.H. 1980) (holding that \$250,000 limit on non-economic damages violated the state's equal protection guarantee); see also *supra* note 94.

¹¹⁷ Knowles v. United States, 544 N.W.2d 183 (S.D. 1996) (holding that \$1 million aggregate limit on total damages in health care liability actions violated the state constitution's substantive due process provision, but also holding the limited non-economic cap of \$500,000 to be acceptable).

¹¹⁸ Lucas v. United States, 757 S.W.2d 687 (Tex. 1988) (holding that the \$500,000 cap in medical malpractice actions violated the "open courts" provision in Texas' constitution).

¹¹⁹ Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985), *appeal dismissed*, 474 U.S. 892 (1985) (holding that \$250,000 limit on non-economic damages in medical malpractice actions does not violate the equal protection or due process guarantees of the state or federal constitution).

¹²⁰ Scholz v. Metro. Pathologists, P.C., 851 P.2d 901 (Colo. 1993), *reh'g denied*, 1993 Colo. LEXIS 502 (Colo. 1993) (holding that \$1,000,000 limit on total damages recoverable in medical malpractice actions does not violate either the due process or equal protection provisions of Colorado's state constitution).

¹²¹ Butler v. Flint Goodrich Hosp. of Dillard Univ., 607 So. 2d 517 (La. 1989) (holding that \$500,000 cap on total damages in a medical malpractice action does not violate equal protection provisions of either the state or federal constitution).

¹²² Adams v. Children's Mercy Hosp., 832 S.W.2d 898 (Mo. 1992), *cert. denied*, 506 U.S. 991 (1992) (holding that \$350,000 limit on non-economic damages in medical malpractice actions did not violate the state or federal constitution guarantee of equal protection, or the open courts or right to remedy provisions in the state constitution).

held the constitutionality of damage caps in medical malpractice liability cases.¹²⁴ This Note argues that the statutory damage cap in medical malpractice liability actions clearly violates the “special legislation” and equal protection provisions of Virginia’s Constitution.

III. *PULLIAM V. COASTAL EMERGENCY SERVICES OF RICHMOND, INC.*

Virginia’s medical malpractice cap faced a recent challenge before the supreme court in *Pulliam v. Coastal Emergency Services of Richmond, Inc.*¹²⁵ The *Pulliam* court held in a unanimous decision that the \$1,000,000 medical malpractice cap was constitutional,¹²⁶ even in light of seven separate and previous constitutional challenges by petitioners.¹²⁷ In upholding the cap’s constitutionality, the court appeared to place stronger emphasis on *stare decisis* than in applying the correct standard of review in medical malpractice cases where potential damages are limited by an arguably ineffective and unnecessary legislative act.

A. *The Facts and Procedural Posture*

Elnora Pulliam went to the emergency room of Southside Regional Medical Center in Petersburg, Virginia, at 3:55 a.m. on December 15, 1995, complaining of aches in her legs.¹²⁸ After an examination by Dr. DiGiovanna,¹²⁹ Mrs. Pulliam was discharged at approximately 5:00 a.m. with a prescription for muscle relaxers and instructions on managing her influenza.¹³⁰ Around 11:00 a.m. that same day, Mrs. Pulliam returned to the emergency room at Southside Regional with complaints of general weakness, specifically in her lower extremities.¹³¹ Dr. Wickizer¹³² examined Mrs. Pulliam, started her on intravenous fluids, took a CT scan and performed a lumbar puncture.¹³³ Soon after, Mrs. Pulliam was transported

¹²³ *Robinson v. Charleston Area Med. Ctr., Inc.*, 414 S.E.2d 877 (W. Va. 1991) (holding that \$1,000,000 cap on non-economic damages in medical malpractice actions did not violate the equal protection, prohibition against special legislation, due process, or right to remedy provisions of the state constitution).

¹²⁴ See White, *supra* note 78, Appendix B.

¹²⁵ 509 S.E.2d 307 (Va. 1999).

¹²⁶ *Id.* at 310.

¹²⁷ *Id.* at 312-19.

¹²⁸ *Id.* at 311.

¹²⁹ *Id.* Dr. DiGiovanna, one of the defendants in this action, was a contractor for Southside Regional employed by Coastal Emergency Services of Richmond. *Id.*

¹³⁰ *Id.* Mrs. Pulliam’s private physician had diagnosed her influenza two days earlier. *Id.*

¹³¹ *Id.*

¹³² *Id.* at 311. Dr. Wickizer was also originally one of the named defendants in this action, but was subsequently non-suited. *Id.* at 311, n.3.

¹³³ *Id.* A lumbar puncture is the insertion of a needle into the lower back to obtain spinal fluid for

to the intensive care unit.¹³⁴ Her condition continued to deteriorate, and Mrs. Pulliam died that evening.¹³⁵ Her cause of death was determined to be "bacterial pneumonia and bacteremia."¹³⁶

Mrs. Pulliam's surviving husband, who was also the executor of her estate, brought this medical malpractice action against Coastal Emergency Services of Richmond, Inc. (Coastal) and Dr. DiGiovanna, alleging negligence in the death of Mrs. Pulliam.¹³⁷ A jury awarded Mr. Pulliam damages in the amount of \$2,045,000, plus interest from the date of Mrs. Pulliam's death, against both defendants.¹³⁸ The trial court subsequently reduced the verdict to \$2,000,000 (the amount originally sought in the ad damnum clause by Mr. Pulliam) pursuant to defendants' motion and further reduced the verdict to \$1,000,000 pursuant to Virginia's medical malpractice cap.¹³⁹ The trial court also denied the award of prejudgment interest accruing from the date of Mrs. Pulliam's death.¹⁴⁰ Mr. Pulliam subsequently appealed this decision to the Virginia Supreme Court.¹⁴¹

B. *The Majority Opinion*

Chief Justice Carrico, writing for the court, upheld the constitutionality of the medical malpractice liability cap and reaffirmed the Virginia Supreme Court's decision in *Etheridge*.¹⁴² In addressing the seven constitutional challenges to the cap, the majority borrowed largely from its reasoning in *Etheridge* and twice expounded on the significant role that *stare decisis* played in its decision.¹⁴³

medical diagnosis. See Joseph B. Martin & Stephen L. Hauser, *Approach to the Patient with Neurologic Disease*, HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, 2277, 2281-82 (Fauci et al. eds., 1998).

¹³⁴ *Pulliam*, 509 S.E.2d at 311.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 310.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.* The Virginia Supreme Court later held that prejudgment interest was intended under the Act to be included in the statutory limitation. *Id.* at 320-21.

¹⁴¹ *Id.*

¹⁴² *Id.* at 310.

¹⁴³ *Id.* at 312. Prior to addressing the constitutional challenges before it in the *Pulliam* case, the majority made clear that *stare decisis* "plays a significant role in the orderly administration of justice by assuring consistent, predictable, and balanced application of legal principles." *Id.* (citing *Selected Risks Ins. Co. v. Dean*, 355 S.E.2d 579, 581 (Va. 1987)). The court also noted that "when a court of last resort has established a precedent, after full deliberation upon the issue by the court, the precedent will not be treated lightly or ignored, in the absence of flagrant error or mistake." *Id.* The majority concluded with a final mention of the critical role *stare decisis* played in a previous case involving the constitutionality of the Virginia Water and Sewer Authorities Act. *Id.* at 321 (citing *Myers v. Moore*, 131 S.E.2d 414, 417 (Va. 1963)).

1. Constitutional Challenges to the Medical Malpractice Cap

Addressing each of the constitutional challenges in turn, the majority first concluded that the statutory cap on medical malpractice damages did not violate Virginia's constitutional protection of the right to a jury trial.¹⁴⁴ The majority relied on its reasoning in *Etheridge* and concluded that "once the jury has ascertained the facts and assessed the damages, . . . the constitutional mandate is satisfied [and thereafter], it is the duty of the court to apply the law to the facts."¹⁴⁵ The medical malpractice cap was described as the "outer limits of a remedy," where a remedy is a matter of law reserved exclusively to the courts.¹⁴⁶ Moreover, the majority made the analogy that if a legislative enactment or modification of a statute of limitations upon medical malpractice actions did not violate the right to a jury trial, then the legislature's enactment of damage caps did not violate the right to a jury trial.¹⁴⁷

Second, the court refused to consider plaintiff's arguments that the Act constituted special legislation in violation of Virginia's constitution.¹⁴⁸ The court cited plaintiff's procedural error in failing to raise this particular argument in the proceedings below.¹⁴⁹ Despite the procedural fault, the court explicitly reaffirmed its position in *Etheridge*,¹⁵⁰ stating that because the Act satisfied the "reasonable and substantial" relation test, it would "survive a special-laws constitutional challenge," as well.¹⁵¹ The majority further added that the legislative ends and means of the Act were reasonable and applied to all persons within the specified class indiscriminately,

¹⁴⁴ Virginia's constitution, article I, section 11 states 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." VA. CONST. art. I, § 11. The Seventh Amendment right to a jury trial in federal civil cases does not apply to the states through the Fourteenth Amendment, and thus challenges to the right to a jury trial in state civil cases must be grounded in an equivalent state provision. *New York Cent. R.R. v. White*, 243 U.S. 188 (1917).

¹⁴⁵ *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.*, 509 S.E.2d 307, 312 (Va. 1999) (quoting *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 529 (Va. 1989)).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 314.

¹⁴⁸ See VA. CONST. art. IV, § 14 ("[T]he General Assembly shall not enact any local, special, or private law. . . [g]ranting to any private corporation, association, or individual any special or exclusive right, privilege, or immunity.").

¹⁴⁹ *Pulliam*, 509 S.E.2d at 316. The plaintiff's attorney failed to mention the special legislation argument in either his appellate briefs or in the record below, and instead raised it for the first time during oral arguments in violation of the Virginia Supreme Court's Rule 5:25. *Id.* The plaintiff's attorney relied on the report "Medical Malpractice Insurance in Virginia," which was attached as an exhibit to Sen. Doc. 29 (1976). *Id.* at 315; see also *supra* Part I.A.2. After restating the plaintiff's argument in a persuasive manner, the majority simply refused to address this argument due to the procedural error. *Pulliam*, 509 S.E.2d at 315-16.

¹⁵⁰ *Pulliam*, 509 S.E.2d at 317.

¹⁵¹ *Id.* at 315.

and therefore, did not constitute special legislation.¹⁵² Additionally, the “as applied” argument that Coastal was not a “health care provider” under the Act failed under the 1994 amended Virginia Code section 8.01-581.1.¹⁵³ Plaintiff’s argument attempted to show that extension of the cap to Coastal, a non-licensed health care provider, failed the reasonable and substantial relation test because it constituted special legislation and did not accomplish the objective of the Act itself.¹⁵⁴

Third, the majority held that the cap did not interfere with the Fifth Amendment’s “takings clause” or with the equivalent state constitutional provision.¹⁵⁵ Relying on the rationale in *Hess v. Snyder Hunt Corporation* that a statute of repose did not constitute a taking even though it effectively extinguished all legal remedies and future causes of action,¹⁵⁶ the majority held that the malpractice cap did not constitute a taking.¹⁵⁷ The court noted that claimants do not have a vested property right in a cause of action that had not accrued at the time the General Assembly imposed the cap.¹⁵⁸

Fourth, the majority held that the due process and equal protection challenges were procedurally defaulted, and thus did not consider plaintiff’s arguments on these issues.¹⁵⁹ Borrowing the “rational basis test” from *Etheridge*,¹⁶⁰ the court determined that the plaintiff “suffered no denial of due process or equal protection from application of the cap to the jury verdict in this case.”¹⁶¹ According to the majority, the Act would be upheld against a due process challenge if the “legislation has a reasonable relation to a proper purpose and is not arbitrary or discriminatory.”¹⁶² Similarly, legislation that creates a classification will be upheld on equal protection

¹⁵² *Id.* at 317.

¹⁵³ *Id.* at 316 (citing VA. CODE ANN. § 8.01-581.1 (Cum. Supp. 1999) which defined “health care provider” as “a corporation, partnership, limited liability company or any other entity, except a state-operated facility, which employs or engages a licensed health care provider and which primarily renders health care services.”). See *supra* note 24.

¹⁵⁴ *Id.* at 316.

¹⁵⁵ *Id.* at 317-18. See VA. CONST. art. I, § 11.

¹⁵⁶ 392 S.E.2d 817, 821 (Va. 1990).

¹⁵⁷ *Pulliam*, 509 S.E.2d at 318.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* Plaintiff’s due process challenge was not considered by the court because the plaintiff attempted to “incorporate by reference the due process arguments considered and rejected by this [c]ourt in *Etheridge*.” *Id.* at 318 n.12. The court stated that all arguments “must be made in appellate briefs.” *Id.* (quoting *Williams v. Commonwealth*, 450 S.E.2d 365, 372 (Va. 1994)). Thus, the court did not address plaintiff’s argument that the Act failed a rational basis test based upon the information in S. Doc. 29 because it was raised for the first time on appeal. *Id.* at 319.

¹⁶⁰ *Id.* at 318. The majority reiterated that in cases involving a due process or equal protection challenge, a rational basis test applies unless a suspect class or fundamental right is involved. The cap on medical malpractice damage awards affects neither of these prerequisites. *Id.* (citing *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 534 (Va. 1989)).

¹⁶¹ *Id.*

¹⁶² *Id.* (citing *Etheridge*, 376 S.E.2d at 530).

grounds as long as it could reasonably promote a legitimate state purpose.¹⁶³ Without any further rationale other than a reference to its *Etheridge* decision, the majority declared that the rational basis test was satisfied in this case.¹⁶⁴

Fifth, the majority combined the separation of powers and province of the judiciary arguments into one section.¹⁶⁵ The majority observed that the legislature has the “power to provide, modify, or repeal a remedy”¹⁶⁶ and may “by the enactment of a general law, modify, or annul any rules adopted or amended pursuant to [Virginia Constitution, Article VI, Section 5].”¹⁶⁷ The majority also noted that the General Assembly has “the power to determine the original and appellate jurisdiction of the courts and the Commonwealth.”¹⁶⁸ Relying again on the rationale used in *Etheridge*, the majority concluded that “whether the remedy prescribed in Code § 8.01-581.15 is viewed as a modification of the common law or as establishing the jurisdiction of the courts in specific cases, clearly it was a proper exercise of legislative power.”¹⁶⁹

2. Scope of the Medical Malpractice Act

The majority also addressed a sixth constitutional challenge on the appropriate definition of “health care provider” under the Act.¹⁷⁰ The court rejected the plaintiff’s argument that Coastal was merely “a specialized type of employment placement service,” and thus the medical malpractice cap should not apply to Coastal.¹⁷¹ Instead, the supreme court concluded that the statutory language applied to Coastal because the corporation was a provider of emergency physicians to area hospitals.¹⁷² As such, Coastal fell within the statutory language of the Act as a corporation that “primarily renders health care services,” and thus, was entitled to benefit from the cap on total damage liability in medical malpractice actions.¹⁷³

Finally, the majority determined that prejudgment interest was intended to be included within the statutory cap under the “plain meaning” of the Act.¹⁷⁴ Distinguishing between prejudgment interest and postjudgment interest, the majority concluded that “prejudgment interest is nor-

¹⁶³ *Id.* (citing *Etheridge*, 376 S.E.2d at 534).

¹⁶⁴ *Id.* at 318-19.

¹⁶⁵ *Id.* at 319.

¹⁶⁶ *Id.* (quoting *Etheridge*, 376 S.E.2d at 532).

¹⁶⁷ *Id.* (quoting VA. CONST. art IV, § 5).

¹⁶⁸ *Id.* (quoting *Etheridge*, 376 S.E.2d at 532). See VA. CONST. art. VI, § 1.

¹⁶⁹ *Pulliam*, 509 S.E.2d at 319 (quoting *Etheridge*, 376 S.E.2d at 532).

¹⁷⁰ *Id.* at 319-20.

¹⁷¹ *Id.*

¹⁷² *Id.* at 320.

¹⁷³ *Id.*; see VA. CODE ANN. § 8.01-581.1(vi) (Cum. Supp. 1999).

¹⁷⁴ *Pulliam*, 509 S.E.2d at 320-21.

mally designed to make the plaintiff whole and is part of the actual damages sought to be recovered.”¹⁷⁵ Post-judgment interest, on the other hand, “is not an element of damages, but is a statutory award for delay in the payment of money actually due.”¹⁷⁶ Thus, the majority determined that prejudgment interest was restricted by the \$1,000,000 limitation on recovery in medical malpractice actions.¹⁷⁷

C. *The Concurring Opinions*

Justices Hassel, Keenan and Koontz concurred, stating that “the result reached by the majority [was] compelled by the absence of a sufficient record in this appeal.”¹⁷⁸ This language suggests, however, that if the plaintiff’s attorney had not made certain procedural errors, then their decisions may have been different. Their concurring opinion focused on the special legislation prohibition found in article IV, sections 14 and 15 of the Virginia Constitution and the corresponding standard of review that must be applied in cases raising such challenges.¹⁷⁹

The concurrence reiterated that application of a “reasonable and substantial relation” analysis is appropriate in cases challenging special legislation and that this standard is a higher standard than rational basis.¹⁸⁰ These concurring justices also noted that the presumption that a legislative classification is reasonable and appropriate unless shown unconstitutional on its face is rebuttable.¹⁸¹ However, the special legislation challenge ultimately failed due to inadequate evidence, or more specifically, evidence presented at the wrong time for judicial review.¹⁸² On all other points of law, Justices Hassell, Keenan, and Koontz agreed with the majority’s rationale.¹⁸³ Therefore, based on the record, these three justices joined the majority in holding that the medical malpractice cap in Virginia is constitutional.

Justice Kinser’s concurring opinion reached the same holding as the majority, but “without considering the role that *stare decisis* should play in this case.”¹⁸⁴ Recognizing that the Virginia General Assembly “has the responsibility to protect the health, welfare, and safety of the citizens of th[e] Commonwealth,” Justice Kinser firmly left these issues to the prov-

¹⁷⁵ *Id.* at 321 (citing *Dairyland Ins. Co. v. Douthat*, 449 S.E.2d 799, 801 (Va. 1994) (quoting *Monessen Southwestern Ry. v. Morgan*, 486 U.S. 330, 335 (1988))).

¹⁷⁶ *Id.* (quoting *Dairyland*, 449 S.E.2d at 801).

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 321-22.

¹⁸⁰ *Id.* at 322.

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.* at 322-23 (Kinser, J., concurring).

ince of the legislature.¹⁸⁵ However, arguing from a public policy perspective, the concurring justice voiced her concern for the “unwarranted injustice” that results in certain situations when those most severely injured in medical malpractice negligence are prevented from receiving full compensation under the Act.¹⁸⁶ She also called upon the General Assembly to “adopt a more equitable method by which to ensure the availability of health care in this Commonwealth.”¹⁸⁷ Her concurring opinion provides a lingering plea to the General Assembly to find a less severe solution to promote affordability and availability in health care in Virginia, although she firmly believes that the court cannot interfere with legislative responsibilities.¹⁸⁸

IV. ANALYSIS

In *Pulliam*, the Virginia Supreme Court upheld *Etheridge*, but ignored two persuasive arguments due to procedural errors.¹⁸⁹ Given the concerns voiced by the concurring opinions in the *Pulliam* case, it is likely that the Virginia Supreme Court will face these arguments again soon—this time preserved by the record, appellate briefs, and careful lawyering.

This Part analyzes Virginia’s medical malpractice cap from two different perspectives: as a special legislation violation and as an equal protection violation. This Part concludes with some alternative solutions to the Act, as well as suggestions for dealing with the malpractice statute in the future if the Virginia Supreme Court continues to uphold its constitutionality.

A. *Special Legislation Exception*

Virginia’s medical malpractice cap undoubtedly falls into the prohibition of “special legislation” in article IV, section 14 of Virginia’s constitution because of the distinct classification and restriction on medical malpractice plaintiffs’ recovery, but not on all other tort plaintiffs.¹⁹⁰ To determine whether a legislative act violates the prohibition against special legislation, the Virginia courts apply a “reasonable and substantial relation” test.¹⁹¹ Given the arguably tenuous need for the Virginia Medical

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 322.

¹⁸⁷ *Id.* at 322-23.

¹⁸⁸ *Id.*

¹⁸⁹ *Id.* 316.

¹⁹⁰ See *supra* note 148.

¹⁹¹ See *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525 (Va. 1989); *Mandell v. Haddon*, 121 S.E.2d 516, 525 (Va. 1961).

Malpractice Act in 1976,¹⁹² as well as today, this Act fails to meet the prescribed test for constitutional validity because it is neither reasonable nor substantially related to its underlying purpose.

Studies that the General Assembly sponsored to evaluate the health care providers insurance crisis in Virginia did not support a medical malpractice cap as the most effective remedy.¹⁹³ In fact, the report by the Bureau of Insurance focused primarily on the problem of continued availability of health care insurance, and not the problem of affordability of malpractice insurance.¹⁹⁴ This was largely due to the Medical Society of Virginia's sponsored health care insurance company, St. Paul Fire and Marine, which kept Virginia's medical malpractice insurance premiums much lower than the national average.¹⁹⁵ Even in 1975, the Board of Insurance realized that convincing constitutional challenges would arise if a medical malpractice cap were imposed.¹⁹⁶ Similarly, another study conducted in 1986 was reluctant to recommend the repeal of the collateral source rule in Virginia. The study observed that collateral payments were the only remaining buffer available to the most seriously injured medical malpractice patients whose damages were restricted by the medical malpractice cap.¹⁹⁷ Moreover, threatened with a perceived widespread liability insurance crisis in the 1980s involving problems of availability and affordability similar to those feared in the 1970s regarding the medical malpractice area,¹⁹⁸ the joint subcommittee refused to recommend a comprehensive cap on tort damages due to the inherent unfairness of preventing a plaintiff from seeking at least full compensatory relief for negligence personal injuries.¹⁹⁹

Despite these studies, the General Assembly and the Virginia Supreme Court continue to stand behind the preamble to the Act as sufficient

192 See discussion *supra* Part I.A.2.

193 See *supra* Part I.A.2.

194 See *supra* Part I.A.2.

195 BUREAU OF INS., *supra* note 27.

196 See *supra* Part I.A.2.

197 See *supra* Part I.A.2.

198 See COMMONWEALTH OF VA., OFFICE OF THE ATTORNEY GEN., LIABILITY INSURANCE REGULATORY REFORM (Sept. 1986) reprinted in S. DOC. NO. 11 *supra* note 49, at APPENDIX D. Several industry areas were reported to be experiencing availability problems in obtaining adequate liability insurance including day care, exterminators, pollution and hazardous waste disposal, restaurants, governmental entities, liquor liability, and asbestos removal. *Id.* Surprisingly, general medical malpractice insurance was also listed in the top twenty and this was ten years after the imposition of the medical malpractice cap to remedy future increases in rate premiums. *Id.* ¶ 3.

199 See S. DOC. NO. 11, *supra* note 49, at 4-5. The report recommends in the Executive Summary:

[t]hat a limitation be placed on the amount of non-economic damages which may be awarded in order to strike a proper balance between affording an injured person his rightful compensation for losses incurred and providing a degree of predictability of loss exposure necessary to a system of compensation such as ours which is largely dependent upon the continued availability of insuranc[e.]

Id. at 5.

justification for this special legislation.²⁰⁰ This view is belied by the creation of disparate treatment under the Act. A narrow view of the classifications created by the cap recognizes two groups that are particularly affected by the imposition of a medical malpractice cap: malpractice insurers and health care providers, who are expected to enjoy lower premiums (in a sense a privilege or immunity), and severely injured patients, who are prohibited from receiving full economic and non-economic damages in a medical malpractice action.²⁰¹

A broader view of the classifications created under the Act recognizes four groups. First, the Act confers a special privilege, immunity, or benefit to the providers of malpractice insurance and practicing physicians.²⁰² Second, it distinguishes between physicians, hospitals, and other health care providers as a group of tortfeasors, from all other tortfeasors.²⁰³ Third, the Act distinguishes between those plaintiffs who suffer from the most debilitating injuries and those who experience minor injuries, and limits the corresponding amount of damages recoverable.²⁰⁴ And fourth, it segregates medical malpractice plaintiffs from all other tort plaintiffs.²⁰⁵ Thus, under either a narrow or broad view of the Act, distinct classifications are created and must be tested for constitutionality.

While the role of Virginia's judiciary is not to judge the prudence of legislation enacted by the General Assembly,²⁰⁶ the Virginia Supreme Court should not ignore that this law continues to violate the constitutional prohibition against special legislation. The state judicial system should question the effect of a medical malpractice cap that effectively shifts the entire burden of the presumed health care liability crisis on those most severely injured by medical malpractice, as only those with devastating injuries in excess of \$1.5 million are affected by the cap.²⁰⁷ In some circumstances, the cap forbids the most seriously injured plaintiffs from recovering even their medical expenses at a time when rapidly escalating medical technology and drug development have made health care costs more expensive for the consumer.²⁰⁸ In fact, one study suggests that the "damages explosion" that is commonly attributed to the modern tort system is in fact attributed largely to the rising costs of medical care and technology.²⁰⁹

²⁰⁰ See discussion *supra* Parts I.B, III.B.

²⁰¹ See VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 1999).

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ See generally Crocca, *supra* note 2.

²⁰⁶ See *Supinger v. Stakes*, 495 S.E.2d 813, 815 (Va. 1998).

²⁰⁷ See VA. CODE ANN. § 8.01-581.15.

²⁰⁸ See Galanter, *supra* note 12, at 1114.

²⁰⁹ *Id.* (arguing that the recent legislative attempts at tort reform to reduce access to the courts and limit damage recoveries are inefficient and ineffective quick-fixes that are by-passing the true

Virginia should look to those states where caps on both economic and non-economic medical malpractice damages have been declared unconstitutional, and where the circumstances leading up to passage of a statutory cap do not provide a reasonable and substantial relation to such a drastic legislative measure. In particular, Ohio and Illinois are two states where the disparate impact of medical malpractice caps on medical malpractice victims has persuaded their respective state supreme courts to find such caps unconstitutional.²¹⁰ If the Virginia Supreme Court questioned the current impact of the medical malpractice cap upon the General Assembly's stated goals in the preamble, and probed into the circumstances surrounding the imposition of the cap in 1976, it would uncover an absence of any reasonable and substantial relationship between the two.

Additionally, the "reasonable and substantial" relationship test adhered to by the Virginia Supreme Court²¹¹ is remarkably similar to an intermediate scrutiny analysis used by courts in federal equal protection challenges. Under federal intermediate scrutiny, the legislature must show that the classification at issue bears a "substantial relationship" to an "important governmental objective."²¹² Intermediate scrutiny applies a "means-ends" analysis, where the chosen means of the legislature in enacting certain legislation must be "substantially related" to the desired ends.²¹³ Although the legislature certainly can enact legislation that is incremental in nature, there still must exist a means-ends justification to the legislation where a classification is created that harms a particular class of individuals.²¹⁴

From this perspective, the "reasonable and substantial" relationship test applied by the Virginia Supreme Court in theory falls in this type of intermediate scrutiny analysis, although in practice the supreme court appears to be applying a rational basis analysis. Thus, the analysis for special legislation challenges is indeed a higher standard than that applied to economic regulation challenges based on equal protection or due process arguments, which are subjected to a rational basis standard.²¹⁵ The Virginia Supreme Court, however, appears to confuse the analysis of these two remarkably distinct standards into one, rationalizing that the bar for constitutionality is very low, and thus, satisfied by the existence of the lan-

problems with the civil system).

²¹⁰ See *supra* Part II.

²¹¹ *Benderson Dev. Co. v. Sciortino*, 372 S.E.2d 751, 757 (Va. 1988) ("[S]tatutes challenged under the special-laws prohibitions in the Virginia Constitution . . . must bear 'a reasonable and substantial relation to the object sought to be accomplished by the legislation,'" (quoting *Mandell v. Haddon*, 121 S.E.2d 516, 525 (Va. 1961))).

²¹² *Craig v. Boren*, 429 U.S. 190, 197 (1976).

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ See *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.*, 509 S.E.2d 307, 315-19 (Va. 1999).

guage in the preamble. This rationalization is erroneous and contrary to the constitutional analysis appropriate to such legislative acts creating classifications. Therefore, the medical malpractice cap under the "reasonable and substantial" relation test, the higher standard, is clearly unconstitutional.

B. *Equal Protection Violation*

The Virginia Supreme Court will "declare legislation invalid only when it is 'plainly repugnant to some provision of the state or federal constitution.'"²¹⁶ However, the court continues to brush aside the valid argument that the cap is unconstitutional because it violates the equal protection guarantees implicit in the state's constitution.

Although the Virginia Constitution does not have an explicit "equal protection" clause, the Virginia courts have interpreted two sections in the state's constitution to be roughly the equivalent of the equal protection clause of the Fourteenth Amendment to the United States Constitution.²¹⁷ Consequently, the Virginia courts have struggled over what standard of review applies in equal protection challenges. The Virginia Supreme Court has held that medical malpractice caps do not create either a suspect class or infringe upon a fundamental right,²¹⁸ and therefore, strict scrutiny is not the appropriate standard of review.²¹⁹ Rather, the Virginia Supreme Court views the cap on medical malpractice damages as an economic regulation subject to the lower bar of the rational basis test.²²⁰ The court has held that for a plaintiff "[t]o withstand an equal protection challenge, a classification that neither infringes upon a fundamental right nor creates a suspect class must satisfy the 'rational basis' test."²²¹ The rational basis test is satisfied "if the legislature could have reasonably concluded that the challenged classification would promote a legitimate state purpose."²²²

²¹⁶ *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 528 (Va. 1989) (citing *Blue Cross of Va. v. Commonwealth*, 269 S.E.2d 827, 832 (Va. 1980)).

²¹⁷ These include the special legislation prohibition in art. IV, section 14, and the anti-discrimination clause in art. I, section 11. See *Boyd v. Bulala*, 647 F. Supp. 781, 785 (W.D. Va. 1986) (describing that Virginia's equal protection guarantee exists through the combination of these constitutional clauses).

²¹⁸ See *Pulliam*, 509 S.E.2d at 318; see also *Taylor & Shields*, *supra* note 14, at 842-44 (discussing equal protection challenges to limitations on recovery in medical malpractice actions). One Ohio case stands out, *Graley v. Satayatham*, as an apparent anomaly where the appellate court applied a "compelling governmental interest test," or a strict scrutiny test, to the statutory limitation on medical malpractice recoveries. 343 N.E.2d 832 (Ct. Common Pleas Ohio 1976).

²¹⁹ See *Pulliam*, 509 S.E.2d at 318.

²²⁰ See *id.*

²²¹ *Etheridge*, 376 S.E.2d at 534. A "suspect class" generally is interpreted to mean a class based on gender, race, or religious disposition, and has been almost unanimously rejected by state courts as applicable to the classes created by statutory medical malpractice caps. *Id.*

²²² *Exxon Corp. v. Eagerton*, 462 U.S. 176, 196 (1983). Three state supreme courts have applied a stricter standard than "rational basis" in analyzing medical malpractice damage caps: Alabama in *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156 (Ala. 1991); New Hampshire in *Carson v. Maurer*,

In Virginia's Medical Malpractice Act, the classification of medical malpractice plaintiffs and defendants does not support a reasonable conclusion that limiting recovery would promote a legitimate state purpose based on both existing and subsequent reports generated for the General Assembly indicating the questionable need for a cap in the mid-1970s.²²³ Furthermore, the General Assembly's sponsored joint subcommittees and independent reports by the Bureau of Insurance all pointed to solutions other than tort reform, including insurance reform and regulation.²²⁴ Thus, although the court must presume all legislative acts to be constitutional, it is also the court's duty to protect individuals from arbitrary legislation that violates protected constitutional rights.²²⁵ In performing the rational basis test, the court should find the historical underpinnings supporting the legislative impetus that created the medical malpractice cap and the subsequent available data helpful in its constitutional analysis.²²⁶

Other states recognize that when equal protection challenges come before the state supreme court, the court may extend greater protections under the state constitution than those afforded under the federal equal protection guarantees.²²⁷ This recognition and practice led several state courts to apply a heightened, means-focused scrutiny when analyzing the constitutionality of medical malpractice caps similar to the "reasonable and substantial" analysis applied to special legislation challenges in the Commonwealth, at least in theory.²²⁸ New Hampshire was one of the first states to successfully apply the "fair and substantial relation" test to an equal protection challenge against broadly sweeping tort reform that included a medical malpractice cap on damages.²²⁹ Other states soon followed, including Alabama and North Dakota.²³⁰ Thus, with the discretion available to the courts to apply a heightened scrutiny in equal protection challenges based on state constitutional protections, the only restriction keeping Virginia from joining this group is its strict adherence to *stare decisis*—the fact that the court is unwilling to create new precedent. How-

424 A.2d 825 (N.H. 1980); and North Dakota in *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).

²²³ See Kimmel, *supra* note 8 (analyzing the appropriate standard of review for equal protection challenges with respect to Virginia's medical malpractice cap).

²²⁴ See *supra* Part I.A.2.

²²⁵ *Blue Cross of Va. v. Commonwealth*, 269 S.E.2d 827, 832 (Va. 1980).

²²⁶ The Supreme Court of Ohio, for example, has referred to outside, independent studies to determine if the legislative goal has indeed had the intended effect before making a "rational basis" determination. See *Morris v. Savoy*, 576 N.E.2d 765, 771 n.4 (Ohio 1991). The Supreme Court of Illinois also referred to outside affidavits concluding that there is no reliable empirical data showing that medical malpractice caps have any significant impact on the availability or affordability of liability insurance or health care in general. See *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1068 (Ill. 1997) (citing Kinney, *supra* note 102, at 1286 and Galanter, *supra* note 12, at 1114).

²²⁷ See, e.g., *Carson*, 424 A.2d at 836-37..

²²⁸ See discussion *supra* Part IV.A.

²²⁹ *Carson*, 424 A.2d at 831.

²³⁰ See *supra* note 222.

ever, as the concurrence of Justices Hassell, Keenan and Koontz suggests, the obvious way around this dilemma is to pursue an effective special legislation challenge.²³¹ The next case to challenge the constitutionality of the medical malpractice cap must sufficiently preserve these issues for appeal and then show the unreasonableness of the General Assembly's justifications behind imposing the Act. As this Note elaborates, this task is not insurmountable.

C. *Private Contracting Alternatives to the Malpractice System*

Aside from the debate over whether the legislature or the court should ultimately be responsible for instituting measures of tort reform,²³² some legal scholars suggest another solution to remedy the apparent deficiency of both entities in dealing with the problems confronted by the modern health care industry.²³³ According to Professor Jeffrey O'Connell, "the current tort system is ineffective in dealing with the medical malpractice system as a deterrent to bad practice and as a compensation mechanism."²³⁴ He argues that there are "uncalculated costs" imposed on the physician-patient relationship from pursuing remedies through the American tort system—a system that has created a "litigation lottery."²³⁵ More specifically, Professor O'Connell advocates a cooperative effort between legislative and contractual reform based on a "no-fault" concept to improve the current malpractice system.²³⁶

Other scholars also recognize the potential benefits of private contracting between patients and health care providers, and advocate changing liability rules in the malpractice system through privately contracted risk allocation.²³⁷ As Professor Richard A. Epstein observed, "there is nothing special, much less sacred, about medical services that justifies exempting

²³¹ *Pulliam v. Coastal Emergency Servs. Of Richmond, Inc.*, 509 S.E.2d 307, 322 (Hassell, Kennan, Koontz, JJ., concurring) (citing *Mandell v. Haddon*, 121 S.E.2d 516, 524 (1961)).

²³² See *supra* note 78. Arguments for legislative lawmaking include the benefit of political accountability and the forum for public opinion. Arguments for judicial lawmaking include the absence of public interest group influence and the benefit of swifter decision-making. *Id.*

²³³ See *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. 125 (1996).

²³⁴ Jeffrey O'Connell, *Neo-No-Fault Remedies For Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 127 (1986).

²³⁵ *Id.*

²³⁶ *Id.* Professor O'Connell does not advocate "no-fault" insurance, but a "no-lawsuit" approach where private contracting alters the doctor-patient relationship in a way that will lead to better compensation to those injured by medical malpractice, similar to the existing workmen's compensation laws. *Id.*

²³⁷ See Clark C. Havighurst, *Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS. 143 (1986); Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS. 201 (1986).

them from ordinary contracting processes.”²³⁸ Although these ideas are provocative, the idea of implementing private contractual remedies to resolve the current debate over malpractice reform “remains largely academic, however, in part because of anticipated judicial hostility.”²³⁹ Furthermore, several legal commentators disagree with the claims of ineffectiveness of the existing tort system to provide adequate remedies in the medical malpractice area, and advocate that the system is capable of handling such claims adequately now and into the future.²⁴⁰

D. *The Plaintiff's Alternative*

A first-year law student learns in Torts class that the “eggshell skull” rule applies to plaintiffs where the tortfeasor is responsible for all injuries resulting from his intentional or negligent actions.²⁴¹ In fact, the “corrective justice” goal of compensatory damages is to make the injured plaintiff whole, or in other words, to place him in the same position he was in before the injury.²⁴² In light of this most basic doctrine, the medical malpractice cap stands in stark opposition to the fundamentals of tort law. Further inquiry into the history of legislative and common law relationships expounds on this facially inconsistent restriction on a plaintiff's right to seek compensation in the tort system for medical malpractice injuries.

If the medical malpractice cap continues to exist as constitutional legislation, plaintiffs engaged in medical malpractice actions in Virginia may have to find alternative solutions to the statutory prohibition to full recovery. If the Virginia Supreme Court continues to value *stare decisis* over the rights of Virginia's patient population, then medical malpractice plaintiffs could likely turn to creative claiming. For example, Mr. Pulliam could sue Coastal Emergency Services for the negligent hiring²⁴³ of Dr. DiGiovanna. This, a separate tort from the medical malpractice claim, may be Mr. Pulliam's last resort in order to obtain the damages that the jury determined he was entitled to for the death of his wife due to medical negligence.

Similarly, a look at other states that have constitutionally upheld caps on medical malpractice damages indicates that the harshness of the caps is being circumvented by strategic lawyering. The situation in Indiana provides a good example for Virginia because Indiana's cap on damages pertains to total damages recoverable, which mirrors the restriction imposed

²³⁸ Epstein, *supra* note 237, at 211.

²³⁹ Havighurst, *supra* note 237, at 143, n.1.

²⁴⁰ See Galanter, *supra* note 12, at 1114; White, *supra* note 78, at 51.

²⁴¹ See, e.g., EPSTEIN, *supra* note 47, at 4-9.

²⁴² *Id.* at 864. Another theory of damages in tort suits is the “deterrence function.” *Id.* Under this theory, tort damages impose a cost to the tortfeasor for engaging in certain types of activities. *Id.*

²⁴³ See John L. Costello, VIRGINIA REMEDIES 643 (2d ed. 1999).

by section 8.01-581.15 in Virginia.²⁴⁴ Researchers who conducted a three-year study of the impact of Indiana's Medical Malpractice Act discovered that plaintiffs' attorneys, by using both periodic payments and structured settlement options, were manipulating damage awards to provide their injured clients with an award in excess of the statutory cap.²⁴⁵ Aside from alternative claiming and strategic lawyering, it is an unfortunate reality that the Virginia Supreme Court may not leave plaintiffs' attorneys with any other option than to force the court, by presenting it with a meticulously prepared case, to correct a constitutional violation created by the General Assembly in 1976.

CONCLUSION

The Virginia Supreme Court will undoubtedly face the constitutional challenges raised in *Pulliam v. Coastal Emergency Services of Richmond, Inc.*, the strongest of those forfeited for procedural reasons, in the near future. The circumstances leading up to the enactment of the Medical Malpractice Act in 1976 do not support continued adherence to the "legislative purpose" contained in the preamble and should be carefully examined. The Commonwealth's constitutional prohibition against special legislation appears to provide the most viable argument against the constitutionality of the cap and should be carefully pursued in the future. If the Virginia Supreme Court remains unwavering in its deference to the General Assembly and the principles of *stare decisis*, then the burden of the Act will remain, unfortunately, on those most severely injured by medical malpractice negligence—those the Act was supposed to benefit through continued availability and affordability of health care service.

*Elizabeth Anne Keith**

²⁴⁴ See *supra* discussion Part II.; VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 1999).

²⁴⁵ See discussion *supra* Part II; Kinney, *supra* note 103, at 1299.

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