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NOTES

BAD CURES FOR BAD BABIES: POLICY CHALLENGES TO THE STATUTORY REMOVAL OF THE COMMON LAW CLAIM FOR BIRTH-RELATED NEUROLOGICAL INJURIES

INTRODUCTION

When Marie Anderson went into labor, the hospital staff failed to carefully monitor her dangerously high blood pressure or detect warning signs of Pregnancy Induced Hypertension ("PIH"),¹ a condition known to cause oxygen deprivation during labor and delivery, or intrapartum asphyxia.² As a result, her infant was born with severe and permanent brain damage.³ In *Anderson v. United*

1. *Anderson v. United States*, 731 F. Supp. 391, 394-95 (D.N.D. 1990). "PIH is a condition that involves constriction of the placental blood vessels allowing less oxygen to the fetus. This lack of oxygen can permanently destroy brain cells . . . PIH in a laboring patient, even if only mild hypertension, can therefore constitute a high-risk condition for her and her fetus." *Id.* at 394.

2. At milder levels of asphyxia, the fetal or newborn physiology will respond to the decrease in oxygen by maximizing blood flow to the brain at the possible expense of other organs. More severe or prolonged asphyxia affects the flow of oxygen to the fetal brain, causing permanent brain damage. STANLEY S. SCHWARTZ & NORMAN D. TUCKER, 2 *HANDLING BIRTH TRAUMA CASES* §§ 23.1-.3 (1989). See *infra* notes 95-102 and accompanying text.

3. See *Anderson*, 731 F. Supp. at 395-98 (finding causation for the infant's brain damage and cerebral palsy in the hospital's negligent failure to diagnose PIH or the infant's resulting intrapartum asphyxia). The infant, Casey Anderson, is unable to walk, talk, or see. He is unable to control his bowels, and must be fed through a tube in his

States,⁴ the court held that the hospital was negligent in failing to properly monitor and diagnose the mother's condition, and that its negligence directly caused the resulting injuries.⁵ In a Virginia malpractice action, *Boyd v. Bulala*,⁶ an obstetrician ordered the delivery room nurses not to call him to the hospital until his patient's labor reached the "crowning" stage.⁷ As a result, the obstetrician was not present when an emergency arose. The patient, Helen Boyd, was attended during labor and delivery only by nurses, none of whom were trained in emergency obstetric measures which would have prevented the resulting injury.⁸ The infant suffered "profound physical and mental handicaps" and later died as a result of oxygen deprivation prior to and immediately following her birth.⁹ The jury found the obstetrician negligent in failing to provide adequate medical care during labor and delivery.¹⁰

The type of negligence occurring in *Anderson* and *Boyd* is not uncommon. Claims alleging birth-related neurological impairment account for more suits against obstetricians than any other obstetric injury.¹¹ Due to the severity of the injury when negligence occurs, successful claims for birth-related neurological injuries also result in the largest damage awards.¹² Historically, these claims have

abdomen at two hour intervals. He requires 24-hour supervision, skilled nursing care to provide feedings, and medication daily. These injuries are all attributed to a lack of oxygen to his brain during birth. *Id.* at 399.

4. 731 F. Supp. 391 (D.N.D. 1990).

5. *Id.* at 395, 398.

6. 647 F. Supp. 781, 784 (W.D. Va. 1986), *aff'd in part and rev'd in part*, 877 F.2d 1191 (4th Cir. 1989), *certifying questions to* *Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990), *conformed to answers of certified question*, 905 F.2d 764 (4th Cir. 1990).

7. *Boyd*, 647 F. Supp. at 784. Crowning is a stage late in labor, when the fetal head becomes visible. Evidence showed that the defendant obstetrician knew this procedure was below the reasonable standard of care, and realized that his order to be called after crowning posed a risk to the patient. *Id.* at 793. The "[d]efendant's own expert agreed that defendant's conduct could be termed 'egregious.'" *Id.* at 791.

8. *Id.* at 784.

9. *Id.*

10. *Id.*

11. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS REPORT 1988; Cynthia L. Gallup, *Can No-Fault Compensation of Impaired Infants Alleviate the Malpractice Crisis in Obstetrics?*, 14 J. HEALTH, POL., POL'Y & L. 691, 692 (1989).

12. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS REPORT 1988. See also Richard P. Perkins, *Perspectives on Perinatal Brain Damage*, 69 OBSTETRICS & GYNECOLOGY 807, 807 (1987) (commenting that there is a "current epidemic of malpractice litigation" relating to perinatal brain damage).

Not only is the cost of future care high due to the severity of these injuries, but as the court in *Anderson* noted, damage awards in these cases may also be enormous, as these are infants who would otherwise have been born normal. *Anderson v. United States*,

been treated like any other medical malpractice action, with victims of obstetric injury having access to the tort system. Currently, however, the ability of plaintiffs like Anderson and Boyd to bring such claims has been threatened by a new wave of legislative reform proposing and implementing the removal of the most severe birth-related injuries from the tort system.¹³ The increased focus on the legal treatment of this narrow category of obstetric injury claims is said to be in response to concerns regarding the impact on the practice of obstetrics of increases in the frequency and severity¹⁴ of medical malpractice claims, and the corresponding rise in the cost of malpractice insurance.¹⁵

Since 1970, forty-nine states have adopted some element of tort reform to address medical malpractice claims generally,¹⁶ with

731 F. Supp. 391, 398 (D.N.D.) 1990). In *Anderson*, the plaintiffs were awarded \$2.4 million for the cost of caring for the child, \$760,000 for lost earnings, \$160,000 for incurred medical expenses, and \$525,000 for lost consortium. *Id.* at 399, 402.

In *Boyd*, the district court found that the jury's award of \$8.3 million was not excessive in light of the severity of the injury. *Boyd v. Bulala*, 647 F. Supp. 781, 793 (W.D. Va. 1986), *aff'd in part and rev'd in part* 877 F.2d 1191 (4th Cir. 1989), *certifying questions to Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990), *conformed to answers of certified question*, 905 F.2d 764 (4th Cir. 1990). The Fourth Circuit Court of Appeals ultimately reversed the District Court and reduced the \$8.3 million award on the sole ground that it exceeded Virginia's statutory limit on damages. *Boyd v. Bulala*, 905 F.2d 764, 767 (4th Cir. 1990). *See also* *Scott v. United States*, 884 F.2d 1280 (9th Cir. 1989) (upholding general validity of a \$10.7 million award — including \$2 million in noneconomic damages — and remanding solely to require the district court to recompute the present value of the lost wages and medical care services portion of the economic damages in a birth asphyxia case); *Nelson v. Trinity Medical Center*, 419 N.W.2d 886 (N.D. 1988) (allowing \$5.7 million verdict for brain damage to infant caused by unmonitored fetal distress).

13. *See infra* Part IV.

14. The terms "frequency" and "severity" are used to represent the increased number of claims being filed and the high dollar amounts being requested and awarded as damages in medical malpractice claims. *See* Peter H. White, Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487, 1495-96 nn.43-44. White notes that "while the number of claims filed per 100 physicians between 1981 and 1985 climbed from 3.2 to 10.1 for all physicians, it climbed from 7.1 to 26.6 for specialists in obstetrics-gynecology." *Id.* at 1496 n.44. Also, White notes that the severity of obstetrics claims has risen sharply, from an average cost per claim of \$70,997 for the period between 1979 and 1983 to an average cost per claim of \$119,249 in 1986. *Id.*

15. *See* 1 INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 112-15 (1989) [hereinafter 1 INSTITUTE OF MEDICINE] (principal factors in the growth of premiums appear to be increased frequency and severity of claims and lower interest rates, reducing insurers' investment income). *See generally id.* at 1-13 (discussing the increased frequency and severity of obstetric claims and the effect on the delivery of obstetric care).

16. *Id.* at 126. For a broad overview of malpractice reforms, *see* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report*

the majority of reform efforts aimed at limiting aspects of tort claims.¹⁷ More recently, however, tort system critics have proposed the adoption of alternatives which, rather than reforming or limiting the tort system, seek to replace it completely for certain injury categories. A primary target for the new proposals are the severe birth-related injuries occurring in obstetrics. Several states have enacted or are currently considering legislation replacing negligence claims for this specific category of severe obstetric injuries.¹⁸

Proponents of the removal of birth-related neurological injuries from the traditional tort scheme have recommended three basic systems to address these injuries: 1) a "no fault" system,¹⁹ 2) an "accelerated compensation event" system,²⁰ and 3) an administrative fault-based system.²¹ Of these three alternative systems being proposed, only the third maintains the element of "fault."

Proponents of "no-fault" have recommended replacing the tort adjudicatory system with an administrative agency system, compensating birth-related neurological injuries irrespective of fault. Two states, Florida and Virginia,²² have legislatively enacted forms of this "no-fault," with other states currently considering implementing similar proposals.²³ The second type of system being proposed recommends an alternative insurance system that would remove this category and specified other severe obstetric

Card, 22 U.C. DAVIS L. REV. 499, 521-32 (1989) (outlining tort reforms through the 1970s).

17. See *infra* notes 76-86 and accompanying text.

18. See, e.g., Florida Birth-Related Neurological Injury Compensation Plan, FLA. STAT. ANN. §§ 766.303-.316 (West Supp. 1992); Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 1990). See also White, *supra* note 14, at 1499 n.58 (noting legislative proposals in Illinois and North Carolina for removing certain birth-related injuries from the tort system). New York has also considered a proposal for an alternative system for obstetric injuries (the New York State Neurological Impaired Infant Compensation Act) that would compensate qualifying medically impaired newborns, irrespective of proving physician fault. The New York proposal is currently being redrafted. Many of these proposals have attempted to expand the range of compensable events, presumably to greater reduce the risk of borderline claims falling within the tort system. For example, Maryland considered expanding the range of compensable injuries in its proposed no-fault insurance program to specifically include cerebral palsy. Gallup, *supra* note 11, at 692.

19. See *infra* Part IV.A.

20. See *infra* Part IV.B.

21. See *infra* Part IV.C.

22. See FLA. STAT. ANN. §§ 766.303-.316 (West Supp. 1992); VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 1990).

23. See *supra* note 18.

injuries from tort litigation. This "accelerated-compensation event" system ("ACE") would instead have private or social insurance compensate predefined injuries.²⁴ Like the legislative "no-fault" systems being proposed and enacted in various states, an ACE system does not maintain the element of "fault" in its operation.²⁵ Finally, in an effort to address perceived flaws in the above proposals, the American Medical Association, in conjunction with thirty-one medical specialty societies, has proposed an administrative fault-based system to replace the tort system.²⁶ Obstetrics in particular is being advocated as a testing ground for implementation.²⁷

Proponents of the alternative systems justify the exclusive treatment of obstetric injuries on the grounds of the unique impact of the increased frequency and severity of obstetric injury claims on the practice of obstetrics.²⁸ Yet not only does evidence demonstrate that the litigation experience in obstetrics is substantially similar to that of other specialized practice areas,²⁹ but selective treatment for other types of claims has been rejected in at least one state giving obstetric injuries such special treatment.³⁰ In addition,

24. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836, 2836 (1991). See *infra* Part IV.B.

25. Bovbjerg et al., *supra* note 24, at 2836. ACE is viewed as a "selective no-fault" system because it is somewhat of a hybrid, having both fault and no-fault attributes. ACE is like a no-fault system in that it promptly pays for pre-defined injuries without adjudicating fault for each individual claim. However, ACE has some attributes of fault-based systems in that it bases the classes of claims for which it will compensate on statistical preventability. *Id.* at 2837.

26. AMA-SPECIALTY SOCIETY'S MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED ADMINISTRATIVE SYSTEM (1988) [hereinafter AMA PROPOSAL].

27. See Roger J. Bulger & Victoria P. Rostow, *Medical Professional Liability and the Delivery of Obstetrical Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 81, 88-90 (1990) (recommending that states focus on alternatives to the tort system for obstetric injuries, including the AMA's fault-based administrative system); David L. Sieradzki, *Throwing Out the Baby with the Bathwater: Reform in the System for Compensating Obstetric Accidents*, 7 YALE L. & POL'Y REV. 538, 547-48 (1989) (considering implementation of the AMA's proposed system for obstetric injuries).

28. See *supra* note 14.

29. See generally 1 INSTITUTE OF MEDICINE, *supra* note 15, at 92-123 (comparison of medical practice areas, noting high cost distinctions between malpractice insurance premiums paid by obstetricians and general family practitioners, yet less disparity between obstetricians and surgeons, another high-risk specialty).

30. The Virginia legislature was the first to adopt a no-fault scheme for obstetric injuries. However, in 1987, the Virginia General Assembly had refused to adopt a limit on noneconomic damages which would have affected all tort victims, or legislation mandating periodic payment of damage awards. See Jane R. Ward, Comment, *Virginia's Birth-Related*

advocates of alternative measures are not primarily arguing that these claims are not the result of negligence or unavoidable injury.³¹ Rather, they assert that the increased frequency and severity of these claims impose high costs on the obstetric malpractice system, which in turn affects the practice of obstetrics.³²

To some degree, this assertion is accurate. Damage awards are higher for this particular category of injury than for most other claims. While economic damages are calculated in relation to tangible economic costs, compensation for pain and suffering frequently makes up nearly half of the damage award for a successful birth-related neurological injury claim.³³ However, rather than addressing frequency of claims by imposing deterrent mechanisms designed to reduce the occurrence of negligence, the alternative systems may in fact underdeter negligence, as physicians may perceive that they can no longer be held liable for their mistakes.³⁴ Further, even though the alternative systems may compensate a larger number of injured infants than would recover under the tort system, this broader recovery is likely to be at the expense of those infants most severely injured by their obstetricians' negligence.³⁵ Finally, if the focus of the alternative systems is to reduce the severity of the awards, the question arises whether this cannot be adequately addressed within the present tort system through a modification, rather than abrogation, of the common law approach.

This note examines the treatment of birth-related neurological

Neurological Injury Compensation Act: Constitutional and Policy Challenges, 22 U. RICH. L. REV. 431, 442, 444-45 nn.89-90 (1988).

31. Evidence shows that many obstetric injuries are both caused by negligence and are avoidable. See *infra* notes 162-68, 246-52 and accompanying text.

32. See *infra* notes 82-86, 112-14 and accompanying text.

33. See *infra* notes 286-87 and accompanying text.

34. See White, *supra* note 14, at 1502 n.74. White states:

The fear, in other words, is that participating obstetricians will perceive that they cannot be held liable, regardless of the quality of their care for the birth of severely injured infants and that they will have a decreased incentive to ensure that their patients do not suffer "birth-related neurological injuries." An obstetrician has an obvious self-interest in having an injured infant whose delivery he attended come within the Program's compensation system, because such a finding would absolve him of liability for that child's injuries.

Id. See also Gallup, *supra* note 11, at 692. Gallup argues that although removing the most severely injured children from the tort system will give "immediate financial relief to obstetricians," such removal "also threatens to lead to an increase in the incidence of birth-related injuries, since obstetricians are absolved of financial responsibility for this class of injury." *Id.*

35. Gallup, *supra* note 11, at 702.

injuries and the question of whether special legislation categorically removing these injuries from the tort system is justified. The three alternative proposals discussed above will be analyzed, with primary focus placed on the no-fault statutes.³⁶ All three systems represent drastic changes in the way a victim of severe obstetric injury would bring a claim for medical malpractice, ultimately abolishing the right to a common law cause of action. The note will evaluate these alternative systems in terms of how they correspond to the fault and causation elements of a tort claim for negligence,³⁷ and in regard to their potential to compensate victims of birth-related injuries³⁸ and to deter negligence.³⁹ Part I of the note considers the traditional approach of tort law in addressing a claim of medical malpractice.⁴⁰ Part II addresses the background of the medical malpractice crisis as it relates to obstetrics and the move from general to directed reform.⁴¹ Part III outlines the features of claims of birth-related neurological injuries,⁴² which are the focus of the directed reform, with Part IV introducing the alternative systems under consideration.⁴³ Part V begins by considering the implications of selective treatment, analyzing the possibility of constitutional and policy challenges to abrogation of the tort claim,⁴⁴ and the possible effects of the alternative systems on the frequency and severity of obstetric injury from negligence.⁴⁵ Part V also analyzes the justifications given for selective treatment of these claims and errors in the underlying assertions used to justify alternative treatment, focusing on the effect of removing claims from juries⁴⁶ and charges of "defensive medicine" within the tort system.⁴⁷ Implications of the proposed systems in terms of meeting the tort objectives of imposing liability for fault, and compen-

36. Additional focus is placed on "no-fault" systems because "no-fault" systems (and modifications of "no-fault") are currently receiving the most legislative consideration. See *supra* note 18.

37. See *infra* notes 51-55 and accompanying text.

38. See *infra* notes 56-62 and accompanying text.

39. See *infra* notes 63-65 and accompanying text.

40. See *infra* Part I.

41. See *infra* Part II.

42. See *infra* Part III.

43. See *infra* Part IV.

44. See *infra* notes 205-16 and accompanying text.

45. See *infra* Part V.A.1.

46. See *infra* Part V.A.2.

47. See *infra* Part V.A.3.

sating and deterring injury, are also considered.⁴⁸ Consideration is also given to the performance of the tort system in meeting these objectives.

Part VI argues that the legislative focus on removal of this narrow category of severe injuries from the tort system unduly threatens the rights of victims of birth-related neurological injuries. This note concludes by making recommendations for reducing the impact of the severity of birth-related neurological injury claims on the cost of obstetric practice by restructuring tort damage awards. Such an approach is needed to maintain the deterrent benefits of the tort system which legislative alternatives have failed to replicate.

I. TRADITIONAL TORT LAW APPROACH TO MEDICAL MALPRACTICE CLAIMS

Medical malpractice has traditionally been governed by tort law.⁴⁹ Under the tort system, a person who is injured by the acts of another has a right to bring a civil claim for compensation.⁵⁰ To recover for negligence, the plaintiff must prove the existence of: (1) a duty on the part of the physician toward the plaintiff; (2) a violation of that duty (as measured by the applicable standard of care); (3) the presence of a compensable injury; and (4) a causal connection between the violation of the standard of care and the injury.⁵¹

Liability for medical malpractice is premised upon "fault" on the part of the defendant which is the legal cause of the plaintiff's injury.⁵² Even in the early history of tort law, when liability without fault was standard in other areas, a distinction was made regarding the liability of physicians.⁵³ This distinction was based on a belief that the practice of medicine was a social good, and that doctors should not be made to pay simply because their actions

48. See *infra* Parts V.B, C.

49. See SYLVIA LAW & STEVEN POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* 1 (1978) ("Today, liability based on 'fault' is the major premise of the tort system. Malpractice . . . is a fault-based system.").

50. See W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 2, at 7 (5th ed. 1984).

51. *RESTATEMENT (SECOND) OF TORTS* § 328A (1965).

52. See LAW & POLAN, *supra* note 49, at 3.

53. Law and Polan point out that "during the heyday of liability without fault, physicians were not to be held liable unless it was proved . . . that the doctor's particular action demonstrated ignorance or lack of skill." *Id.* at 7.

produced injury, but only when their actions were found to be unreasonable or lacking in due care.⁵⁴ Current legal theory continues to support the notion that the physician should only pay when at fault.⁵⁵

The justifications for imposing tort liability on the negligent actor can be summarized as follows: First, the imposition of tort liability serves to compensate the victims of negligence for their injuries; second, it deters behavior society deems to be unreasonable.⁵⁶ Tort law seeks to allocate the cost of losses resulting from human activity⁵⁷ by compensating those injured by the negligent acts of another.⁵⁸ Full tort damages generally include both economic losses, such as medical costs and loss of future earnings, as well as noneconomic losses, such as pain and suffering awards determined by a jury.⁵⁹ The calculation of damages can be particularly high in obstetric injury claims due to the severity of some

54. *Id.* at 6-8. This distinction for medical malpractice was noted as early as 1767. *See id.* at 6 (referring to *Slater v. Baker and Stapleton*, 95 Eng. Rpt. 860, 862 (K.B. 1767)).

55. *See* KEETON ET AL., *supra* note 50, § 4, at 21-23 (imposing liability for "legal" or "social" fault); *see also* LAW & POLAN, *supra* note 49, at 1-2. The authors comment on the evolution of the law to a tort system that is now fault-based:

If people were required to pay the victim whenever their actions caused physical injury to another, there would be strong incentives to be careful, and also to abstain from activities which are dangerous to people even when carefully done This was in fact the operable principle of our own liability system until the last hundred years. [This was derived from t]he primitive Germanic concept . . . that "the doer of a deed was responsible whether he acted innocently or inadvertently, because he was the doer."

. . . . In the last half of the nineteenth century, with the coming of the Industrial Revolution, [this] principle was stood on its head The exceptions swallowed the rule, and the rule became that the victim must prove "fault" in order to recover payment from the person who caused the injuries.

Id.

56. *See* PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 3 (1985), where the author states:

The tort system of liability for negligence has two main purposes. First, it provides compensation to those injured as a result of the negligence of others, thereby acting as a source of insurance. Second, by imposing sanctions on persons found negligent, it acts as a deterrent to future negligent behavior.

Id. *See also* LAW & POLAN, *supra* note 49, at 1 (noting that the two basic rationales for imposing liability for negligence are deterrence and compensation).

57. KEETON ET AL., *supra* note 50, § 1, at 6 ("The law of torts . . . is concerned with the allocation of losses arising out of human activities.") *See also* LAW & POLAN, *supra* note 49, at 1.

58. KEETON ET AL., *supra* note 50, § 1, at 6 ("So far as there is one central idea, it would seem that it is that liability must be based upon conduct which is socially unreasonable.")

59. *See* SCHWARTZ & TUCKER, *supra* note 2, §§ 6.8-11 (outlining economic and noneconomic damages available in birth injury cases).

injuries resulting in high medical costs,⁶⁰ the increased length of time in estimating lost future earnings for an infant,⁶¹ and higher than average awards for noncompensatory damages.⁶²

In addition to compensating the victim for the injury, the tort system seeks to deter future occurrence of the injury, through both economic⁶³ and moral deterrence.⁶⁴ Some argue that deterrence is the primary value of maintaining the tort system.⁶⁵

Until recently, the practice of obstetrics has not been regarded as requiring special rules.⁶⁶ However, recent changes in medical malpractice generally and the practice of obstetrics specifically have prompted increased focus on reform efforts targeting obstetric injury claims.⁶⁷ Since the 1970s, attention has been placed on what has been characterized as a medical malpractice "crisis"⁶⁸ — the increased frequency and severity⁶⁹ of malpractice claims, and a corresponding rise in the cost of malpractice insurance.⁷⁰ The fol-

60. Sieradzki, *supra* note 27, at 539-40.

61. See, e.g., cases cited *supra* note 12.

62. See *infra* notes 235, 286-87 and accompanying text.

63. See generally, William M. Landes & Richard A. Posner, *The Positive Economic Theory of Tort Law*, 15 GA. L. REV. 851, 851 (1981) (suggesting that judges, when deciding cases, should attempt to promote the most efficient allocation of resources).

64. See Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 992 (1984) (concluding that the essential deterrent value of the tort system is psychological: "the declaration of wrongfulness and the social stigma that goes with [it] . . .").

65. See *id.* at 990-93. See also DANZON, *supra* note 56, at 9 (primary rationale for tort liability is deterrence).

66. See Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451, 1452 (1988) (calling the Virginia Birth-Related Neurological Injury Compensation Act an "ominous[] exception to the general approach" of the medical malpractice system).

67. See *supra* note 18.

68. The use of quotation marks around the word "crisis" indicates the lack of consensus among commentators over the precise definition of the term. Bovbjerg, *supra* note 16, at 500 n.1 ("The quotation marks reflect the lack of consensus about the precise extent of problems and their social import . . .").

For example, Danzon would presumably argue that the "crisis" is the high rate of negligence that occurs without the victims ever filing malpractice claims. See DANZON, *supra* note 56, at 28-29. On the other hand, Law and Polan view the crisis as a much broader problem that runs through the basic economic structures of medicine, law, and the insurance industry. LAW & POLAN, *supra* note 49, at xiii.

69. As noted *supra* note 14, the term "frequency" refers to the number of claims filed and "severity" refers to the dollar amount requested and awarded as damages in medical malpractice claims.

70. See Bovbjerg, *supra* note 16, at 502-03 (discussing the large increases in the cost of malpractice insurance caused by increased frequency and severity of claims).

lowing section describes initial reform efforts to address medical malpractice claims generally, then considers the particular focus on obstetrics.

II. GENERAL TORT REFORM AND THE "CRISIS" IN OBSTETRICS

Concern over the changes in medical malpractice since the 1970s has prompted considerable reform.⁷¹ Efforts have focused on three areas: the insurance market, medical practice, and the legal environment.⁷² Many of the reforms were responses to problems with access to medical malpractice insurance, and aimed at making insurance more reasonably priced or more available.⁷³ Others aimed at improving medical quality; for example, encouraging peer review, increasing the disciplinary power of state medical boards, and mandating more elaborate continuing medical education.⁷⁴ But the dominant focus of reform has been directed at addressing legal doctrine or process within the tort system.⁷⁵

Since 1970, every state but one has enacted some measure of tort reform.⁷⁶ Unlike the alternative systems under consideration, the traditional approach to addressing problem or crisis areas in medical liability has been limitation of the existing tort system, rather than abandonment of the entire system for whole classes of injured patients.⁷⁷ Through the 1970s and 1980s, state legislatures passed varying tort reform measures addressing the frequency and severity of medical malpractice claims in general.⁷⁸ While claim

71. *Id.* at 503.

72. *See id.* at 504-10 (outlining the three areas of focus for malpractice reform efforts).

73. *Id.* at 514-19 (discussing reforms including (1) Joint Underwriting Associations, (2) Patient Compensation Funds, (3) limiting insurance cancellations, (4) mandating liability coverage, and (5) reporting requirements).

74. *Id.* at 519-20.

75. *Id.* at 521 (discussing reforms aimed at reducing the number of lawsuits, the size of recoveries, the costs of winning a lawsuit, and the cost to the judicial process).

76. White, *supra* note 14, at 1497 n.51 (citing U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION, REPORT TO CONGRESSIONAL REQUESTERS 8 (1987)). Despite the positive effects of a number of these reform efforts on the malpractice problem, there remains a push to make even more sweeping changes. Doctors Bulgar and Rostow, summarizing the findings of a two-year study by a committee of the Institute of Medicine of the National Academy of Sciences, noted that tort "reforms have not had a dramatic effect on the overall costs of the tort system . . . in resolving claims of obstetrical malpractice." Bulgar & Rostow, *supra* note 27, at 87. The committee also concluded that "[d]espite ample discussion of possible alternatives [to the tort system], . . . these alternatives have not been adequately tested" *Id.*

77. White, *supra* note 14, at 1497.

78. *See* Bovbjerg, *supra* note 16, at 521-22, stating:

frequency and severity continued to rise, a number of the reforms have shown signs of effectiveness in slowing the increase.⁷⁹ However, focus continues to be placed on the practice of obstetrics,⁸⁰ which is considered to be one of the high-risk specialty areas.⁸¹

Originally, the changing atmosphere of medical malpractice particularly impacted the practice of obstetrics.⁸² In some states, the malpractice situation affected not only the affordability, but also the availability of insurance coverage.⁸³ While other practice areas experienced increases in the cost of insurance, the practice of obstetrics felt both a rise in premiums and, in some areas, increased difficulty in obtaining malpractice insurance regardless of cost.⁸⁴ The availability crisis appears to have been "adequately ad-

[O]ne can group reforms into five categories, according to apparent legislative intent in enacting the provisions[:] . . . (1) the first group addresses the number of lawsuits or insurance claims brought (insurance "frequency"); (2) another group targets the size of recoveries ("severity" in insurance jargon); (3) a third set addresses plaintiffs' likelihood of winning (or the costs of building successful cases); (4) other reforms target the functioning or cost of the judicial process; (5) finally, a miscellaneous set of largely minor reforms also exists.

79. The rise in claim frequency and severity does not indicate that reform efforts have had no effect. Danzon notes that states with shorter statutes of limitations and outer limits on discovery rules have had less growth in claims frequency than states more lenient to plaintiffs, with a one year cut from a statute of limitation for adults reducing claims by eight percent. Also, allowing offset of collateral benefits has reduced claim severity by eleven to eighteen percent and claims frequency by fourteen percent as compared with states without collateral source offset. Caps on damage awards, although constitutionally challenged in some states, have reduced severity by an average of twenty-three percent. Arbitration statutes, while causing claim frequency to increase, have reduced overall average severity with a net effect of increasing total claim costs, yet compensating more claimants. See Patricia M. Danzon, *The Frequency and Severity of Malpractice Claims: New Evidence*, LAW & CONTEMP. PROBS., Spring 1986, at 57, 78-79. Decreases in the frequency and severity of claims achieved through implementation of some of these measures make the move toward alternative systems appear even more drastic. Rather than waiting to see if reform efforts would be effective, states like Virginia and Florida removed the common law cause of action completely. The "crisis" of insurance availability is not enough to explain this, as alternative measures existed to address insurance problems.

80. See Gallup, *supra* note 11, at 691; White, *supra* note 14, at 1495.

81. See generally 1 INSTITUTE OF MEDICINE, *supra* note 15, at 92-123 (suggesting that obstetricians' malpractice insurance premiums are higher than average physicians' because obstetrics is a high-risk specialty).

82. See *supra* notes 11-12 and accompanying text.

83. Gallup, *supra* note 11, at 691.

84. Gallup has noted that "[d]ramatic rises in premiums and episodic refusals of insurers to offer coverage constitute what is commonly referred to as a medical malpractice crisis in obstetrics." *Id.*

One report indicates that average premiums paid by obstetrician-gynecologists rose 113% between 1982 and 1985, from \$10,900 to \$23,300 per year. See U.S. DEPARTMENT

ressed by the creation of physician-owned insurance companies, joint underwriting associations, and the conversion to claims-made policies [from occurrence policies]."⁸⁵ The affordability issue, however, appears more difficult to assess; while the cost of malpractice coverage remains higher for obstetrics than for other lower-risk practice areas, obstetricians' income is also generally higher than that of most other physicians.⁸⁶

Like other practice areas, obstetrics has experienced a dramatic increase in the frequency and severity of negligence claims.⁸⁷ However, research conducted by the Institute of Medicine of the National Academy of Sciences found that obstetric claims are even more numerous and more severe than claims in other specialty areas.⁸⁸ Much of the increased severity is due to birth-related neurological injury claims.⁸⁹ Recent legislation and reform efforts have concentrated on this narrow category of obstetric injuries which, occurring during the birth process and resulting in neurological injury, account for the largest number of claims against obstetricians and the highest rate of damage awards.⁹⁰ The following section defines the category of birth-related neurological injuries which are the focus of the legislation and reform.

OF HEALTH AND HUMAN SERVICES, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 14 (1987) [hereinafter TASK FORCE REPORT]. In 1982, malpractice premiums were 10% of a typical obstetrician's average total expenses; by 1985 this figure had climbed to 18%. For all physicians, premiums as a percent of total expenses merely rose from 7% to 10% for the same time period. *Id.* at 172 (information derived from a table contained in the TASK FORCE REPORT).

"The St. Paul's Fire & Marine Insurance Company, the largest insurer of medical malpractice, raised the premiums of obstetricians from a national average of \$12,481 in 1982 to \$51,240 in 1987, an increase of 311 percent . . ." Gallup, *supra* note 11, at 691.

85. 1 INSTITUTE OF MEDICINE, *supra* note 15, at 8-9. See Bovbjerg, *supra* note 16, at 518 ("Traditional 'occurrence' policies pay for any claim resulting from an occurrence in the policy year, no matter how long afterwards the claim may be brought By contrast, premiums collected from 'claims-made' policies . . . cover only claims made during the policy year.").

86. See 1 INSTITUTE OF MEDICINE, *supra* note 15, at 107 (171% increase in malpractice premiums between 1982 and 1986 also accompanied by a 21% increase in obstetricians' net income).

87. See Bulger & Rostow, *supra* note 27, at 84 (increase in severity and frequency of claims is one principal factor in increase in obstetricians' malpractice premiums).

88. *Id.* ("[T]he committee noted that obstetrical claims are more numerous and more severe than those in other specialties, and that these differences recently have been magnified.").

89. See *infra* notes 91-99 and accompanying text.

90. See *supra* note 18 and accompanying text.

III. BIRTH-RELATED NEUROLOGICAL IMPAIRMENT

While injuries occurring during labor and delivery make up the largest proportion of all obstetric and gynecology verdicts,⁹¹ claims alleging birth-related neurological impairment account for more suits against obstetricians than any other type of obstetric injury, almost one-third of all obstetric malpractice claims.⁹² They also result in the largest damage awards.⁹³

Birth-related neurological injuries impose high costs on infants, their families, the medical profession, and society.⁹⁴ When an infant is born with neurological damage that cannot be explained by prenatal injury, drugs, infection, or trauma, the term "birth asphyxia" is often used to describe the neonatal depression.⁹⁵ The term "asphyxia" implies a lack of oxygen flow to the brain with retention of carbon dioxide.⁹⁶ "Hypoxia [asphyxia] . . . and trauma (mechanical injury) to fetuses and newborns during or close to delivery can cause stillbirths and neonatal deaths [, neurological] disabilities and malformities such as cerebral palsy, mental retardation, nerve deficits, [and] hearing and vision impairment"⁹⁷

91. Steven Daniels & Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases*, in 2 INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 161, 175 (1989).

92. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS REPORT 1988. Gallup, *supra* note 11, at 692.

93. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS REPORT 1988. *See also* Gallup, *supra* note 11, at 692.

94. Sieradski, *supra* note 27, at 539.

95. Savas M. Menticoglou et al., *Severe Fetal Brain Injury Without Evident Intrapartum Asphyxia or Trauma*, 74 OBSTETRICS & GYNECOLOGY 457, 457 (1989). The term "neonatal" refers to the period immediately before birth through the first month. STEDMAN'S MEDICAL DICTIONARY 832 (3d ed. 1972).

96. P. Agustsson & N. Patel, *Intrapartum Asphyxia and Subsequent Disability*, in 2 BAILLIERE'S CLINICAL OBSTETRICS & GYNAECOLOGY 167, 169 (1988).

97. Sieradzki, *supra* note 27, at 539 (citing T. Barden, *Perinatal Care*, in GYNECOLOGY & OBSTETRICS: THE HEALTH CARE OF WOMEN 595, 647-49 (2d ed. 1981)). *See also* J.A. Young, *Definitions and Size of the Problem*, in 2 BAILLIERE'S CLINICAL OBSTETRICS & GYNAECOLOGY 1, 4-7 (1988) (addressing various conditions that can arise as a result of trauma or asphyxia).

It is estimated that between 2.0 and 2.5 infants out of every 1000 live births are born with cerebral palsy. Agustsson & Patel, *supra* note 96, at 169. Cerebral palsy can be divided into three main types. First, spastic diplegia is a paralysis or lack of muscle control of corresponding parts on both sides of the body, and is commonly associated with prematurity. A second type, spastic hemiplegia, is characterized by lack of control of one side of the body, and is traditionally attributed to asphyxia or trauma. Finally, spastic quadriplegia, affecting the entire body, is characterized by the most extensive neurological damage and is most commonly accompanied by mental retardation. Infants suffering from this last type of cerebral palsy are the ones most commonly involved in litigation. *See*

Cerebral palsy and mental retardation constitute the most prevalent forms of neurological impairment, with some degree of overlap.⁹⁸ Medical treatment is expensive, and while many injured infants die at an early age, others need long-term care and assistance.⁹⁹

While recent studies indicate that perinatal asphyxia may not be the cause of as many neurological injuries as previously assumed,¹⁰⁰ the studies nonetheless continue to demonstrate a significant association between severe asphyxia occurring during labor and delivery and resulting severe neurological impairment.¹⁰¹ In

Perkins, *supra* note 12, at 808-09.

Paneth and Stark, in an epidemiologic review, found that severe mental retardation is most likely caused by a biological insult to the brain, 8 to 10 percent of which they estimated to occur through perinatal asphyxia. Nigel Paneth & Raymond I. Stark, *Cerebral Palsy and Mental Retardation in Relation to Indicators of Perinatal Asphyxia*, 147 AM. J. OBSTET. GYNECOL. 960, 961 (1983).

98. "About 50% of children with cerebral palsy have IQ's within the normal range; of the remainder, about one half are severely retarded, and 10 to 20% of the severely retarded have cerebral palsy." Paneth & Stark, *supra* note 97, at 962.

99. Retarded children with birth injuries usually require institutional care by the age of seven, and frequently die at an early age (50% within six years of institutionalization, and 74% by the age of 20). Robert H. Chaney et al., *Birth Injury as the Cause of Mental Retardation*, 67 OBSTETRICS & GYNECOLOGY 771, 773 (1986).

100. Some medical researchers argue that many neurological injuries actually occur during pregnancy rather than as a result of asphyxia and poor obstetrical care during delivery. Paneth and Stark note:

[T]here is little consensus as to how much of the burden of neurologic handicap in the community is attributable to intrapartum and neonatal asphyxia, as measured clinically. A review of the available epidemiologic information suggests that the role of perinatal events in the genesis of more severe mental retardation and cerebral palsy is not as large as popularly thought. Of all neurologic handicaps, cerebral palsy bears the closest relationship to adverse perinatal events, but at least 50% of all cases have no documented depression at the time of birth. No more than 15% of severe mental retardation can be attributed to perinatal events. Severe mental retardation without cerebral palsy does not appear to be attributable to birth asphyxia.

Paneth & Stark, *supra* note 97, at 960.

The relationship between fetal asphyxia and long-term central nervous system impairment has become one of the most controversial issues in obstetrics. C. Amiel-Tison et al., *Cerebral Handicap in Full-Term Neonates Related to the Mechanical Forces of Labour*, in 2 BAILLIERE'S CLINICAL OBSTETRICS & GYNAECOLOGY 145, 145 (1988). This is perhaps a response to increased physician liability. Researchers have considered other possible causes of neurological impairment in infants, spanning from genetic and environmental causes to maternal or neonatal hazards. See Eva Alberman, *Epidemiology and Causative Factors*, in 2 BAILLIERE'S CLINICAL OBSTETRICS & GYNAECOLOGY 9, 9-14 (1988) (outlining various causes of neurological impairments).

101. A significantly high risk of cerebral palsy due to severe birth asphyxia has been demonstrated. See Alberman, *supra* note 100, at 17-18. See also Paneth & Stark, *supra* note 97, at 962 ("A strong relationship between . . . birth asphyxia and cerebral palsy has been demonstrated . . .")

the event of severe neurological injury, the resulting impairment can sometimes be attributed to poor obstetrical care during delivery, with the mismanagement causing "birth asphyxia."¹⁰² While a percentage of neurological injuries caused by maternal drug use can mask as being the result of asphyxia,¹⁰³ there is evidence that a substantial percentage of injury is the result of oxygen deprivation and mechanical injury during labor, caused by negligent obstetric treatment. The injuries occurring in *Anderson* and *Boyd* are examples of such treatment. Further, tort liability is not being imposed over incorrect use or failure to use new advanced technologies, but over failure to adequately follow established procedures and techniques,¹⁰⁴ suggesting that rather than liability being imposed over failure to use new techniques or "defensive" measures, it is in response to a lack of tolerance for failure to follow established

In another recent study, of 142 cases reviewed, the causes of cerebral palsy were prenatal in 50% of the cases, perinatal in 33%, postnatal in 10%, and mixed in the remaining 7%. Vanja A. Holm, *The Causes of Cerebral Palsy: A Contemporary Perspective*, 247 JAMA 1473, 1474 (1982). The researchers estimated that as much as 10 percent of cerebral palsy occurrence might be preventable through use of measures designed to avoid asphyxia. *See id.* at 1477. In addition, it is generally recognized that severe mental retardation is caused by perinatal asphyxia between 10 and 15% of the time. *See* Paneth & Stark, *supra* note 97, at 960.

The results of studies showing a strong relationship between birth asphyxia and neurologic injury can be reconciled with studies minimizing this relationship in that it appears that even those who argue against asphyxia as the major cause of neurologic injury admit that it is a cause in a significant percentage of cases. This figure is approximately ten percent where asphyxia is the sole cause of injury without alternative explanations. *See* Chaney et al., *supra* note 99, at 771 (indicating that, despite a showing that perinatal asphyxia was not as significant a causative factor in mental retardation cases as previously thought, perinatal injuries still caused 10% of mental retardation. The distinguishing factor seems to be that severe asphyxia is a cause of similarly severe neurological impairment, or the more severe cases of cerebral palsy and mental retardation. Presumably, these severe injuries are the ones most likely to receive compensation through the tort system.

102. *See, e.g.*, Perkins, *supra* note 12, at 807. *See also* Amiel-Tison et al., *supra* note 100, at 145. The authors note that "[s]ome investigators believe that there is a direct relationship between intrapartum fetal asphyxia and [central nervous system] injury while others reject this hypothesis as having little scientific foundation." *Id.* In summarizing laboratory data and clinical observations relating the mechanical stress of labor to its consequences, the authors go on to argue that both hypotheses are untenable, concluding instead that CNS injury is a response to three factors: 1) the duration and severity of asphyxia, 2) the ability of a given fetus to tolerate stress, and 3) the circumstances under which stress occurs (for example the impact of mechanical forces on the fetus' head). *Id.*

103. *See* Epstein, *supra* note 66, at 1469 (discussing the high incidence of maternal drug use, noting that under a standard of negligent liability it is highly unlikely that any of these injuries would create a "colorable case for liability," while under alternative systems like no-fault, all of them do).

104. Daniels & Andrews, *supra* note 91, at 189.

procedures, particularly when severe injuries result. Generally, successful obstetric malpractice claims arising out of labor and delivery involve these severe injuries.¹⁰⁵ Although tort reform efforts were previously aimed at addressing the medical malpractice climate generally, more recent efforts have focused on this narrow category of severe injuries, even though these injuries are highly correlated with obstetricians' negligence and result in irreparable damage to affected infants. While plaintiffs in these cases appear to be the most deserving of greater protection, the alternative systems seriously restrict the rights and protections of injured infants. The following section outlines the structure of these alternative systems.

IV. INTRODUCTION OF ALTERNATIVE PROPOSALS UNDER CONSIDERATION

A. The Limited No-Fault Statutes

Although prior reform measures made dramatic changes in the tort system, "they did not alter its fundamental premise that compensation should be based on a finding of fault on the part of the provider."¹⁰⁶ More recent reform efforts, however, have advocated abandoning both the tort system and the premise of liability based on fault. The first two systems to be considered, no-fault statutes and selective no-fault systems, are examples of this trend. The basic premise of "no-fault" is that injured parties can seek compensation for their injuries without having to prove that the injury is a result of negligence. "No-fault" proponents have suggested the replacement of the tort malpractice claim with such a system where victims of medical injury are compensated irrespective of a showing of fault on the part of the physician. Obstetrics is the first medical area where no-fault has been statutorily adopted. Shortly after a district court declared Virginia's \$1 million cap on damages unconstitutional and upheld an \$8.3 million damage award in *Boyd*,¹⁰⁷ Virginia's largest medical malpractice insurer threatened

105. See *id.* at 177 ("Generally, the injuries in obstetrics and gynecology cases were likely to be more rather than less severe. About 60 percent of the cases involved a permanent injury or death . . .").

106. White, *supra* note 14, at 1497.

107. *Boyd v. Bulala*, 647 F. Supp. 781, 789 (W.D. Va. 1986) (damage cap infringed state and federal constitutional right to jury trial), *aff'd in part and rev'd in part*, 905 F.2d 764 (4th Cir. 1990) (damage cap constitutional), *certifying questions to Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990) (answering questions of statutory construction and Virginia common law), *conformed to answers of certified questions*, 905 F.2d 764 (4th Cir.

to drop coverage of many of the state's obstetricians.¹⁰⁸ In response, the Virginia legislature passed the first no-fault medical injury statute, removing the right to a tort claim for victims of birth-related neurological injuries.¹⁰⁹ One year later, Florida followed suit, enacting the Florida Birth-Related Neurological Injury Compensation Plan.¹¹⁰ Other states are currently considering enactment of similar statutes.¹¹¹

1. The Virginia Birth Related Neurological Injury Compensation Act

By 1986, the medical malpractice insurance market had left 140 of Virginia's 600 obstetricians uninsured.¹¹² Following the ruling in *Boyd*, PHICO, Virginia's principle insurer, withdrew from the market, and two other insurers restricted coverage on new obstetricians and refused to cover the obstetricians previously covered by PHICO.¹¹³ The insurers stated that the only way they would be induced back into the system would be through legislative removal of the worst obstetric cases from the insurers' exposure.¹¹⁴ The Virginia legislature responded by enacting the Virginia Birth-Related Neurological Injury Compensation Act.¹¹⁵ "By

1990).

108. Gallup, *supra* note 11, at 691-92.

109. *Id.* See VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 1990); *infra* notes 112-41 and accompanying text.

110. FLA. STAT. ANN. § 766.301-.316 (West 1992). See *infra* notes 142-59 and accompanying text.

111. See *supra* note 18.

112. Gallup, *supra* note 11, at 691.

113. *Id.* at 691-92. Gallup states:

After a federal district court declared Virginia's \$1 million cap on damages unconstitutional and upheld an award of \$8.3 million to an infant judged to have been negligently harmed by an obstetrician, one of the principal carriers in Virginia, the Pennsylvania Hospital Insurance Company (PHICO), withdrew from the market. The other two carriers writing obstetrical malpractice insurance in Virginia, St. Paul's and the Virginia Insurance Reciprocal Company, had previously restricted coverage of new obstetricians and refused to insure the obstetricians abandoned by PHICO. Approximately 25 percent of the state's obstetricians could not obtain insurance at any price.

Id.

114. See Jeffrey O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 VA. L. REV. 1475, 1478 (1988) ("Dispositive of the . . . decision to back the [Virginia Act] was an opinion from one of the state's principal medical malpractice insurer [sic], the Virginia Insurance Reciprocal, that only a bill removing the worst obstetrical cases from the insurer's exposure would induce the insurer to cover obstetric risks.").

115. VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 1990).

compensating these children on a no-fault basis and removing them from the tort system, Virginia's legislators [hoped] both to lower malpractice costs and to increase their predictability, thus making the obstetrical malpractice market more attractive to insurers."¹¹⁶ The Act, effective as of January 1, 1988, was the first reform effort to adopt no-fault compensation for medical liability.¹¹⁷

The Virginia Act is a limited no-fault system since it targets only a select group of birth-related injuries and removes these specific classes of injuries from the tort system.¹¹⁸ The Act is restricted to a limited class of injuries, stating:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a "birth-related neurological injury" within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living.¹¹⁹

The Act further specifies that the definition applies to live birth only and "[does] not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse."¹²⁰

The Virginia Act provides for claims to be filed with, and heard by, the State Industrial Commission, which also hears workers' compensation claims.¹²¹ A claimant can file a petition with the Commission setting forth all information relevant to the claim.¹²² The Board of Medicine evaluates the petition and "if it

116. Gallup, *supra* note 11, at 693-94.

117. *Id.* at 692 (discussing Virginia as a leader for other states attempting to reduce costs of birth-related neurological injuries).

118. *Id.* ("[T]his act provides reimbursement for a highly limited category of neurologically impaired children without regard to the fault of the provider. In turn, the law prohibits children or their families from pursuing recovery for their injuries through the tort system."). All other obstetric injuries not falling within these specific groups would have access to the tort system.

119. VA. CODE ANN. § 38.2-5001 (Michie 1990).

120. *Id.*

121. *Id.* §§ 38.2-5003 to -5004.

122. *Id.* § 38.2-5004 (requiring petitions to include "[a] brief statement of the facts and

determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the Board"¹²³

The Virginia Act provides the exclusive remedy for the injured infant.¹²⁴ However, a civil action against a non-participating physician or hospital is available provided that no participating physician¹²⁵ or hospital¹²⁶ is made a party to the action.¹²⁷ The Act contains no provision requiring a participating physician or hospital to notify the patient of participation in this no-fault system prior to treatment.¹²⁸

The Act provides for interrogatories and depositions¹²⁹ and a hearing between 45 and 120 days after the filing of the petition, with the claimant and the Program as required parties to the hearing.¹³⁰ Most notably, the obstetrician is absent from the list of parties to the hearing. While arguably the obstetrician would still be required at the hearing to give information about the services delivered, his or her participation is considerably less than that required by the tort system.¹³¹ The deans of the medical schools of the Virginia Commonwealth are called on to "develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians [which] shall file [a] report and recommendations as to whether the injury alleged is a birth-related neurological injury"¹³²

circumstances surrounding the birth-related neurological injury and giving rise to the claim").

123. *Id.* § 38.2-5004(2)(B).

124. *Id.* § 38.2-5001(B). However, a civil action is not foreclosed against a physician or hospital if there is clear and convincing evidence that the injury was intentionally or willfully caused, provided that such suit is filed prior to and in lieu of an award under the Act. *Id.* § 38.2-5001(C).

125. A physician may become a participating physician by paying an annual assessment to the Virginia Birth-Related Neurological Injury Compensation Program of \$5000 a year. *Id.* § 38.2-5020(A).

126. A hospital may become a participating hospital for a particular year by paying an annual participating hospital assessment of \$50 per live birth for the previous year. *Id.* § 38.2-5020(C).

127. *Id.* § 38.2-5020(D).

128. *See id.* § 38.2-5020(c) to (d) (listing requirements for a participating hospital or physician, but failing to include a requirement to disclose participatory status).

129. *Id.* § 38.2-5007.

130. *Id.* § 38.2-5006.

131. This removes the deterrent effect of participation in the adjudication process. *See infra* notes 281-84 and accompanying text.

132. VA. CODE ANN. § 38.2-5008(B). The Act also contains a rebuttable presumption

Like Virginia's workers' compensation statute,¹³³ the Virginia Birth-Related Neurological Injury Compensation Act compensates for "[a]ctual medically necessary and reasonable expenses,"¹³⁴ limited compensation for loss of earnings,¹³⁵ and reasonable expenses incurred in filing the claim, including reasonable attorneys' fees.¹³⁶ Compensation through the Act is offset by any collateral sources such as private insurance.¹³⁷ While the alternative systems discussed below have the possibility of a discretionary award for noncompensatory damages, the Virginia statute does not compensate for pain and suffering, or any other noneconomic losses.¹³⁸ The program is funded by assessments against obstetricians, hospitals, and all physicians.¹³⁹

As noted previously, there is no requirement under the Virginia Act that either participating obstetricians or hospitals notify patients of participation in the plan,¹⁴⁰ even though provider participation effectively bars patients from the right to file a tort claim.¹⁴¹

that the injury is a "birth-related neurological injury" where it has been demonstrated that the infant has sustained an injury defined within the act. *Id.* § 38.2-5008(A)(1). For the text of the statute defining "birth-related neurological injury," see *supra* text accompanying notes 119-20.

133. VA. CODE ANN. §§ 65.2-500 to -531 (Michie 1992) (compensation provisions of Virginia Workers' Compensation statute).

134. *Id.* § 38.2-5009(1). This calculation of expenses does not include those expenses reimbursed by another source such as government assistance, prepaid health plans or other private insurance. *Id.* § 38.2-5009(1)(a) to (d).

135. A conclusive presumption allows an infant sustaining birth-related neurological injuries to receive fifty percent of the average weekly wage of private, nonfarm workers for the period between ages eighteen and sixty-five. *Id.* § 38.2-5009(3).

136. *Id.* § 38.2-5009(4).

137. See *supra* note 134.

138. VA. CODE ANN. § 38.2-5009 (listing the types of losses for which compensation is allowed under the statute).

139. *Id.* § 38.2-5020. Constitutionality of this type of funding has been challenged in Florida by physicians who did not provide obstetric services. A Florida court upheld the funding scheme because the program's funding was not based on an arbitrary or discriminatory classification and therefore did not violate due process or raise equal protection concerns. See *McGibony v. Birth-Related Neurological Injury Compensation*, 564 So. 2d 177, 178 (Fla. Dist. Ct. App.), *cause dismissed*, 576 So. 2d 289 (Fla. 1990), *cert. denied*, 113 S. Ct. 194 (1992).

140. See *supra* note 128 and accompanying text.

141. See Epstein, *supra* note 66, at 1473. Epstein opposes this lack of consumer notice, pointing out that in failing to require disclosure, the Act fails to force each physician to evaluate the effect of his or her decision to join the Program on his or her medical practice. *Id.*

2. The Florida Birth-Related Neurological Injury Compensation Plan

Exactly one year after the Virginia Act went into effect, Florida enacted a similar system, titled the Florida Birth-Related Neurological Injury Compensation Plan.¹⁴² Modeled after the Virginia Act, the stated purpose of the Florida Plan is to "provid[e] compensation, irrespective of fault, for birth-related neurological injury claims."¹⁴³ However, the legislative findings suggest that the primary motivation for the Act was to decrease malpractice premiums for obstetricians more so than to provide compensation to severely injured infants.¹⁴⁴ Florida's act differs from Virginia's in several respects. First, Florida's statute assesses a tax against all licensed physicians and hospitals,¹⁴⁵ whereas Virginia's program permits hospitals to choose whether or not to participate.¹⁴⁶ Second, unlike the Virginia Act, the Florida Plan provides for notice to obstetrical patients by hospitals and physicians participating in the limited no-fault alternative.¹⁴⁷ The Florida Plan contains a provision for \$100,000 in damages to the parents.¹⁴⁸ In addition, while the Virginia plan provides for a three member medical advisory panel, the Florida plan specifically provides for the makeup of the panel.¹⁴⁹ Each claim is reviewed by the medical advisory panel

142. FLA. STAT. ANN. § 766.301-316 (West 1992).

143. *Id.* § 766.303. The statute states:

"Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mental and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

Id. § 766.302(2).

144. Section 766.301 states the legislative findings and intent, in part, as:

(a) Physicians practicing obstetrics are high-risk medical specialists for whom malpractice insurance premiums are very costly, and recent increases in such premiums have been greater for such physicians than for other physicians.

(b) Any birth other than a normal birth frequently leads to a claim against the attending physician; consequently, such physicians are among the physicians most severely affected by current medical malpractice problems.

Id.

145. *Id.* § 766.314(4)(a)-(b).

146. See *supra* notes 125-28 and accompanying text.

147. FLA. STAT. ANN. § 766.316.

148. *Id.* § 766.31(1)(b). For a more complete discussion of the compensation available under the Florida Plan, see *infra* notes 154-57 and accompanying text.

149. *Id.* § 766.308. The Florida statute also specifically provides for the makeup of the

made up of three physicians appointed by the Division of Workers' Compensation; the panel includes one pediatric neurologist or neurosurgeon, one obstetrician, and one neonatologist or pediatrician.¹⁵⁰ The medical advisory panel files a report recommending whether the injury alleged in the claim is a birth-related neurological injury.¹⁵¹ The Plan provides for claims to be determined by the judge of compensation claims of the Division of Workers' Compensation,¹⁵² in a hearing occurring between 60 and 120 days after the filing of a petition by the claimant.¹⁵³

The Plan compensates "[a]ctual expenses for medically necessary and reasonable medical . . . expenses,"¹⁵⁴ reasonable expenses incurred in filing a claim, including reasonable attorneys' fees,¹⁵⁵ and periodic payments of an award not to exceed \$100,000 to the parents or legal guardians of an infant found to have sustained a compensable injury.¹⁵⁶ Yet the Act does not guarantee the amount of the periodic payment, or state what the payment replaces.¹⁵⁷ The Florida Plan limits the filing of claims to seven years after the birth of the infant.¹⁵⁸

Finally, when the Florida Plan went into effect, it became the exclusive remedy for an infant with a "birth-related neurological injury."¹⁵⁹

Florida Birth-Related Neurological Injury Compensation Association, a board of five directors which oversees the Plan. Section 766.315 provides that the board shall consist of one citizen representative and one representative each from participating physicians, hospitals, casualty insurers, and non-participating physicians. *Id.* § 766.315(1)(c).

150. *Id.* § 766.308(1).

151. *Id.* While the panel may be highly educated on neurological injuries in obstetrics, its member may be biased in favor of obstetricians and against individuals claiming compensable injuries under the Plan, making a compensable claim more difficult to obtain for the injured infant. For discussion of the potential anti-claimant bias of medical disciplinary boards and associations like those provided for in the Florida and Virginia statutes, see *infra* notes 239-43 and accompanying text.

152. FLA. STAT. ANN. § 766.304.

153. *Id.* § 766.307(1). Like the Virginia Act, under the Florida Plan the parties to the hearing include the claimant and the association which administers the plan, with no reference to the physician being present. See *supra* notes 130-31 and accompanying text.

154. *Id.* § 766.31(1)(a) (also noting that these expenses do not include payments from the federal government, private insurance companies, or prepaid health plans).

155. *Id.* § 766.31(1)(c) (listing time, labor, difficulty, length of the professional relationship, and experience of the lawyer as factors considered in determining the award).

156. *Id.* § 766.31(1)(b). At the discretion of the judge of compensation, this award can be given in a lump sum. *Id.*

157. *Id.*

158. *Id.* § 766.313.

159. *Id.* § 766.303(2) (only allowing a civil action where clear and convincing evidence of bad faith, malicious purpose, or willful conduct is established).

B. Selective No-Fault Accelerated Compensation Event System

The Accelerated Compensation Event ("ACE") System is a proposed alternative insurance system aimed at removing the most severe obstetric injuries from litigation, by locating "classes of medical injuries determined in advance by medical experts to be readily identifiable, normally preventable with good care, and nondistorting of medical decision-making."¹⁶⁰ The system proposes to remove these classes of obstetric injuries from malpractice litigation and instead provide private or social insurance to cover predefined accelerated-compensation events.¹⁶¹

ACE systems cover adverse outcomes determined by medical experts to be (1) relatively avoidable,¹⁶² (2) easily identifiable,¹⁶³ and (3) unlikely to cause distortions in medical decision-making regarding treatment.¹⁶⁴ A group of obstetric specialists, reviewing data from insurance claims and adverse hospital outcomes, created a list of forty-eight types of injuries, in eleven categories, which qualify as obstetrical ACEs.¹⁶⁵

The authors of the ACE system proposal distinguish it from "no-fault" based on the system's reliance on statistical preventability, as ACEs are categories of injuries deemed to be statistically preventable with good care,¹⁶⁶ making ACEs "akin to fault."¹⁶⁷ Therefore, the system is termed "selective no-fault," as "ACEs cover only those medical injuries selected for coverage by professional judgment."¹⁶⁸ However, the ACE system proponents limit

160. Bovbjerg et al., *supra* note 24, at 2836. Similar to the no-fault statutes, injuries not included within the classification of compensable injuries would presumably be able to file a claim for negligence in the tort system. *Id.* at 2861.

161. *Id.* Prior writings on this proposal characterized ACEs as "designated compensable events." However, the authors of this current proposal felt this "emphasized the intentional nature of constructing a listing," and chose instead to emphasize what they perceived to be the major benefit of ACEs, accelerated compensation. *Id.* at 2837.

162. Avoidability means the use of methods of diagnosis and treatment that could prevent the injury and recognizes the capability of timely intervention upon recognition of a bad outcome to mitigate its long-term effects. *Id.* at 2836.

163. The objective of identifiability is to ensure that only avoidable events are included. *Id.*

164. The purpose of this criterion is to avoid distortions in medical decisionmaking, whereby a physician would elect a less than optimal treatment modality because it would be unlikely to result in an ACE. *Id.*

165. *Id.* at 2836-37 (including, for example, nerve injuries, puncture or laceration wounds, and failure to diagnose).

166. *Id.* ("ACEs have to be injuries that are preventable in a specified share of cases receiving good care.").

167. *Id.* at 2837.

168. *Id.* (finding that the ACE system falls somewhere between "no-fault" and fault-

this association with fault, as the system is designed to avoid individualized fault-finding.¹⁶⁹

Accelerated-compensation events would be compensated by the responsible insurer without legal proceedings.¹⁷⁰ Damages would include actual pecuniary loss and some allowances for nonpecuniary damages, according to preset qualitative standards, possibly "scheduled on the basis of severity and duration of injury,"¹⁷¹ with periodic payments of future losses.¹⁷² Currently no state has adopted an ACE system, although the Institute of Medicine of the National Academy of Sciences has proposed it as a method for states to consider.¹⁷³

C. The Fault-Based Alternative: The AMA-Specialty Society's Fault-Based Administrative System

The AMA-Specialty Society Fault-Based Administrative System¹⁷⁴ is both a rejection of the tort system as well as a response to the "no-fault" and "selective no-fault" systems. Member-societies believed that tort reform efforts were incomplete solutions to an inherently flawed system and although a radical alternative was called for, systems removing the fault inquiry were not the answer.¹⁷⁵ Society members were concerned with the unknown potential costs of a no-fault system, the effect on deterrence, and the fairness of holding physicians responsible for injuries that may be a natural consequence of nonnegligent treatment or disease.¹⁷⁶

The AMA-Specialty Society, comprised of the American Medical Association ("AMA") and 31 national medical specialty societies, including the American College of Obstetricians and Gynecologists ("ACOG"), have proposed that a state administrative agency¹⁷⁷ have power both to resolve medical liability disputes

based systems).

169. *Id.* at 2841.

170. *Id.* at 2837 (noting that this type of administration resembles health or disability insurance rather than liability insurance).

171. *Id.*

172. *Id.* at 2842.

173. See Bulger & Rostow, *supra* note 27, at 88 (recommending the American Medical Association's no-fault scheme, private contracts, and ACE systems as alternatives to the tort system).

174. AMA PROPOSAL, *supra* note 26.

175. See *id.* *supra* note 26, at 12-16 (asserting that "no-fault" systems remove deterrence, increase costs, and are not suited to the problems of medical liability).

176. *Id.* at 14.

177. The administrative agency would be a modification of the existing state medical

and to discipline doctors.¹⁷⁸ "The proposal calls for a fault-based administrative system, under the jurisdiction of strengthened state medical boards or a new state agency, which would totally replace the existing court/jury system."¹⁷⁹ Proponents hope that the system will be adopted in one or more states, with obstetrics as an initial area for implementation.¹⁸⁰

"The proposed system has three basic parts: (1) a claims resolution function,¹⁸¹ (2) a credentialling and disciplinary process,¹⁸² and (3) a codification of the legal elements of medical liability."¹⁸³ In contrast to the prevailing system of decision through the civil jury system, all three components would be administered by the revamped state medical board, which would be vested with the additional authority to review and decide medical liability claims.¹⁸⁴ The proposal recommends a seven member Medical Board, with a requirement of at least two physicians and one health care professional on the Board.¹⁸⁵ But no more than three health care practitioners would be permitted to serve on the Board at the same time.¹⁸⁶

Under the claims resolution function, a medical malpractice complaint would be presented to the administrative agency for an initial screening.¹⁸⁷ The proposal suggests that most claims would

disciplinary board or a newly created administrative agency, which could also be labeled a medical board. *Id.* at 17.

178. *Id.*

179. AMA-Specialty Society Medical Liability Project, Press Release, Medical Groups Offer Proposal to Resolve Malpractice Crisis 2 (1988) [hereinafter Press Release].

180. See, e.g., Carter G. Phillips & Elizabeth H. Esty, *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims: The AMA-Specialty Society Medical Liability Projects' Proposal and Its Relevance to the Crisis in Obstetrics*, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 136, 149 (1989).

181. The system uses an expert administrative agency instead of the court system to determine cases in hopes of dismissing most claims at this stage. Press Release, *supra* note 179, at 2.

182. The purpose behind this feature is to strengthen the administrative agency's ability to oversee physicians, and thus, its authority to implement disciplinary practices. *Id.* at 2-3.

183. *Id.* at 2.

184. *Id.* Alternatively, states could create a separate agency to serve this claim resolution function. *Id.*

185. See AMA PROPOSAL, *supra* note 26, at 67-71 (not requiring the remaining five members to meet any specific criteria).

186. *Id.* (noting that the plaintiffs' bar would withdraw support for the Board if physicians were permitted to form a majority).

187. Press Release, *supra* note 179, at 2.

be dismissed or settled at this initial review.¹⁸⁸ Throughout the process, the claimant has the option of free representation by attorneys from the agency's office of general counsel, while the physician would be represented by private counsel.¹⁸⁹ A hearing would be conducted on all unsettled claims before a hearing examiner.¹⁹⁰ Unlike the "no-fault" and "selective no-fault" systems, the physician would be a necessary party to the hearings.¹⁹¹

This system also proposes credentialling and disciplinary functions, relying heavily on a revamped State Medical Board.¹⁹² First, all settlements and awards would be reported to an investigative branch of the agency for screening to determine if a pattern of substandard care exists.¹⁹³ Physician performance credentialling would be conducted periodically with substandard overall performance reported to the Board.¹⁹⁴ Insurers would be required to report insurance cancellations and failure to renew if related to competence. This information would be maintained in a clearinghouse.¹⁹⁵ Disciplinary procedures would be implemented by the state board.¹⁹⁶ The system also proposes changes in the standard of care rules, while maintaining negligence as the principle for decisionmaking.¹⁹⁷

The AMA plan proposes scheduled compensation for economic damages determined by the agency's board, plus the possibility of recovering non-economic damages, determined at the discretion of the hearing examiner.¹⁹⁸

While addressing the issue of fault differently, the alternative systems outlined above share certain similarities. All remove claims from the jury process.¹⁹⁹ All but the AMA proposal remove any

188. *Id.*

189. *Id.*

190. *Id.*

191. See AMA PROPOSAL, *supra* note 26, at 21. See *supra* notes 130-31, 153 and accompanying text.

192. Press Release, *supra* note 179, at 2.

193. *Id.*

194. *Id.*

195. *Id.*

196. AMA PROPOSAL, *supra* note 26, at 60.

197. *Id.* at 90-101 (asserting that the customary standard of care, whereby similar physicians in similar situations provide the standard of care, should be replaced because (1) physicians are reluctant to testify against each other, (2) certain geographic areas maintain too low of a standard of care, and (3) the current system serves to perpetuate the practice of defensive medicine).

198. *Id.* at 144-52 (consolidating all types of non-economic damages into one category and placing a cap on the maximum award allowed).

199. See *supra* notes 118-20, 143 and accompanying text (Florida's and Virginia's statu-

fault inquiry.²⁰⁰ Each compensates for economic damages through scheduled payments.²⁰¹ All but the Virginia act contemplate the possibility of limited noneconomic damages,²⁰² and the inclusion of or the amount of such noncompensatory damages is discretionary.²⁰³ The systems rely largely on medical panels both to determine compensable claims and to provide limited deterrence,²⁰⁴ with no other deterrent mechanisms outlined in the systems.

The following section will analyze the alternative systems further in terms of addressing the fault and causation standards and objectives of the tort system of compensating and deterring negligence. First, however, the justifications for exclusive treatment of birth-related neurological injuries is questioned.

V. EVALUATION OF SELECTIVE TREATMENT FOR BIRTH-RELATED NEUROLOGICAL INJURIES: WITHSTANDING CONSTITUTIONAL AND POLICY CHALLENGES

It is likely that the statutory restrictions on the rights of victims of birth-related neurological injuries will withstand constitutional challenges.²⁰⁵ The funding tax on nonparticipating physicians has already been upheld against a challenge on due process and equal protection grounds.²⁰⁶ A potential plaintiff is unlikely to be successful in an equal protection challenge because a rational

tory removal of certain injuries from the tort system) and *supra* notes 160-68 and accompanying text (discussing ACE system's removal of certain classes of medical injuries from the tort system).

200. ACEs, however, predetermine fault in deciding categories of compensable events, but remove the individual finding of fault at the time a claim is filed. *See supra* notes 165-69 and accompanying text.

201. *See supra* notes 133-38, 154-57, 170-72, 198 and accompanying text (discussing the provisions of the Virginia, Florida, ACE, and AMA plans that allow recovery for economic damages).

202. *See supra* text accompanying note 138.

203. *See supra* notes 156, 171 and accompanying text.

204. *See supra* notes 132, 149-51, 165, 178 and accompanying text (discussing the role of medical boards in each system).

205. *See White, supra* note 14, at 1504 (outlining the 3 types of constitutional challenges that these statutes are likely to receive and to withstand, including the right to trial by jury, equal protection, and the right to due process of law). *But see Ward, supra* note 30, at 436-50 (arguing that the Virginia Act is unconstitutional because it discriminates against the class of children who suffer serious neurological injuries).

206. *See McGibony v. Birth-Related Neurological Injury Compensation*, 564 So. 2d 177, 179 (Fla. Dist. Ct. App.), *cause dismissed*, 576 So. 2d 289 (Fla. 1990), *cert. denied*, 113 S. Ct. 194 (1992) (upholding the constitutionality of the funding mechanism of the Florida plan).

basis standard is usually adopted in these challenges.²⁰⁷ Where a medical malpractice crisis exists, a valid legislative purpose may be found.²⁰⁸ The U.S. Supreme Court has stated that commonlaw rights can be legislatively altered without violating due process²⁰⁹ where the new arrangement is not arbitrary or unreasonable.²¹⁰ Because vocal insurer and physician interest groups advocate that the current medical malpractice climate in obstetrics is in a state of crisis, and that birth-related neurological injury claims are a substantial cause of this crisis,²¹¹ statutory restrictions like no-fault and the alternative systems are likely to continue to receive legislative support.

While arguably constitutionally permissible, legislation that abrogates the rights of an underrepresented class of victims²¹² of birth-related neurological injuries is insupportable on policy grounds. Analysis of the current malpractice situation in obstetrics demonstrates that removal of the common law right to bring these claims is arbitrary and unreasonable, as these claims are neither the

207. See White, *supra* note 14, at 1509-10 (asserting these infants have no fundamental right to sue and the category composed of the most severely injured infants is not a suspect class).

208. See *id.* at 1510 (asserting that stabilizing the insurance market is a valid legislative objective). However, the Rhode Island Supreme Court has found that, absent a medical malpractice crisis, a system providing unequal and separate treatment of medical malpractice litigants violates the equal protection clause. *Boucher v. Sayeed*, 459 A.2d 87, 93 (R.I. 1983). The Court stated:

[T]he Fourteenth Amendment permits states a wide scope of discretion in enacting laws that affect some classes of citizens differently from others. The critical question is whether there exists an appropriate governmental interest suitably furthered by the differential treatment. Both the nature of the classification and the individual rights upon which it may infringe must be scrutinized to determine legislative compliance with equal-protection standards. (citations omitted).

Id. at 91.

209. See Ward, *supra* note 30, at 438; *Munn v. Illinois*, 94 U.S. 113, 134 (1876) ("A person has no property, no vested interest, in any rule of the common law.").

210. See Ward, *supra* note 30, at 438-39 (discussing *New York Cent. R.R. v. White*, 243 U.S. 188, 202 (1917), which requires the due process analysis to consider "whether the new arrangement is arbitrary and unreasonable, from the standpoint of natural justice.").

211. See *supra* notes 82-93 and accompanying text.

212. At the same time that potential plaintiffs were largely unrepresented in consideration of the Virginia Act, physician and insurance groups participated in its implementation. See Ward, *supra* note 30, at 444 n.85, where the author comments on the relative political powerlessness of this small class of children in light of the enactment of the Virginia Act: "When the Act was passed the affected children were unborn. In addition, most people do not consider the possibility of having a catastrophically injured child. Therefore, no one was in a position to take a personal stand against the Act when it was proposed."

cause of the "crisis" — if in fact a crisis exists²¹³ — nor the solution. Further, statutory restrictions will have an adverse impact on the rights of the most severely injured infants, arguably the category most in need of protection.

A. Justifications for Selective Treatment of Birth Injury Claims:
Analysis and Criticism

Claims of a medical malpractice crisis in obstetrics requiring alternative treatment rest on a number of largely unsupported assertions about the effectiveness of the tort system: 1) that there is an increase in the frequency and severity of claims which is affecting both the cost and availability of insurance;²¹⁴ 2) that juries are incapable of fairly determining an obstetric injury claim and, as a result, verdicts are arbitrary, excessive, and based on jury sympathy;²¹⁵ and 3) that treatment is being adversely driven by the threat of liability through "defensive medicine," raising the cost of treatment.²¹⁶ While these assertions were initially made with little reliance on statistical data, recent evidence suggests they are unfounded.

1. Responding to the Frequency and Severity of Claims

Proponents of the alternative systems argue that the malpractice experience in obstetrics has been more dramatic than in other practice areas,²¹⁷ yet many of these assertions are based on comparisons of obstetrics with general practice and historically lower risk practices.²¹⁸ When the obstetric situation is compared with other high risk specialty areas, it is not significantly different in terms of the frequency of plaintiffs bringing claims²¹⁹ from medical spe-

213. See Elliot Martin Blake, *Rumors of Crisis: Considering the Insurance Crisis and Tort Reform in an Information Vacuum*, 37 EMORY L.J. 401, 402 (1988) (finding the premise that a liability crisis exists difficult to prove because of the limited amount of supporting evidence available); *supra* note 68 and accompanying text.

214. See *infra* notes 217-28 and accompanying text.

215. See *infra* notes 229-43 and accompanying text.

216. See *infra* notes 244-52 and accompanying text.

217. See *supra* notes 82-93, 112-14 and accompanying text; see also Bulger & Rostow, *supra* note 27, at 84 (noting that obstetric claims are more numerous and severe than claims in other specialty areas).

218. See *supra* note 81 and accompanying text.

219. See generally Daniels & Andrews, *supra* note 91. The authors compare obstetric claims with the claims experiences of other high-risk specialty areas and note that a small percentage of injury-causing medical errors lead to claims against physicians. While Daniels and Andrews found obstetric claims were more frequently brought, this increased frequency was considerably less dramatic when compared with other high-risk areas. Fur-

cialties where similar treatment has been rejected.²²⁰ The past twenty years have also seen a significant rise in litigation generally.²²¹

Further, underlying the increase in frequency is evidence that rather than a surge in nonmeritorious claims, even more negligence is occurring than claims are being filed.²²² This evidence strongly suggests that the focus should not be placed on reducing the frequency of claims by shrinking the categories of compensable claims. Such measures will limit legitimate plaintiffs' abilities to bring claims at the risk of decreased deterrence. Moreover, birth-related neurological injuries are more expensive than other claims. Successful cases involve severe injury, with costly medical care and calculations of lost future earnings based on the normal life expectancy of an infant.²²³ In addition, the severity of obstetric claims is alleged to have caused an increase in the cost of insurance, and specific to the practice of obstetrics, a decrease in insurance availability.²²⁴ Insurance premiums have risen for all medical practice areas, and although the cost is higher in obstetrics, it is not significantly different from other high-risk specialty areas.

The crisis of availability has been adequately addressed without

ther, while claims for birth-related neurological injuries make up the largest percentage of obstetric claims, other obstetric injury claims are also of high frequency. Yet these other claims have not been targeted for specialized legislative treatment. *Id.*

220. See *supra* note 30.

221. WALTER OLSON, *THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT 6* (1991). Medical malpractice and obstetric malpractice are not the only areas to experience a claims increase, as increases have occurred in all areas of litigation, making the experience in obstetrics less remarkable, and therefore less justified for selective treatment. See *id.*

222. Danzon, *supra* note 79, at 18-29 (noting also the results of a California Medical Association study which found that roughly 1 of 20 hospital admissions result in a negligent injury and that this figure may be an underestimate). Danzon's findings are further bolstered by the conclusions of a recent study conducted by Harvard University on the incidences of medical negligence. The Harvard investigation concluded that "150,000 Americans are killed annually by medical treatment, with more than half of those deaths 'due to negligence' . . . not too many, but rather too few suits were brought for the negligent medical injury inflicted on patients." Miles Benson, *Doctors' Negligence More Deadly Than Traffic*, CLEVELAND PLAIN DEALER, May 8, 1993, at A4 (reporting on the findings of the Harvard study). A recent study published in the *Annals of Internal Medicine*, based on 8231 cases of medical malpractice over a 15 year span, also concluded that "contrary to popular belief, unjustified payments are rare." Robert Pear, *Medical Malpractice Study Finds Unjust Payments are Rare*, N.Y. TIMES, Nov. 1, 1992, § 1, at 42 (reporting on the recently released study).

223. See *supra* notes 60-62 and accompanying text. An adult injury claim would generally involve a shorter time span.

224. See *supra* notes 83-84, 108, 112-14 and accompanying text.

abolishing common law rights.²²⁵ But in 1989, the Institute of Medicine of the National Academy of Sciences released the results of its two-year study on the effects of medical professional liability on the delivery of obstetric services.²²⁶ Their research found that obstetric claims represented approximately ten percent of malpractice claims nationwide and accounted for nearly half of all indemnity payments.²²⁷ As noted below, almost one-half of the damage awards for this category of injuries goes toward pain and suffering.²²⁸ These results, in relation to the discussion above on claim frequency, suggest that reduction in the severity of these claims may be accomplished by addressing noncompensatory damages within the tort system.

2. Removing Claims from Jury Deliberation

Critics of the tort system also argue that juries are unable to decide claims adequately and as a result verdicts are arbitrary, excessive, and based on sympathy for plaintiffs, particularly where the victim is a severely injured infant.²²⁹ However, evidence shows that these allegations are largely unfounded in regard to jury verdicts in birth-related injury claims.²³⁰ Research for the Institute of Medicine in which various types of obstetrical and gynecological injuries were separated by jury verdicts found that while labor and delivery injury claims had a greater likelihood of success, the injuries were highly correlated with medical mismanagement and negli-

225. See *supra* note 85 and accompanying text.

226. See Bulger & Rostow, *supra* note 27, at 82.

227. *Id.* at 82-83. See generally GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS (1986) (examining six state malpractice statutes and the cost of medical malpractice insurance and claims in those states, especially in high risk specialties like obstetrics, gynecology, and neurosurgery).

228. See *infra* notes 235, 287-88 and accompanying text. See, e.g., *Estrada v. Columbia Presbyterian Medical*, No. 16438/84 (N.Y. Sup. Ct., Oct. 5, 1992) (awarding total damages of \$12.7 million, including \$8 million for pain and suffering, for medical malpractice that resulted in permanent brain injury to an infant).

229. Edward C. Martin, *Limiting Damages for Pain and Suffering: Arguments Pro and Con*, 10 AM. L. TRIAL ADVOC. 317, 329 (1986). But see Daniels & Andrews, *supra* note 91, at 163 ("Despite the fact that jury verdicts in medical malpractice cases are roundly criticized, there have been surprisingly few studies of what actually happens in malpractice cases that go to court and virtually no studies of cases involving obstetricians and gynecologists.").

230. Daniels & Andrews, *supra* note 91, at 188, 191 (noting that awards are not excessive given the seriousness of birth-related injuries).

gent treatment rather than jury arbitrariness.²³¹ "The low success rates and low award structures for more severe injuries in hysterectomy and tubal ligation cases suggest that juries are not simply making emotional decisions based solely on severity of injury."²³²

While awards may be larger, economic damages are structured to the cost of medical care and treatment, which is expensive for this type of injury.²³³ Yet critics complain that sympathy is reflected in the calculation of excessive noneconomic damages like pain and suffering.²³⁴ Pain and suffering awards account for close to half of jury verdict damage awards.²³⁵ There is no standard of calculation by which juries arrive at noneconomic awards. Therefore, any sympathy for the plaintiff may be reflected in calculations of noneconomic damages. While arguably the claims of severely injured infants are deserving of sympathetic awards of higher damages, such awards place a heavy burden on insurers and possibly obstetricians if the award exceeds liability coverage. Addressing this additional burden may remove some of the pressure in the obstetric malpractice situation.

Exceedingly high noneconomic damage awards are not justified under either the compensation or deterrence rationales underpinning common law tort liability.²³⁶ A limit imposed on pain and suffering does not infringe on a right of the parent or injured infant as the award is based on intangible rather than economic loss. If the award is within the obstetrician's liability coverage, it does not provide any further incentive to exercise care than other deterrence mechanisms. But if liability exceeds coverage, it may impose a financial cost beyond what the obstetrician can bear. The unpredictability of noneconomic awards also affects insurers who cannot calculate or reflect the cost of future claims in determining premiums.²³⁷ Yet problems with the unpredictability of noneconomic damage awards can be addressed without removal of

231. *Id.* at 183, 188-91 (asserting that greater care is needed in this area).

232. *Id.* at 188.

233. *See id.* at 177 (implying that the medical care costs for injured infants are high because approximately 60% of obstetrical malpractice claims involve permanent injury or death).

234. *See* Martin, *supra* note 229, at 329.

235. DANZON, *supra* note 56, at 170; *supra* note 228.

236. *See supra* notes 56-65 and accompanying text.

237. Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 NW. U. L. REV. 908, 908 (1989).

birth injury claims from the tort system.²³⁸

With the exception of the ACE system,²³⁹ the alternative systems replace a jury's determination with that of an administrative agency similar to a workers' compensation commission,²⁴⁰ with claims reviewed by medical review panels to determine compensability. These panels rely on physicians, often obstetricians,²⁴¹ to determine whether claims are compensable. This method is likely to result in problems similar to those presented by reliance on medical personnel to provide disciplinary mechanisms for negligent obstetricians, a process generally recognized as ineffective.²⁴² Particularly when the medical review panel is made up of obstetricians deciding causation, the panel may be more likely to find that an injury was not birth-related. This is particularly true in light of the current medical controversy over causation of these injuries.²⁴³ While modeled after workers' compensation boards, the structure of these panels would be most analogous to a Worker's Compensation board made up of employers in the specific field where the alleged injury occurred. It is highly unlikely that either panel would be able to avoid its bias, with the resulting bias impacting on those most severely injured by negligent obstetric care.

3. Defensive Medicine

Critics of the tort system allege that the cost of obstetric care is being driven up by implementation of litigation-avoiding "defensive medicine."²⁴⁴ Measures receiving the most attention are fetal

238. See discussion *infra* notes 286-97 and accompanying text.

239. The ACE system attempts to predefine all compensable injuries, allowing claims to go directly to the responsible insurer, in a manner similar to the administration of health or disability insurance. See Bovbjerg et al., *supra* note 24, at 2837.

240. The Florida and Virginia no-fault statutes are both heard by the states' workers' compensation boards. FLA. STAT. ANN. § 766.302(4) (West 1992); VA. CODE ANN. § 38.2-5001 (Michie 1990).

241. See *supra* notes 149-51 and accompanying text. While the Virginia Act does not specify the makeup of the medical review panel, Florida's plan specifies a panel of one pediatric neurologist or neurosurgeon, one obstetrician, and one neonatologist or obstetrician, which will review the claim and file a report recommending whether the injury is a birth-related neurological injury. FLA. STAT. ANN. § 766.308 (West 1992).

242. See, e.g., Ward, *supra* note 30, at 452 n.129 (noting that physicians recognize the proven ineffectiveness of disciplinary measures within the medical community).

243. *Id.* See *supra* notes 100-03 and accompanying text.

244. See, e.g., Bulger & Rostow, *supra* note 27, at 85-87 (concluding that the threat of liability has resulted in the performance of often unnecessary tests and procedures which in turn creates higher costs with questionable, if any, corresponding increase in the quality of care).

monitoring and other diagnostic procedures.²⁴⁵

The primary function of fetal surveillance during labor is the prevention of perinatal asphyxia.²⁴⁶ Fetal heart rate monitoring is the conventional method. In the majority of studies, fetal heart rate monitoring has led to an increase in the cesarean section rate,²⁴⁷ which provides a gentler birth when there is a risk of asphyxia.²⁴⁸ The American Medical Association and others have criticized some of the procedures followed by obstetricians as purely defensive measures used to avoid litigation rather than for any true preventative value.²⁴⁹ However, other research has demonstrated the value of fetal heart rate monitoring as an effective diagnostic measure, particularly when combined with fetal scalp blood sampling and cord blood analysis when the fetal heart rate monitoring is irregular.²⁵⁰ Clinical advances in technology are expanding the array of diagnostic and therapeutic procedures available to detect potential problems.²⁵¹

"Defensive" medicine, rather than being a negative result of fear of litigation, may support the effectiveness of the tort system as a deterrent, as defensive medicine may lead to better care and better results. Further, evidence shows that negligence in obstetrics is not usually the result of the failure to practice so-called "defensive medicine," but rather is the result of obstetricians' failure to follow older established procedures of the standard of care.²⁵² The immunity from tort liability provided by the alternative systems is even more unjustified in light of the evidence that injury is generally the result of failure to meet medically established standards of care rather than purportedly "litigation-driven" standards.

In addition to the issues raised above regarding questionable

245. AMERICAN MEDICAL ASSOCIATION, THE FUTURE OF OBSTETRICS AND GYNECOLOGY 10 (1987).

246. Agustsson & Patel, *supra* note 96, at 171.

247. *Id.*

248. See Schwartz & Tucker, *supra* note 2, at 316.

249. AMERICAN MEDICAL ASSOCIATION, THE FUTURE OF OBSTETRICS AND GYNECOLOGY 16, 19 (1987).

250. Agustsson & Patel, *supra* note 96, at 171-73.

251. AMERICAN MEDICAL ASSOCIATION, THE FUTURE OF OBSTETRICS AND GYNECOLOGY 15 (1987).

252. Daniels and Andrews found that many of the infant injury claims in their study were the result of the use of Oxytocin, a labor-inducing drug. Contraindications for use of Oxytocin began appearing in 1962, and were widely recognized by the medical profession by the 1970s. Sixteen of the 23 studied Oxytocin injury cases were over situations where the use of the drug was clearly contraindicated by contemporary medical sources. Daniels & Andrews, *supra* note 91, at 189-91.

justifications for providing alternative treatment of this select category of injuries, there are concerns about whether the alternative systems are adequate replacements for the right to a common law cause of action. The following section will consider the alternative systems in light of the standards and goals of the tort system.

B. The Imposition of Liability: The Fault and Causation Inquiry

The tort system asks two initial questions regarding a claim of medical malpractice: first, whether the injury was caused by the medical care; and, second, whether the obstetrician (or medical care provider) was at fault. Part of the plaintiff's *prima facie* case is the establishment of causation and fault.²⁵³ The no-fault and selective no-fault statutes would remove any inquiry into negligence or fault of the provider.²⁵⁴ Some researchers argue that many birth-related neurological injuries are not caused by negligent treatment during labor and delivery, but occur prenatally, during pregnancy, without any fault on the part of the obstetrician.²⁵⁵ Under these circumstances, the imposition of liability for negligent treatment during labor or delivery would be inappropriate. There are, however, two problems with this position. First, the birth-related neurological injuries currently being compensated in the tort system and targeted by the alternative systems are highly correlated with negligence.²⁵⁶ Second, by removing the fault inquiry under the no-fault systems, injuries occurring perinatally (during pregnancy) are likely to fall within the definition of a compensable event. Injuries from birth defects and maternal drug use are often difficult to distinguish from the category of injuries designated by the no-fault system.²⁵⁷ It is highly unlikely that the no-fault systems were intended to be a compensation plan for injuries from birth defects or maternal drug use.²⁵⁸ While compensation may benefit the injured infant (who would not qualify for compensation under the tort system), it is unfair to accomplish this at the expense of non-negligent obstetricians and hospitals contributing to the funding of the systems.

253. RESTATEMENT (SECOND) OF TORTS § 328A (1965) (elements of a negligence claim).

254. *See supra* Part IV.A., B.

255. *See supra* note 100.

256. The alternative systems, particularly ACEs, recognize that ACE categories are based on events that are avoidable and unlikely to occur in the absence of fault. *See supra* notes 160-67 and accompanying text.

257. Epstein, *supra* note 66, at 1469.

258. *Id.*

Further, due to the vague role of causation in the no-fault statutes, litigation is expected to ensue over the causation element prior to claims being filed with the commissions.²⁵⁹ The ACE system is also unlikely to decrease litigation costs.²⁶⁰ By confining compensation to events where there is a strong presumption of negligence, the system will only remove claims where the issue of negligence is clear cut, precisely the claims that would not entail large litigation costs under the tort system.²⁶¹

Not only will the alternate systems fail to decrease litigation costs, proving causation may be a roadblock to some claimants under each of the alternative systems. If a claim is rejected, the issue of causation would have to be litigated prior to qualification for compensation. While under the tort system, attorneys' fees for plaintiffs are generally contingency fees that are paid out of the damage award, under each of the alternative systems compensation is calculated strictly in terms of expenses for medical care and treatment.²⁶² Assuming a claimant could hire an attorney on a contingency basis to litigate causation, any cost of this "borderline" litigation would have to be subtracted from dollars allocated toward tangible expenses of providing care to the injured infant.

C. Meeting the Tort Objectives: Compensation and Deterrence

The alternative systems are premised in part on assumptions that the tort system is either failing in its own objectives of compensating the injured and deterring medical malpractice, or achieving these goals at too great a cost. However, the proposed alternative systems will not achieve these goals any better, and will work to the detriment of severely injured infants. The alternative meth-

259. See *id.* at 1468-70 (arguing that litigation will ensue over many birth defect, maternal drug use, and ambiguous causation cases); Sieradzki, *supra* note 27, at 559 ("Litigation over these 'boundary' cases will probably ensue.").

260. See DANZON, *supra* note 56, at 217-18.

261. *Id.* Danzon's empirical analysis of claims disposition demonstrates that claims involving clear error tend to be settled out of court, with relatively low litigation costs. Cases where negligence is in question will remain in the civil justice system, entailing large litigation costs because the parties cannot come to a settlement agreement.

262. Both the Florida and Virginia statutes do provide for compensation of reasonable expenses, including attorney's fees, incurred in the filing of successful claims. FLA. STAT. ANN. § 766.31(1)(c) (west 1992); VA. CODE ANN. § 38.2-5009(4) (Michie 1990). It is unclear, however, whether these provisions would cover attorney's fees for borderline litigation. The discretionary \$100,000 award for noneconomic damages under the Florida plan could potentially cover attorney fees for such litigation, although there is no indication that this was the purpose of including the discretionary award in the statute. See FLA. STAT. ANN. § 766.31(b).

ods of addressing obstetric injuries in terms of their ability to provide fair compensation to the injured infant and socially beneficial incentives for injury avoidance will be considered below.

The medical malpractice system ties compensation to a finding of fault. In compensating injuries, a distinction is made between losses resulting from natural misfortune and self-inflicted behavior, and losses resulting from the wrongful conduct of another. The tort system seeks to address the latter,²⁶³ leaving the former to methods of social insurance. One objective of the law in compensating injuries is to adjust these losses, and to provide compensation to the injured patient for injuries occurring as a result of the negligent conduct of another.²⁶⁴ The following section will examine the alternative systems in terms of compensating injury.

1. Compensation in the Alternative Systems

It is unlikely that the alternative systems will compensate a larger number of injured infants, as most of the infants qualifying for compensation under the alternative systems would have recovered under the tort system.²⁶⁵ The no-fault statutes compensate irrespective of a showing of fault on the part of the obstetrician, yet the category of events compensable under such statutes is highly correlated with negligence.²⁶⁶ While the ACE system proposes the compensation of clearly defined events, those events selected for compensation are also generally related to fault.²⁶⁷ Similar to the current system, the AMA proposal also ties compensation of injuries with a finding of fault, retaining negligence as the principle decision-rule for compensating.

As noted above, implementation of the alternative compensation systems will impact claimants who are initially rejected and have

263. See White, *supra* note 14, at 1495 n.42 (citing DEP'T OF HEALTH AND HUMAN SERVICES, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 18 (1987)) ("A compensation system for medical injury should compensate avoidable medical injury due to provider fault and should not compensate injury which is unavoidable by standard medical practice.").

264. See *supra* Part I (discussing objectives of the tort system). See also KEETON ET AL., *supra* note 50, at 6 (suggesting that the fundamental principle of tort law is that the remedy must be based upon socially unreasonable behavior which injures another).

265. Gallup, *supra* note 11, at 702 (noting that this category of fault-based claims typically fares well in the tort system). Further, the category is designed specifically to remove these successful tort claims from the tort system to reduce the severity of the claims.

266. Gallup, *supra* note 11, at 702.

267. See *supra* notes 160-67 and accompanying text.

to pursue costly "borderline" litigation to prove causation. But the greatest impact will be felt by the most severely injured who would have recovered the largest awards under the tort system for both economic and noneconomic damages. All of the systems, like the tort system, provide for compensation of past and future medical expenses and tangible losses. However, this compensation is subject to the collateral source rule²⁶⁸ and is made in scheduled payments rather than a lump sum.²⁶⁹ Such features reduce the cost of compensation to the fund or insurance system, and also address cases where the infant dies earlier than life expectancy calculations or medical expenses are less than what might have been projected.²⁷⁰ All but the Virginia statute provide some possibility of compensation for nonpecuniary damages, but in each system the provision is discretionary and does not clearly state what the award reflects, such as pain and suffering damages. The Florida plan is also the only system to specify the actual amount of nonpecuniary damages available.²⁷¹ If the determination is left to a medical panel, this provision may suffer results similar to disciplinary actions determined by medical boards. Physicians may be unwilling to include high nonpecuniary damages if the inclusion suggests additionally faulty behavior on the part of the obstetrician. As a result, infants and families who are victims of the most severe obstetric injuries and who would have received the largest pain and suffering awards under the tort system will stand to lose the most. Rather than limiting or structuring pain and suffering awards to provide some jury guidance and insurer predictability,²⁷² the alternative systems are likely to remove the award completely for those most severely injured by physician negligence.

268. See FLA. STAT. ANN. § 766.31(1)(a) (West 1992); VA. CODE ANN. § 38.2-5009(1)(a) to (d) (Michie 1990).

269. See, e.g., FLA. STAT. ANN. § 766.31(2) ("The award shall require the immediate payment of expenses previously incurred and shall require that future expenses be paid as incurred.")

270. In *Boyd*, the court upheld an 8.3 million award, two components of which were future medical expenses and lost earnings, even though the infant died three years after judgment. *Boyd v. Bulala*, 647 F. Supp. 781, 792-93 (W.D. Va. 1986), *aff'd in part and rev'd in part*, 877 F.2d 1191 (4th Cir. 1989), *certifying questions to Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990), *conformed to answers of certified question*, 905 F.2d 764 (4th Cir. 1990).

271. FLA. STAT. ANN. § 766.31(b).

272. See discussion *infra* notes 286-97 and accompanying text.

2. Deterrent Mechanisms in the Alternative Systems

The second objective of a system should be to provide a level of deterrence that reduces both the cost of injuries and the cost of avoiding injuries.²⁷³ The system should provide incentives that reduce the frequency and severity of birth-related injuries, while providing a standard of medical care that promotes optimal injury avoidance without encouraging nonbeneficial treatment measures.

Reduction in the frequency and severity of birth-related injuries is central to the deterrence goal. To achieve cost reduction through deterrence, the cause of the injury must be within the physician's control. If obstetric practices had no effect on the frequency and severity of birth-related neurological claims, a decreased incentive to avoid negligent practice might be less cause for concern. However, as noted previously, studies of claims alleging obstetrical malpractice as the cause of neurological injury have found substantial connections between questionable practice procedures and resulting impairment.²⁷⁴

The alternative systems, both the no-fault and fault-based proposals, are likely to decrease physicians' incentives to exercise the proper level of care,²⁷⁵ and to fail at achieving deterrence. This result will occur primarily for two reasons: first, the alternative systems rely almost solely on discipline by existing or revamped medical boards as their deterrent mechanism, although these have historically proven highly ineffective as a mechanism of deterrence;²⁷⁶ second, the alternative systems fail to take account of deterrent mechanisms underlying the tort adjudicatory process. Failure to deter negligence is more likely to occur with state medical boards not enforcing their own standards, as statistics demonstrate that a large percentage of malpractice is committed by a small percentage of physicians.²⁷⁷ These statistics suggest that the

273. GUIDO CALABRESI, *THE COSTS OF ACCIDENTS* 26-31 (1970) (discussing the reduction of accident costs generally through the deterrent effect of the tort system).

274. See, e.g., Gallup, *supra* note 11, at 696 (discussing a 1987 study of 591 obstetrical malpractice claims); see *supra* notes 103-05 and accompanying text.

275. See Gallup, *supra* note 11, at 700 (commenting that by reducing the intangible losses and obstetrician responsibility for damages in excess of liability coverage found in the tort system, the Virginia Act will decrease deterrence). See also Ward, *supra* note 31, at 433 (arguing that "elimination of fault-based liability is antithetical to the deterrent goal of the traditional tort system . . .", and that such a course of action "could result in increased injuries.").

276. See Gallup, *supra* note 11, at 696, 700.

277. *Id.* at 697, 700. Gallup notes that, in the no-fault systems, there is a likelihood of

negligent physicians have been targeted, but disciplinary actions or increased educational efforts either have failed or have not been implemented. If the alternative systems had some other deterrent mechanisms, reliance on medical disciplinary efforts would be less of a concern. However, the alternative systems remove the other deterrent mechanisms of the tort system without providing any replacement other than ineffective medical disciplinary review.

Some commentators assert that deterrence is the primary justification for maintaining tort liability.²⁷⁸ The tort system's process of adjudicating claims accomplishes its deterrent objective through both economic and nonmonetary means. Injury prevention can be costly. Without some return on the dollars spent on prevention, the incentive to take preventative measures will decrease.²⁷⁹ Avoidance of liability provides an initial incentive to exercise care in the tort system. Some argue that the deterrent effect of the tort system is destroyed by the introduction of liability insurance into the claims process, as it covers all or some of the practitioner's monetary loss associated with a negligence judgment or settlement.²⁸⁰ However, even if insurance covers all monetary loss, there are nonmonetary costs to the physician in defending a claim of negligence,²⁸¹ including the uninsured lost practice time and reputation costs in defending a claim or being found negligent.²⁸² Further, the threat of litigation alone has been shown to have a deterrent effect upon negligent practices.²⁸³

"adverse selection." This theory contends that high-risk obstetricians will elect to participate in the plans while those who are lower risk will reject the additional payment required by the funding. *Id.*

278. See, e.g., DANZON, *supra* note 56, at 9 (deterrence of negligence by encouraging optimal investment in the prevention of injury by physicians is primary economic rationale of tort system).

279. *Id.* at 10.

280. *Id.* at 118 (discussing liability insurance and its effect of externalizing, or insulating physicians from, the monetary costs associated with malpractice).

281. *Id.* at 135.

282. See Gallup, *supra* note 11, at 700 (addressing the nonmonetary costs imposed by the tort system through "lost time, embarrassment, and worry, and risk [of] diminished professional reputation.").

283. Many doctors have responded that the threat of liability has altered their practice.

[A]ccording to a 1985 survey conducted by the American College of Obstetricians and Gynecologists, thirty-five percent of the obstetricians surveyed reported that they had changed the way they practiced obstetrics as a result of the risks of professional liability. Among the changes reported were the increased use of testing and other diagnostic and monitoring procedures, the increased use of written informed consent, more frequent consultations with other physicians, increased attempts to provide written or tape-recorded information to patients,

The alternative systems remove the deterrent effect of uninsurable costs, by not requiring physician participation in the claims hearing²⁸⁴ and removing claims from the tort process, thereby removing lost time costs, the threat of reputation damage in the event of a finding of liability, and the moral deterrent effects of the tort system. Yet this is done without any adequate replacement. Even the threat of financial liability, present in the tort system if damage awards exceed liability coverage, is removed by compensating the victim entirely through established funds or third-party insurance.

In the final analysis, the alternative systems may reduce the financial magnitude of obstetric claims by decreasing compensation to the infants and families most severely and permanently harmed by negligence. Further, such systems risk increasing the frequency of injury to infants through ineffective deterrence. The possibility of increased incidents of birth-related neurological injury undercuts any potential benefit to physicians and insurers through exclusive treatment of this narrow category of injury. Unlike the alternatives proposed, the tort system already incorporates deterrent mechanisms to address the future frequency of claims by providing incentives for injury-avoidance. While increased monitoring efforts by medical review boards should be encouraged, these efforts alone cannot be relied on as the sole deterrent. Problems surrounding the severity of claims can be adequately addressed in other ways while maintaining the traditional tort system. This could be achieved through modification of damage awards.

VI. RECOMMENDATIONS FOR MAINTAINING THE COMMON LAW CAUSE OF ACTION

The severity of birth-related neurological injury claims, in part, is a natural result of the intensity of the injury. This is reflected in

and more frequent explanation of the potential risks of a recommended procedure (citations omitted).

Bulger & Rostow, *supra* note 27, at 86-87.

284. See David G. Duff, *Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia*, 27 HARV. J. ON LEGIS. 391, 418-19 (1990). Duff argues that the no-fault statutes disassociate the physician and hospital from involvement in claims resolution, through "no provision for their participation in formulating any response to the claim, nor for their appearance at the hearing" *Id.* Instead, the commissions act as parties in place of the physician and hospital. This disassociation results in a claims process whereby the deterrent effect associated with traditional litigation is minimized, if not eliminated. *Id.*

the cost of compensating for tangible economic losses, including medical care and maintenance. Efforts to limit damage awards through caps on the maximum amount of economic damages may face constitutional challenges.²⁸⁵ However, there are permissible methods of reducing the severity of claims by restructuring damage awards that would not infringe upon the rights of injured infants or families, and would provide both guidance to juries in determining noneconomic award calculations and predictability to physicians and insurers, while still meeting the objectives of compensation and deterrence. Three methods which, if used conjunctively, would reduce the severity of claims are structuring of pain and suffering awards, periodic payment of economic damages, and the abrogation of the collateral source rule.

Noneconomic damages make up an estimated 40 percent of awards determined by jury verdicts.²⁸⁶ In birth-related injury claims, this percentage is likely to be considerably higher.²⁸⁷ Yet these amounts are "the least well-defined and most variable component of damage awards,"²⁸⁸ with no legally-provided objective benchmark by which juries calculate intangible loss.²⁸⁹ The unpredictability of these claims threatens the liability insurance system, as the risk of loss cannot be calculated and spread through premiums.²⁹⁰

"Pain and suffering" is a term covering several categories of nonpecuniary loss, including the physiological pain of the injury, anguish, emotional distress, long term loss of love and companion-

285. See, e.g. *Boyd v. Bulala*, 647 F. Supp. 781 (W.D. Va. 1986) (holding that award caps restrict the jury's ability to assess damages and are therefore violative of the Seventh Amendment), *aff'd in part and rev'd in part*, 877 F.2d 1191 (4th Cir. 1989) (damage cap constitutional), *certifying questions to* *Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990), *conformed to answers of certified questions*, 905 F.2d 764 (4th Cir. 1990). See also *supra* notes 205-11 and accompanying text (discussing other potential constitutional challenges).

286. DANZON, *supra* note 56, at 170.

287. This is probably due in part to the nature of the claim in that damages are awarded to both the infant and the parents. However, the magnitude of the award is also likely to be a result of the lack of jury guidance in determining intangible loss and some jury sympathy for an infant severely injured by physician negligence.

288. Bovbjerg et al., *supra* note 237, at 909.

289. *Id.* at 910-12; DAN B. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 545 (1973) ("Courts have usually been content to say that pain and suffering damages should amount to 'fair compensation' or a 'reasonable amount,' without any more definite guide.").

290. Bovbjerg et al., *supra* note 237, at 908. See also PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 54-56 (1991) (noting the erratic nature of the process by which the size of pain and suffering awards are determined).

ship for family members, and the loss of enjoyment of life.²⁹¹ Although some reformers argue for abolishment of pain and suffering awards entirely,²⁹² compensation for intangible loss is largely recognized as a legitimate element of damages.²⁹³ Because these awards contemplate conscious pain and suffering, the argument could be posed that the award is meritless for this severely injured class of infants, where conscious pain and suffering is unlikely to be experienced by the newborn victim. However, complete elimination of this category of damages would not be wise as it could potentially result in "moral hazard," with efforts by providers and insurers to make borderline cases meet the definition of this narrow category to avoid higher noncompensatory damages. In addition, complete removal of this form of damages in cases where pain and suffering is not consciously experienced by the victim would have the greatest adverse impact upon those most severely injured,²⁹⁴ and would not provide any more guidance in jury calculations of noncompensatory damages to the parents of the infant.²⁹⁵

However, pain and suffering awards could be structured to guide juries in their calculations and also provide greater predictability for insurers. One attractive method for accomplishing this is through scheduled noneconomic damages computed using an "award matrix," an approach proposed by Bovbjerg, Sloan and Blumstein.²⁹⁶ Under this system, a matrix of values would be calculated to award fixed damage amounts according to the severity of the injury.²⁹⁷ A variation on this method could allow some range of values within which the jury may determine an award. This approach would still provide some flexibility in the jury calculation, and yet impose an overall structure to guide juries.

Another method for reducing the severity of claims would be

291. WEILER, *supra* note 290, at 34.

292. *See, e.g.,* Bovbjerg et al., *supra* note 237, at 931 nn.120-23 and accompanying text.

293. *See id.* at 909, 928; *see also* DOBBS, *supra* note 289, at 136-38.

294. A similar problem is presented by caps, or upward limits, on pain and suffering damages where jury verdicts are reduced to an amount less than or equal to the cap's ceiling. To illustrate, with a \$500,000 cap, if a jury awarded \$500,000 to a relatively minor but sympathetic injury claim, the verdict would stand, whereas a larger verdict for a severe injury would be reduced to the same \$500,000 cap. WEILER, *supra* note 290, at 59.

295. It is also possible that juries would compensate for the exclusion of awards for the pain and suffering of the infant by increasing the amount of awards to parents.

296. Bovbjerg et al., *supra* note 237, at 939-53.

297. *See id.*

through the periodic payment of malpractice awards as expenses are incurred by the victim. Payments could then cease in the event of the infant's death.²⁹⁸ This prevents "potential 'windfalls' resulting from damage awards based on inaccurate estimates of future medical expenses"²⁹⁹ It also avoids results like that in *Boyd v. Bulala*, where the infant died within three years after an award including over \$3 million for future medical expenses and lost earnings.³⁰⁰ While the tragic death of an infant makes the award difficult to characterize as a windfall,³⁰¹ it is still difficult to justify, in terms of either compensation or deterrence, payment for medical expenses which will never be incurred. The payments do not offset any actual economic loss, and are likely to be funded by liability insurance. The potential windfall to an insurer relieved of further periodic payments in cases of death is illusory, as it is not the insurer's behavior which is sought to be deterred through the tort system. Further, deterrence in the tort system is accomplished to a large extent through other nonmonetary measures.³⁰² Periodic payments made as expenses are incurred, with cessation in the event of death, is essentially the compensation approach of the alternative systems. An important difference between such alternatives and the tort system, in terms of compensation, is that parents like the Boyds would still receive noneconomic damages. The alternative systems make these damages discretionary. In the alternative systems, in the event of infant death, payments would cease. Because there is no guarantee of a noneconomic award, the parents would receive no recognition of intangible loss upon the infant's injury or death.³⁰³ Under the tort system, although this approach

298. State provisions mandating periodic payments of medical malpractice awards ceasing upon death of the patient have been upheld. See, e.g., *Florida Patient's Compensation Fund v. Von Stetina*, 474 So. 2d 783, 789 (Fla. 1985); *State ex rel Strykowski v. Wilkie*, 261 N.W.2d 434, 443 (Wis. 1978).

299. Ward, *supra* note 30, at 434.

300. In *Boyd*, the district court rejected the defendant's motion to amend the action to convert it to a wrongful death action or order remittitur, as the judgment had already been finalized and amendment was therefore not allowed by the relevant statutes. *Boyd v. Bulala*, 647 F. Supp. 781, 795-96 (W.D. Va. 1986), *aff'd in part and rev'd in part*, 877 F.2d 1191 (4th Cir. 1989), *certifying questions to Bulala v. Boyd*, 389 S.E.2d 670 (Va. 1990), *conformed to answers of certified question*, 905 F.2d 764 (4th Cir. 1990).

301. *But see Carson v. Maurer*, 424 A.2d 825, 838 (N.H. 1980) ("[A]lthough there may be a windfall to the claimant's family if the periodic payments are not terminated at the claimant's death, there is also a windfall benefit to the defendant's insurer . . . if the claimant dies.")

302. See *supra* notes 278-83 and accompanying text.

303. In a case like *Boyd*, the family would potentially receive damages equal to the

would stop payment in the event of the infant's death, the parents would usually have already been compensated to some extent for intangible loss through the tort award for noncompensatory pain and suffering damages.

Another method to reduce the severity of claims is abrogation of the collateral source rule.³⁰⁴ "Statutes permitting or mandating the offset of collateral benefits have apparently reduced malpractice claim severity by eleven to eighteen percent . . . relative to comparable states without collateral source offset" rules.³⁰⁵ The economic costs are still compensated, though not directly through the obstetrician's liability insurer. Similar to periodic payment schedules, offset by collateral sources should have no affect on deterrence particularly where the offset method is imposed in a system where other deterrent mechanisms exist.

CONCLUSION

Birth-related neurological injuries impose high costs on injured infants and families, obstetric care providers, and the liability insurance system. They impose severe damages and costly medical expenses for injured infants and families. Due to their severity, and because they are correlated with obstetric negligence, they frequently result in successful tort litigation and some of the largest malpractice awards. As a result, this category of injuries has become the focus of reform efforts to decrease the frequency and severity of obstetric malpractice claims. Yet while reformers attempt to decrease the number and cost of claims for obstetricians and insurers, they are doing so at the cost of the rights of injured infants and families who are being adversely impacted by the abrogation of the common law cause of action.

The malpractice experience in obstetrics generally and this category of claims in particular is not so significantly different from other medical practice areas as to justify special treatment.

cost of the three years of medical expenses incurred prior to the infant's death, and nothing more. This result is particularly unsettling in light of the Virginia statute's failure to include any deterrent mechanisms.

304. Legislation implementing abrogation of the collateral source rule has been held constitutionally valid. *See* *Fein v. Permanente Medical Group*, 695 P.2d 665, 684-85 (Cal.), *appeal dismissed*, 474 U.S. 892 (1985). The alternative systems proposed also support recognition of collateral sources as a method of decreasing costs. *See, e.g.,* Virginia's Plan, *supra* notes 134, 137 and accompanying text.

305. Danzon, *supra* note 79, at 78.

Further, systems based on variations of no-fault and administrative agency models are not adequate replacements for the tort system. By compensating for actual economic loss only as it is incurred, the systems do not guarantee any compensation for noneconomic damages, a recognized category of loss. Removing claims from the jury process and placing them at the discretion of medical panels made up largely of obstetric care providers will result in bias against compensability, and is likely to result in costly "borderline" litigation over causation. In addition, it provides a shield of immunity to obstetricians for a category of claims strongly associated with negligent care. Economic and moral deterrence, and the beneficial incentives toward preventative medicine, are removed by the alternative systems without any reliable deterrent mechanism imposed in replacement.

Finally, in addressing the frequency and severity of claims, the alternative systems merely shift claims frequency to an alternative forum, rather than reduce the number of claims brought. To reduce claims severity, abolishment of the common law cause of action is both unnecessary and unjustified when effective and equitable methods could be implemented within the tort system, such as structuring "pain and suffering" awards, using periodic payments for incurred expenses, and accounting for contributions from collateral sources, without eliminating access to the tort system that is available to all other victims of medical malpractice.

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