

MEDICAL MALPRACTICE LAW

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I. INTRODUCTION

Health care reform took center stage on a national level over the past year. Despite suggestions that medical liability reform might be incorporated into the federal legislation, in the end, it was not. Similarly, this year saw few legislative developments at the state level in medical malpractice law, as the Virginia General Assembly focused its energy primarily on the budget shortfall and other issues. There were, however, several health care legislative and case developments of note which will impact the medical liability landscape in the coming years. Board of Medicine activity and medical malpractice trial results of interest are also highlighted as we look back at the year's noteworthy legal developments in Virginia medical malpractice law.

II. NOTEWORTHY OPINIONS FROM THE SUPREME COURT OF VIRGINIA

The Supreme Court of Virginia evaluated several key issues in medical malpractice cases in the past year, including qualifications of expert witnesses in different specialties, permissible evidence at trial from a treating physician, proof of proximate causation, and waiver of the attorney-client privilege in discovery.¹

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1. The Supreme Court of Virginia also decided an important case on the issue of election between wrongful death and survival actions. *See Centra Health v. Mullins*, 277 Va.

These recent decisions will impact trial practice in Virginia at the circuit court level and beyond.

A. Jackson v. Qureshi

In January of 2009, the Supreme Court of Virginia decided *Jackson ex rel. Jackson v. Qureshi*, a case involving a key aspect of medical malpractice cases—the qualification of expert witnesses.² The trial court precluded an expert from testifying because he had a different area of practice and specialty than the defendant, and the supreme court reversed, finding that the record below demonstrated that the witness met the requisite knowledge and active clinical practice requirements that were previously addressed in *Wright v. Kaye*.³ The plaintiff alleged that the defendant physician, Dr. Faiqa A. Qureshi, negligently failed to admit her infant to the hospital when the infant presented with signs of respiratory distress and pertussis.⁴ The plaintiff alleged that Dr. Qureshi's failure to admit the infant resulted in the infant's death.⁵ During discovery, plaintiff identified a medical expert to testify on the issue of standard of care.⁶ John F. Modlin, a physician licensed in New Hampshire, was board certified in pediatrics and pediatric infectious disease.⁷ The defendants moved to exclude Dr. Modlin's testimony, arguing that Dr. Modlin was not qualified to testify against Dr. Qureshi, a pediatric emergency department physician, on the standard of care.⁸

The trial court granted the defendants' motion to exclude, holding that Dr. Modlin was not qualified to testify as to the standard of care applicable to Dr. Qureshi.⁹ The parties had agreed the tri-

59, 670 S.E.2d 708 (2009). That case is the subject of an article previously published in the *2009 Annual Survey of Virginia Law*. See L. Steven Emmert, *Annual Survey of Virginia Law: Election of Remedies in the Twenty-First Century: Centra Health, Inc. v. Mullins*, 44 U. RICH. L. REV. 149 (2009). It is not, therefore, addressed here.

2. *Jackson ex rel. Jackson v. Qureshi*, 277 Va. 114, 671 S.E.2d 163 (2009).

3. See *id.* at 117–18, 671 S.E.2d at 164–65 (citing *Wright v. Kaye*, 267 Va. 510, 518, 593 S.E.2d 307, 311 (2004)).

4. *Id.*, 671 S.E.2d at 165.

5. *Id.* at 118, 671 S.E.2d at 165.

6. *Id.*

7. *Id.*

8. See *id.*

9. *Jackson*, 277 Va. at 120, 671 S.E.2d at 166. The trial court dismissed the case with prejudice in light of a stipulation reached by the parties that (1) plaintiff would not name a replacement standard of care expert and (2) plaintiff's representation that "the case would

al court could base its ruling on Dr. Modlin's deposition testimony, voir dire testimony in a prior case, and a letter from the Department of Health Professions certifying that Dr. Modlin's credentials met the requirements for licensure in Virginia.¹⁰ The plaintiff appealed the trial court's ruling, arguing that the trial court abused its discretion by holding that Dr. Modlin was not qualified to testify as an expert on the standard of care.¹¹

The oft litigated issues of what constitutes a "related field of medicine" and an "active clinical practice"¹² were addressed on appeal. The supreme court considered the relevant statute, Virginia Code section 8.01-581.20, in deciding this issue.¹³ That statutory section provides, in relevant part:

Any physician . . . who is licensed to practice in Virginia shall be presumed to know the statewide standard of care in the specialty or field of medicine in which he is qualified and certified. This presumption shall also apply to any physician who is licensed in some other state of the United States and meets the educational and examination requirements for licensure in Virginia. . . . An expert witness who is familiar with the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in this Commonwealth. A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action.¹⁴

The supreme court found that "[t]he statutory presumption applied to Dr. Modlin. . . . Thus, it was presumed that Dr. Modlin knew the statewide standard of care in his specialties of pediatrics and pediatric infectious diseases."¹⁵ The court then evaluated the "knowledge" and "active clinical practice" requirements as they pertained to Dr. Modlin. The court concluded that Dr. Modlin satisfied the "knowledge" requirement of Virginia Code section 8.01-581.20, reasoning that "the standard of care, as it pertains to

come to a close" if the court found that Dr. Modlin could not testify. *Id.* at 118, 120–21, 671 S.E.2d at 165–66 (internal quotation marks omitted).

10. *Id.* at 118, 671 S.E.2d at 165.

11. *Id.* at 121, 671 S.E.2d at 166.

12. *See, e.g., Sami v. Varn*, 260 Va. 280, 535 S.E.2d 172 (2000).

13. *Jackson*, 277 Va. at 121–22, 671 S.E.2d at 167.

14. VA. CODE ANN. § 8.01-581.20(A) (Cum. Supp. 2010).

15. *Jackson*, 277 Va. at 122, 671 S.E.2d at 167.

the medical procedure at issue, is the same for a physician with specialties in pediatrics and pediatric infectious diseases as it is for a physician with a specialty in pediatric emergency medicine.”¹⁶

With regard to the “active clinical practice” requirement, which requires the expert to maintain an “active clinical practice in either the defendant’s specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action,”¹⁷ the court reasoned that the only relevant medical procedure at issue was whether the infant should have been admitted to inpatient hospital care.¹⁸ “Although Dr. Modlin admitted that he had not treated a patient presenting with pertussis in an emergency room during the relevant time frame, he testified that he had treated such patients in the urgent care clinic[,] which was a ‘very similar’ clinical setting[].”¹⁹ The court concluded, therefore, that Dr. Modlin met the “active clinical practice” requirement.²⁰

The court went on to find that: “The provisions of Code § 8.01-581.20 do not set a minimum threshold amount of time a physician must spend in clinical practice to establish that such physician maintains an ‘active clinical practice,’ and this Court is not free to impose one.”²¹ The court thereby rejected the defendant’s argument that the twenty-five to thirty percent of Dr. Modlin’s time spent on direct patient care was insufficient.²² The court acknowledged, however, that “there may be instances when the expert’s clinical practice with regard to the medical procedure at issue is so *de minimis* that the witness would not meet the ‘active clinical practice’ requirement,” but Dr. Modlin did not fall to the level of *de minimis* practice in this case.²³

Based on its findings that Dr. Modlin met the “knowledge” and “active clinical practice” requirements, the court held that the tri-

16. *Id.* at 123–24, 671 S.E.2d at 168 (citing *Lloyd v. Kime*, 275 Va. 98, 109–10, 654 S.E.2d 563, 569–70 (2008); *Sami*, 260 Va. at 284, 535 S.E.2d at 174).

17. § 8.01-581.20(A).

18. *Jackson*, 277 Va. at 124, 671 S.E.2d at 169.

19. *Id.* at 124–25, 671 S.E.2d at 169.

20. *Id.* at 125, 671 S.E.2d at 169.

21. *Id.*

22. *Id.*

23. *Id.*

al court abused its discretion, and it reversed the judgment and remanded for further proceedings.²⁴

B. *Graham v. Cook*

In September of 2009, the Supreme Court of Virginia decided *Graham v. Cook*, a case that required it to evaluate the rules applicable to the testimony of non-party treating physicians in medical malpractice cases.²⁵ At issue was the distinction between statements of a factual nature and those that impart a medical diagnosis subject to the requirement of Virginia Code section 8.01-399 that diagnoses be stated within a reasonable degree of medical probability.²⁶ Here, the plaintiff alleged that the defendant physician, Dr. Cook, “negligently caused a screw to be placed into Graham’s left hip joint. . . . [This] caused the erosion of the femoral head that resulted in the hip resurfacing surgery performed by Dr. Gross.”²⁷ At trial, Dr. Cook argued that the damage to plaintiff’s hip was caused by avascular necrosis, and he presented testimony, including deposition testimony where the deponents read from their reports, of three treating health care providers—Dr. Gross, Dr. Grady, and Dr. Man—to support that argument.²⁸

24. *Id.* at 126, 671 S.E.2d at 169 (citation omitted).

25. 278 Va. 233, 682 S.E.2d 535 (2009).

26. *Id.* at 242–43, 682 S.E.2d at 540.

27. *Id.* at 238, 682 S.E.2d at 537.

28. *Id.* at 238–42, 682 S.E.2d at 537–39. The portion of Dr. Gross’s operative report at issue reads: “On the femoral side, I did not see any gouging of the femoral head from any hardware. There was a large area of collapse of the femoral head. [Graham] clearly had Stage III avascular necrosis as his major problem.” *Id.* at 238, 682 S.E.2d at 537–38 (alteration in original). Plaintiff objected to two portions of Dr. Grady’s testimony:

There is flattening and small defects in the upper lateral aspect of the left femoral head which could be posttraumatic with superimposed osteoarthritis and subchondral cysts/sclerosis. *The possibility of avascular necrosis is not excluded.* . . . Mild lateral subluxation of the left femoral head and mild-moderate osteoarthritis in the left hip. Flattening of the superolateral left femoral head could also be related to prior trauma and degenerative change but *avascular necrosis cannot be excluded.*

Id. at 239, 682 S.E.2d at 538. The objectionable portions of Dr. Man’s testimony were:

There is a defect in the anterior aspects of the femoral head associated with cortical irregularities as well as diffuse demineralization involving the femoral head. *This raises the suspicion for avascular necrosis.* . . . Bony defect now seen involving the anterior aspect of the femoral head associated with cortical irregularities and demineralization *suggesting fracture and avascular necrosis.*

Dr. Gross, the physician who performed the hip resurfacing surgery, was asked at the beginning of his deposition “to express only those opinions that he held within a reasonable degree of medical probability.”²⁹ Plaintiff objected, arguing those “statements were inadmissible because they expressed medical opinions that were not stated within a reasonable degree of medical probability as required by Code § 8.01-399(B).”³⁰ In response, the defense argued “that the challenged statements merely expressed Dr. Gross’s observations that were made during surgery and were recorded contemporaneously in his operative report.”³¹ Dr. Cook also argued that because Dr. Gross was instructed at the beginning of his deposition “to express only those opinions that he held within a reasonable degree of medical probability,” this standard was also satisfied.³² The trial court allowed the contested portion of Dr. Gross’s videotaped deposition testimony to be played to the jury on the grounds that “the preliminary colloquy satisfied the requirements of Code § 8.01-399(B).”³³ The jury entered a verdict in favor of Dr. Cook, and the plaintiff appealed.³⁴

Plaintiff contended on appeal that the testimony of Dr. Man and Dr. Grady was inadmissible because it was not stated to a reasonable degree of medical probability, and argued “that the preliminary directive . . . that Dr. Gross state only those opinions held within a reasonable degree of medical probability [] was insufficient to establish a foundation for the admission of [Dr. Gross’s] testimony regarding avascular neurosis and the absence of femoral head gouging.”³⁵ On appeal, the court considered the relevant provision of Virginia Code section 8.01-399(B),³⁶ which provides:

If the physical or mental condition of the patient is at issue in a civil action, the diagnoses, signs and symptoms, observations, evaluations, histories, or treatment plan of the practitioner, obtained or formulated as contemporaneously documented during the course of the practitioner’s treatment, together with the facts communicated

Id. at 240, 682 S.E.2d at 538.

29. *Id.* at 239, 682 S.E.2d at 538.

30. *Id.* at 238, 682 S.E.2d at 538.

31. *Id.* at 238–39, 682 S.E.2d at 538.

32. *Id.* at 239, 682 S.E.2d at 537–38.

33. *Id.* at 238–39, 682 S.E.2d at 537–38.

34. *Id.* at 242, 682 S.E.2d at 539–40.

35. *Id.*, 682 S.E.2d at 540.

36. *Id.* at 243, 682 S.E.2d at 540.

to, or otherwise learned by, such practitioner in connection with such attendance, examination or treatment shall be disclosed but only in discovery pursuant to the Rules of Court or through testimony at the trial of the action. . . . Only diagnosis offered to a reasonable degree of medical probability shall be admissible at trial.³⁷

Relying on the language of the statute and its prior holdings, the court upheld the ruling below, concluding that:

[T]he challenged statements made by Dr. Grady and Dr. Man were factual in nature and related the physicians' impressions and conclusions formed when treating Graham. . . .

The statements by Dr. Grady and Dr. Man did not constitute diagnoses, because the statements did not purport to identify specifically the cause of Graham's health condition based on his signs and symptoms. Therefore, because the statements of Dr. Grady and Dr. Man did not impart a diagnosis, the statements were admissible under Code § 8.01-399(B), regardless [of] whether they were stated within a reasonable degree of medical probability.³⁸

The court also concluded that the plaintiff failed to raise and preserve an objection regarding the "prefatory exchange" at the beginning of Dr. Gross's deposition.³⁹ This is an issue that is increasingly finding its way into Virginia jurisprudence. Plaintiff objected on the basis that the testimony was "an opinion, and . . . not contemporaneously recorded in his notes."⁴⁰ The court held the issues raised by the plaintiff on appeal regarding Dr. Gross's testimony "could have been cured by timely objections at the time the deposition testimony was taken," so it declined to consider the merits of his arguments on that issue.⁴¹ Similarly, with regard to plaintiff's objection to Dr. Man's testimony about his habit or routine, because plaintiff did not specifically object to Dr. Man's testimony on the basis that Code section 8.01-397.1 did not permit the testimony, plaintiff did not adequately preserve his objection;

37. VA. CODE ANN. § 8.01-399(B) (Cum. Supp. 2010).

38. *Graham*, 278 Va. at 244–45, 682 S.E.2d at 541 (internal citations omitted).

39. *Id.* at 246, 682 S.E.2d at 542.

40. *Id.* (internal quotation marks omitted).

41. *Id.* at 246–47, 682 S.E.2d at 542 (citing VA. SUP. CT. R. pt. 4, R. 4:7(d)(3)(B) (Repl. Vol. 2010)). The court also ruled that plaintiff's objection to testimony by Dr. Man regarding his habit of checking for hardware when reviewing a CT scan of a patient's joint was not properly preserved. *Id.* at 248, 682 S.E.2d at 543. The court also ruled that the trial court did not abuse its discretion in prohibiting plaintiff from comparing X-rays during his closing argument when no evidence comparing the evidence was presented at trial. *Id.* at 250, 682 S.E.2d at 544.

therefore, he did not raise that issue on appeal.⁴² The trial court's judgment for the defendant was affirmed.⁴³

C. Howell v. Sobhan

In September of 2009, the Supreme Court of Virginia decided *Howell v. Sobhan*, a case involving the issue of whether the plaintiff failed to prove proximate causation.⁴⁴ The plaintiff alleged that the defendant physician, Dr. Sobhan, negligently performed abdominal surgery on her by removing more colon than was necessary and using inappropriate anastomosis techniques.⁴⁵ The supreme court overturned the trial court's summary judgment ruling for the defendants, entered after the trial court sustained a motion to strike the plaintiff's evidence on the ground of insufficient evidence of causation.⁴⁶

In this case, the defendant physician performed a subtotal colectomy, a surgery to remove a portion of the colon, after several polyps were detected during a colonoscopy.⁴⁷ Plaintiff experienced a leak after the surgery and developed other complications.⁴⁸ She alleged that Dr. Sobhan removed too much of her colon and used an inappropriate anastomosis technique.⁴⁹ At trial, the plaintiff presented testimony from two medical experts—Dr. Ludi and Dr. Hercules. On causation, Dr. Ludi testified that the “plaintiff would have had a 95 percent probability of returning to a normal bowel scenario if Dr. Sobhan had performed one of the alternative surgical procedures Dr. Ludi [suggested],” and that Dr. Sobhan's procedure left the plaintiff with no chance of returning to normal.⁵⁰ Dr. Ludi also testified that the plaintiff would have chronic diarrhea and electrolyte abnormalities, and that she would not

42. *Id.* at 247–48, 682 S.E.2d at 542–43 (citing *Nusbaum v. Berlin*, 273 Va. 385, 406, 641 S.E.2d 494, 505 (2007)). The court further held that plaintiff “affirmatively abandoned” his objection to this testimony at trial. *Id.* at 248, 682 S.E.2d at 543.

43. *Id.* at 250, 682 S.E.2d at 544.

44. 278 Va. 278, 280, 682 S.E.2d 938, 939 (2009).

45. *Id.* at 281, 682 S.E.2d at 940.

46. *Id.* at 280, 682 S.E.2d at 939–40.

47. *Id.* at 280–81 & n.1, 682 S.E.2d at 940 & n.1 (citing *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 445, 2101 (20th ed. 2005)).

48. *Id.* at 281, 682 S.E.2d at 940.

49. *Id.*

50. *Id.* at 282, 682 S.E.2d at 941.

have had a fistula if Dr. Sobhan had performed one of the procedures he suggested.⁵¹

Dr. Hercules similarly testified that Dr. Sobhan's performance of the procedure "did not [leave the plaintiff with] enough colon . . . to allow for normal bowel functioning."⁵² Both experts made significant concessions on cross-examination, however. Dr. Ludi acknowledged that fistula and diarrhea are known complications of colon surgery.⁵³ Defendants argued both could occur in the absence of negligence.⁵⁴ Dr. Hercules "also admitted that a fistula could have developed even if Dr. Sobhan had not performed a subtotal colectomy."⁵⁵

At the close of the plaintiff's evidence, the defendants moved to strike, arguing plaintiff had failed to prove proximate causation.⁵⁶ The trial court denied the defendant's motion.⁵⁷ At the close of all of the evidence, the defense renewed its motion to strike.⁵⁸ The trial court granted the motion and entered summary judgment for the defendants, stating: "There can be no dispute that there's no proximate cause. It's a terrible result. [Howell] did have these complications, but they were normal complications that just happened in this case. . . . The jury can't dispute over that."⁵⁹

On appeal, the supreme court, viewing the evidence in the light most favorable to the plaintiff, concluded that the plaintiff presented sufficient evidence on proximate causation, and that

[r]easonable minds could differ about whether Dr. Sobhan's breach of the standard of care was a proximate cause of Howell's injuries. In other words, a jury could decide Dr. Sobhan's breach of the standard of care by performing a surgical procedure that removed nearly all [of] Howell's colon caused her chronic diarrhea and fistula.⁶⁰

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* at 283, 682 S.E.2d at 941.

55. *Id.* at 282, 682 S.E.2d at 941.

56. *Id.* at 283, 682 S.E.2d at 941.

57. *Id.*

58. *Id.*

59. *Id.* (alterations in original).

60. *Id.* at 284, 682 S.E.2d at 942.

The circuit court's decision was reversed, and the case was remanded for a new trial.⁶¹

D. *Walton v. Mid-Atlantic Spine Specialists, P.C.*

In June of 2010, the Supreme Court of Virginia decided *Walton v. Mid-Atlantic Spine Specialists, P.C.*⁶² While *Walton* was a medical malpractice case, the supreme court analyzed an issue faced in all types of civil litigation—waiver of the attorney-client privilege.⁶³ Although the disclosure of a letter a doctor wrote to his attorney regarding potential negligence in his examination of X-rays was inadvertent, the court held that the doctor waived his attorney-client privilege by failing to take sufficient precautions to prevent the inadvertent disclosures.⁶⁴

The physician defendant in this case, Dr. Moore, wrote a letter to his counsel in October of 2001 after reviewing X-rays at issue in a worker's compensation case pursued by Ms. Walton.⁶⁵ In that letter, Dr. Moore indicated that when he wrote his report of a previous X-ray, he may have inadvertently been looking at a prior X-ray, so he questioned the impression he documented of the X-ray at issue.⁶⁶ During discovery in the worker's compensation case, a subpoena was issued to Mid-Atlantic Spine Specialists, and a document company—Smart Copy Corporation—collected and produced the responsive documents.⁶⁷ Although the letter at issue was purportedly kept in a separate place from the medical records, it was copied and produced to the plaintiff.⁶⁸

When the subsequent medical malpractice case reached the discovery phase, plaintiff disclosed in her interrogatory answers that she was in possession of the letter, "which [she] consider[ed] to be an admission and/or probative of liability."⁶⁹ The defendant filed a motion for a protective order, seeking to prohibit plaintiff from using or distributing the letter on the basis of the attorney-

61. *Id.* at 285, 682 S.E.2d at 942.

62. 280 Va. 113, 694 S.E.2d 545 (2010).

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

67. *See id.* at 119, 694 S.E.2d at 547.

68. *Id.* at 118–19, 694 S.E.2d at 547.

69. *Id.* at 119, 694 S.E.2d at 547–48.

client privilege.⁷⁰ The defense claimed the letter “contain[ed] retrospective critical analysis of the case by [Dr. Moore] and his attorney.”⁷¹ After several hearings, the trial court granted the defense motion, “ruling that the letter was privileged, [that it] had been ‘involuntarily’ disclosed, and [that] there had been no waiver.”⁷² In its order, the trial court prohibited plaintiff from distributing the letter to anyone, including her experts, and from mentioning it at trial.⁷³ At the conclusion of the trial, the jury returned a defense verdict, and the plaintiff appealed.⁷⁴

On appeal, “the parties [did] not dispute the existence of an attorney-client relationship or that the letter was privileged at the time it was written. The issue presented [was] whether Dr. Moore waived the privilege attached to the letter.”⁷⁵ The court initially evaluated the issue of whether the disclosure of the letter was inadvertent or involuntary; contrary to the trial court, it held the disclosure was inadvertent, not involuntary, because “[t]here was no evidence suggesting that the letter was knowingly produced by someone other than the holder of the privilege through criminal activity or bad faith All of the evidence indicates that the doctors mistakenly produced the letter, and therefore its disclosure was inadvertent, not involuntary.”⁷⁶ The court further noted that “[w]hile knowingly, but mistakenly, producing a document may be an inadvertent disclosure, unknowingly providing access to a document by failing to implement sufficient precautions to maintain its confidentiality may also result in an inadvertent disclosure.”⁷⁷

In this case of inadvertent disclosure, the court applied a multi-factor test to determine whether the defendant waived the attorney-client privilege. The factors considered were:

70. *Id.*, 694 S.E.2d at 548.

71. *Id.* (second alteration in original).

72. *Id.* at 119–21, 694 S.E.2d at 548.

73. *Id.* at 122, 694 S.E.2d at 549.

74. *Id.*

75. *Id.* at 123, 694 S.E.2d at 550.

76. *Id.* at 125, 694 S.E.2d at 551. The court found support for its holding in a number of federal cases. *See id.* at 125–26, 694 S.E.2d at 551 (citing, inter alia, *In re Maldonado v. N.J. ex rel. Admin. Office of the Courts—Prob. Div.*, 225 F.R.D. 120, 125–26 (D.N.J. 2004); *Resolution Trust Corp. v. Dean*, 813 F. Supp. 1426, 1430 (D. Ariz. 1993); *In re Grand Jury Proceedings Involving Berkley & Co.*, 466 F. Supp. 863, 869 (D. Minn. 1979)).

77. *Id.* at 126, 694 S.E.2d at 552.

(1) the reasonableness of the precautions to prevent inadvertent disclosures, (2) the time taken to rectify the error, (3) the scope of the discovery, (4) the extent of the disclosure, and (5) whether the party asserting the claim of privilege or protection for the communication has used its unavailability for misleading or otherwise improper or overreaching purposes in the litigation, making it unfair to allow the party to invoke confidentiality under the circumstances.⁷⁸

Taking all of these factors into consideration, as well as “any other factors arising from the posture of the case at bar that have a material bearing on the reasonableness issues,” the court held the defendant doctors waived the attorney-client privilege.⁷⁹ Specifically, the court held that the defendants did not meet the first criteria because they did not show that they made “sufficient efforts to supervise the Smart Copy employees or to prevent intermingling of the letter with unprivileged, non-confidential documents.”⁸⁰ They did not, therefore, take reasonable precautions to prevent inadvertent disclosure.⁸¹ With regard to the second factor, the court held that, when the doctors received the plaintiff’s interrogatory answer identifying the letter, they should have immediately sought a protective order from the trial court, rather than waiting a year and a half to do so.⁸² The court also found that the third and fourth factors weighed in favor of waiver because the discovery was not expedited or extensive, and the disclosure was complete—it was disclosed to the plaintiff and the attorney for her employer in the worker’s compensation case, and there was no indication it had been kept confidential by those parties.⁸³

The fifth and final factor, the interests of justice, merited further analysis from the court, but it “also tip[ped] in favor of Walton.”⁸⁴ The court held that “parties should not be permitted to use the [attorney-client] privilege as both a shield, preventing the admission of evidence, and as a sword to mislead the finder of

78. *Id.* at 127, 694 S.E.2d at 552 (citing, inter alia, *Koch v. Cox*, 489 F.3d 384, 390 (D.C. Cir. 2007); *United States v. Desir*, 273 F.3d 39, 45 (1st Cir. 2001); *United States v. Yerardi*, 192 F.3d 14, 18 (1st Cir. 1999); *United States v. Workman*, 138 F.3d 1261, 1263–64 (8th Cir. 1998)).

79. *Id.*

80. *Id.* at 128–29, 694 S.E.2d at 553.

81. *Id.* at 129, 694 S.E.2d at 553.

82. *Id.*

83. *Id.* at 130, 694 S.E.2d at 554.

84. *Id.*

fact.”⁸⁵ The trial court’s ruling on the letter permitted defense counsel “to engage in questioning that had significant potential to mislead the jury,” and the letter may also have been used for impeachment.⁸⁶ Based on its ruling that the trial court erred and the privilege was, in fact, waived, the supreme court reversed the judgment and remanded the case to the circuit court for further proceedings.⁸⁷

E. Durand v. Richard

Judge Weckstein of the Roanoke City Circuit Court issued an interesting letter opinion when setting aside a medical malpractice verdict for the defendants after he concluded that the court had erred in allowing certain medical literature testimony at trial.⁸⁸ The court found that it was error to allow the defendants to introduce statements through direct examination of their own experts that the defendants had not timely designated and provided to the opposing party pursuant to Virginia Code section 8.01-401.1.⁸⁹

In the defendant’s case-in-chief, over objection from the plaintiff, the defendant introduced through his expert witness on direct examination statements contained in articles the plaintiff had designated.⁹⁰ These articles and statements had not been designated by the defense in the manner provided for by the relevant code section.⁹¹ During trial, the court ruled “that literature designated [by any party] can be used [by any party].”⁹² The court subsequently reconsidered that ruling. After examining the case law, including *Budd v. Punyanitya* and *May v. Caruso*, the court found that the admission of this evidence was an error.⁹³ Reasoning that

85. *Id.*

86. *Id.*

87. *Id.* at 131, 694 S.E.2d at 554.

88. *Durand v. Richards*, 78 Va. Cir. 432, 432 (Cir. Ct. 2009) (Roanoke City).

89. *Id.* at 432, 434.

90. *Id.* at 433.

91. *Id.*; see VA. CODE ANN. § 8.01-401.1 (Repl. Vol. 2007 & Cum. Supp. 2010) (providing that medical literature testimony “introduced through an expert witness upon direct examination . . . shall be provided to opposing parties thirty days prior to trial unless otherwise ordered by the court”).

92. *Durand*, 78 Va. Cir. at 433 (alterations in original).

93. *Id.* at 434 (discussing *Budd v. Punyanitya*, 273 Va. 583, 643 S.E.2d 180 (2007), and *May v. Caruso*, 264 Va. 358, 568 S.E.2d 690 (2002)).

the error was not harmless, the court granted the plaintiff's post-trial motion to set aside the jury's verdict and ordered a new trial on liability and damages.⁹⁴

F. *Hawkins v. Johnston Memorial Hospital, Inc.*

Hawkins v. Johnston Memorial Hospital, Inc. was a federal court medical malpractice case where the plaintiff alleged that while he was a patient recovering from knee surgery at the defendant hospital in 2005, he suffered a serious infection from an unsanitary shower in his patient room.⁹⁵ He alleged that the infection caused him to undergo a repeat operation with medical expense and to suffer continuing pain and discomfort.⁹⁶ Approximately two weeks before trial, the hospital served an Offer of Judgment under Federal Rule of Civil Procedure 38 on the plaintiff, offering to accept judgment against it in the amount of \$150,000.⁹⁷ The next day, however, defense counsel received pharmacy records provided by the plaintiff that revealed for the first time that the plaintiff had received numerous prescriptions for narcotic pain medications from other doctors.⁹⁸ In earlier discovery, the plaintiff had specifically denied that he had received pain medications from other sources.⁹⁹

When the discovery of the new records came to light, the hospital withdrew their Offer of Judgment and filed a motion in limine "to exclude any claim for pain and suffering or, in the alternative, to continue the trial and allow further discovery."¹⁰⁰ The defense argued that this information was "highly significant" to two "critical issues in the case"—plaintiff's claim of continued pain and his credibility.¹⁰¹ A few hours before those motions were to be heard, plaintiff filed a Notice of Acceptance of Offer of Judgment.¹⁰² The court found that the disclosed records were highly significant to the issues in the case and thus allowed the

94. *Id.* at 432.

95. No. 1:09CV00024, 2010 U.S. Dist. LEXIS 44111, at *1 (W.D. Va. May 5, 2010).

96. *Id.*

97. *Id.* at *2–3.

98. *Id.* at *3.

99. *Id.*

100. *Id.* at *4.

101. *Id.* at *5–6 (internal quotation marks omitted).

102. *Id.* at *4.

Offer of Judgment to be withdrawn because of “exceptional factual situations,” namely that “the defendant relied on the plaintiff’s material misrepresentation about his medical history.”¹⁰³

III. LEGISLATIVE DEVELOPMENTS

The primary focus of the 2010 legislative session of the General Assembly was passing a balanced biennium budget in the face of a \$4 billion budget shortfall caused by falling revenues. Cutbacks in health care, education, public safety, and Medicare were all part of the focus. Although there were no significant legislative enactments directly addressing medical liability, several substantive health care measures may have an impact on health care law, and thus future medical malpractice litigation. They are therefore mentioned here.

A. *Lyme Disease*

A quintet of bills on Lyme disease were introduced and considered during the 2010 session.¹⁰⁴ Four of the bills were continued to 2011, and the fifth was tabled. The bills were collectively aimed at reforming reporting requirements and promoting long-term antibiotic use as effective treatment for the symptoms of Lyme disease.¹⁰⁵ Various physician experts addressed the House Health, Welfare and Institutions Committee’s subcommittee #1. Although the offered legislation did not pass, as a result of the subcommittee meeting, Virginia Commissioner of Health Karen Remley distributed a letter to all health care practitioners in Virginia to increase awareness of Lyme disease.¹⁰⁶

103. *Id.* at *4–8 (quoting *Colonial Penn Ins. Co. v. Coil*, 887 F.2d 1236, 1240 (4th Cir. 1989)). For a discussion of *Antisdel v. Ashby*, 217 Va. 42, 688 S.E.2d 163 (2010), in which the Supreme Court of Virginia clarified the law on the appointment of an administrator of an estate for purposes of a wrongful death action versus a survivorship action, see John R. Walk & Andrew P. Sherrod, *Annual Survey of Virginia Law: Civil Practice and Procedure* 183, 191–94 (2010).

104. See H.B. 1288, Va. Gen. Assembly (Reg. Sess. 2010); H.B. 1017, Va. Gen. Assembly (Reg. Sess. 2010); H.B. 897, Va. Gen. Assembly (Reg. Sess. 2010); H.B. 512, Va. Gen. Assembly (Reg. Sess. 2010); H.B. 36, Va. Gen. Assembly (Reg. Sess. 2010).

105. See sources cited *supra* note 104.

106. See Sarah Bruyn Jones, *Virginia Sees Rise in Lyme Disease*, ROANOKE TIMES, June 4, 2010, at A1.

B. *Podiatry*

Following *Hollingsworth v. Norfolk Southern Railway Co.*, a Supreme Court of Virginia decision upholding the longstanding precedent that only a medical doctor (and therefore not a podiatrist) may testify as an expert regarding causation of human physical injury,¹⁰⁷ the General Assembly passed legislation clarifying the role of podiatrists to include “diagnosis” as part of the practice of podiatry.¹⁰⁸ The legislation also mandates that a podiatrist shall not be permitted to testify as an expert witness against a doctor or osteopath where such doctor or osteopath is a defendant in a medical malpractice case or a medical malpractice review panel proceeding.¹⁰⁹

C. *Privileged Communications*

Chapter 196 of the 2010 Acts of Assembly amended Virginia Code section 8.01-581.17 to clarify that the exchange of privileged health care-related information between committees, boards, groups, commissions, or other entities that function primarily to review, evaluate, or make recommendations regarding health care shall not be a waiver of privilege.¹¹⁰ For example, this language would seem to enable hospital “A” to share with hospital “B” privileged patient safety data without waiving the privilege attached to that data.

D. *Determining Brain Death*

Critical care specialists were added to the list of medical specialists who can make a determination of when a patient is brain dead.¹¹¹ The existing list of specialists already included any duly

107. 279 Va. 360, 368, 689 S.E.2d 651, 656 (2010).

108. Act of Apr. 13, 2010, ch. 725, 2010 Va. Acts ___ (codified at VA. CODE ANN. § 8.01-401.2:1 (Cum. Supp. 2010); codified as amended at VA. CODE ANN. § 54.1-2900 (Supp. 2010)).

109. VA. CODE ANN. § 8.01-401.2:1 (Cum. Supp. 2010).

110. Act of Apr. 7, 2010, ch. 196, 2010 Va. Acts ___ (codified as amended at VA. CODE ANN. § 8.01-581.17(F) (Cum. Supp. 2010)); *see also* § 8.01-581.16 (Cum. Supp. 2010) (establishing civil immunity for members of or consultants to medical boards or committees).

111. Act of Mar. 8, 2010, ch. 46, 2010 Va. Acts ___ (codified as amended at VA. CODE ANN. § 54.1-2972 (Supp. 2010)).

licensed physician who practiced as a specialist in neurology, neurosurgery, or electroencephalography.¹¹²

E. *Immunity*

Health care practitioner immunity was expanded to include services provided at federally qualified health centers designated by the Centers for Medicare & Medicaid Services (“CMS”), in addition to other free clinics that were already covered by Virginia Code section 54.1-106.¹¹³ The immunity provision only applies when the practitioner acts within the limits of his license, voluntarily and without compensation, and provides such services to the patient without charge.¹¹⁴ The immunity is limited to acts of simple negligence as opposed to gross negligence or willful misconduct.¹¹⁵

F. *Liens*

Chapter 343 of the 2010 Acts of Assembly revised various provisions for recovery of costs for such things as bad checks, damages for loss of use of vehicle, and negligence causing personal injury to account for cost of living and inflation.¹¹⁶ This resulted in an increase to \$2500 (from \$2000) per hospital or nursing home, and \$750 (from \$500) in the amount of the lien that could be asserted for medical bills in a personal injury action.¹¹⁷

G. *Student-Athlete Concussions*

State Senator Ralph Northam, a pediatric neurologist, introduced Senate Bill 652,¹¹⁸ which was ultimately passed by the

112. § 54.1-2972 (Repl. Vol. 2009).

113. Act of Apr. 10, 2010, ch. 353, 2010 Va. Acts ___ (codified as amended at VA. CODE ANN. § 54.1-106 (Supp. 2010)).

114. § 54.1-106(A) (Supp. 2010).

115. *Id.*

116. Act of Apr. 10, 2010, ch. 353, 2010 Va. Acts ___ (codified as amended in scattered sections of VA. CODE ANN.).

117. *Id.*

118. S.B. 652, Va. Gen. Assembly (Reg. Sess. 2010); Virginia General Assembly, <http://legis.state.va.us> (follow “Senate” hyperlink, then “Senators” hyperlink, then “Northam, Ralph S.”).

General Assembly.¹¹⁹ This new law requires that the Board of Education distribute guidelines to each local school division to inform and educate coaches, student-athletes, and their parents or guardians about the nature and risks of concussions.¹²⁰ The policies shall become effective on July 1, 2011.¹²¹ Local school divisions in turn are required to “develop policies and procedures regarding the identification and handling of suspected concussions in student-athletes.”¹²² This legislation was intended to better protect student-athletes who are suspected of having a concussion during play. First, all such athletes must be removed from play and evaluated.¹²³ Next, the legislation establishes guidelines outlining how and when a student can return to play once he or she has been diagnosed with a concussion.¹²⁴ The new law also provides that written clearance from a licensed health care provider is required before the student-athlete can return to competition.¹²⁵

H. *Federal Legislation—Medicare Secondary Payer Reporting*

Although the concept of Medicare as a secondary payer, and funding source of last resort, has been present since Medicare's inception in 1965, recent legislative enactments have added complexity to dealing with medical malpractice cases where medical bills incurred as a result of the events at issue were paid by Medicare. A heightened reporting requirement has put the onus on professional liability insurance carriers to ensure that Medicare liens are satisfied when a medical malpractice case is brought to resolution. Under a revised CMS Section 111 program, liability and other insurers are required to report all qualifying payments, which include settlements, judgments, and awards in medical malpractice cases, made to Medicare beneficiaries.¹²⁶ Section 111 adds reporting rules to the existing statutory provisions and regu-

119. Act of Apr. 11, 2010, ch. 483, 2010 Va. Acts ___ (codified at VA. CODE ANN. § 22.1-271.5(A) (Cum. Supp. 2010)).

120. § 22.1-271.5(A) (Cum. Supp. 2010).

121. *Id.* § 22.1-271.5 note (Cum. Supp. 2010).

122. *Id.* § 22.1-271.5(B) (Cum. Supp. 2010).

123. *Id.* § 1-271.5(B)(2) (Cum. Supp. 2010).

124. *Id.*

125. *Id.*

126. 42 U.S.C. § 1395y(b)(7)–(8) (Supp. II 2008).

lations, including those requirements which originally arose under the Medicare Secondary Payer Act of 1980.¹²⁷

Beginning January 1, 2011, each Responsible Reporting Entity must report to the Coordinator of Benefits Contractor certain information required by CMS.¹²⁸ The information to be reported includes the Total Payment Obligation above the applicable thresholds provided by CMS which occur on or after October 1, 2010.¹²⁹ Covered entities which fail to comply with the reporting requirements mandated by 42 U.S.C. § 1395y are subject to a fine in the amount of \$1000 per day, per claim, for noncompliance.¹³⁰ The complexities of these reporting obligations are beyond the scope of this survey article, but without question this legislation will have significant impact on the negotiation and payment of future medical malpractice claims.

IV. VERDICTS REPORTS

Although verdicts are not formally tracked or reported in a manner that allows for identification of each medical malpractice case result, the *Virginia Lawyers Weekly* publishes attorney-submitted case reports. It is presumed that most, although certainly not all, malpractice cases that go to verdict are included in these reports, which can reflect interesting anecdotal evidence of trends in malpractice cases.¹³¹ Of the twenty-one verdicts in Vir-

127. See Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, tit. I, sec. 111, 121 Stat. 2492, 2497-99 (codified at 42 U.S.C. § 1395y(B)(7)-(8) (Supp. II 2008)).

128. CENTERS FOR MEDICARE & MEDICAID SERVICES, MMSEA SECTION III MSP MANDATORY REPORTING: LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION USER GUIDE 6, 46, 52 (Version 3.1) (July 12, 2010), available at <http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3.1.pdf>.

129. *Id.* at 46.

130. 42 U.S.C. § 1395y(b)(7)(B)(i), (b)(8)(E)(i) (Supp. II 2009).

131. Previous years' largest verdict reports from *The Virginia Lawyers Weekly* noted: fifteen million-dollar verdicts in 2008 (four of which were medical malpractice cases); twenty million-dollar verdicts in 2007 (three medical malpractice cases); twenty-nine million-dollar verdicts in 2006 (ten medical malpractice cases), and nineteen million-dollar verdicts in 2005 (nine medical malpractice cases). *Virginia's Largest Verdicts of 2008*, VA. LAW. WKLY., <http://valawyersweekly.com/virginias-largest-verdicts-of-2008/> (last visited Oct. 30, 2010); *Virginia's Largest Verdicts of 2007*, VA. LAW. WKLY., <http://valawyersweekly.com/virginias-largest-verdicts-of-2007/> (last visited Oct. 30, 2010); *Virginia's Largest Verdicts of 2006*, VA. LAW. WKLY. (Jan. 15, 2007), <http://valawyersweekly.com/blog/2006/01/15/largest-verdicts-of-2006/>; *Virginia's Largest Verdicts of 2005*, VA. LAW. WKLY. (Jan. 23, 2006), <http://valawyersweekly.com/blog/2006/01/23/largest-verdicts-of-2005-363952/>.

ginia that exceeded \$1 million in 2009, seven involved medical malpractice cases.¹³² Several examples are noted below.

In *Cox v. Gamache*, plaintiff alleged negligent failure to timely diagnose breast cancer.¹³³ Plaintiff's decedent underwent a double mastectomy, chemotherapy, and radiation, but she died after a five-year battle with the disease.¹³⁴ Plaintiff's experts testified that the patient's chances for a full recovery were between 70% and 80% at the time defendant allegedly misdiagnosed her, and that those chances were reduced to 50% by the time she was accurately diagnosed.¹³⁵ A Spotsylvania jury returned a verdict in the amount of \$7.5 million.¹³⁶ The verdict was reduced to the applicable medical malpractice cap of \$1.6 million.¹³⁷

In another significant case, plaintiff alleged negligent failure to diagnose bacterial endocarditis by defendant primary care physician, resulting in a stroke.¹³⁸ Plaintiff underwent a root canal for an abscessed tooth, and he subsequently "developed a fever, fatigue, headache, runny nose and sinus pain."¹³⁹ His primary care physician treated him with antibiotics for sinusitis four times over the next few months.¹⁴⁰ Bacterial endocarditis is a somewhat rare disease with nonspecific symptoms, but plaintiff alleged that his failure to respond to repeated courses of antibiotics should have alerted his physician to the possibility of endocarditis and prompted him to order intravenous antibiotics, which could have cured the infection.¹⁴¹ Plaintiff claimed he could no longer work as an attorney as a result of the brain damage he sustained.¹⁴² An Alexandria jury returned a verdict for the plaintiff in the amount

132. *Virginia's Largest Verdicts of 2009*, VA. LAW. WKLY., <http://valawyersweekly.com/virginias-largest-verdicts-of-2009/> (last visited Oct. 30, 2010).

133. *Breast Cancer Metastasizes After Negative Mammogram*, VA. MED. L. REP., May 2009, at 11, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-may-2009.pdf>.

134. *Id.*

135. *See id.*

136. *Id.*

137. *Cox v. Gamache*, VA. LAW. WKLY. (Jan. 20, 2010), <http://valawyersweekly.com/blog/2010/01/20/cox-v-gamache/>.

138. Alan Cooper, *Lawyer-Plaintiff Wins \$7M*, VA. MED. L. REP., Jan. 2009, at 1, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-jan-2009.pdf>.

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

of \$7 million.¹⁴³ The verdict was reduced to the applicable medical malpractice cap of \$1.8 million.¹⁴⁴

In a case before a Newport News jury, plaintiff alleged negligent failure to diagnose cardiomyopathy by emergency room (“ER”) physicians.¹⁴⁵ The plaintiff was twenty-six years old and five months postpartum when she presented to the ER complaining of cough, chest pain, and shortness of breath.¹⁴⁶ An X-ray showed an enlarged heart.¹⁴⁷ She was seen two additional times in the hospital over the next month and a half, and she was treated for bronchitis and nausea.¹⁴⁸ On the third visit, an electrocardiogram was performed, which was abnormal, and she had swelling in her legs.¹⁴⁹ After being subsequently diagnosed with postpartum cardiomyopathy, she underwent a heart transplant, which she claimed would not have been necessary if she had been properly diagnosed.¹⁵⁰ The defendant argued that his care was appropriate, and that the plaintiff would have needed a transplant even if the diagnosis had been made correctly.¹⁵¹ The jury returned a verdict for the plaintiff in the amount of \$4 million.¹⁵² The verdict was reduced to the applicable medical malpractice cap of \$1.8 million.¹⁵³

In *Martin v. Wills*, plaintiff alleged negligent failure to timely diagnose a bowel injury by defendant radiologist.¹⁵⁴ Plaintiff was injured in an automobile accident, and she presented to the ER approximately eleven hours later complaining of abdominal pain.¹⁵⁵ A CT scan performed in the ER revealed a relatively minor abdominal injury, but the delay in diagnosis resulted in the need for five hospitalizations, ten surgeries, and significant medi-

143. *Id.*

144. *Id.* at 10.

145. Alan Cooper, *Woman Who Needed Heart Transplant Wins \$4M Verdict*, VA. MED. L. REP., July 2009, at 6, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-jul-2009.pdf>.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *See id.*

151. *Id.*

152. *Id.*

153. *See id.*

154. *Radiologist Fails to Recognize Bowel Injury*, VA. MED. L. REP., May 2009, at 10, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-may-2009.pdf>.

155. *Id.*

cal bills, all of which she contended could have been avoided if the radiologist had obtained immediate consultation with a general surgeon and an exploratory laparotomy.¹⁵⁶ The defense contended that the plaintiff's allergy to iodine complicated his analysis of the CT scan, and that he was only one member of a multimember medical team.¹⁵⁷ A Prince Edward County jury returned a verdict for the plaintiff in the amount of \$3.5 million plus interest.¹⁵⁸ The verdict was reduced to the applicable medical malpractice cap of \$1.85 million.¹⁵⁹

In *Drake v. Walter*, plaintiff alleged that an error by defendant surgeon during a procedure to treat gastroesophageal reflux caused bleeding, cardiac complications, and anoxic brain injury.¹⁶⁰ Plaintiff's experts opined that a Helical tack used during the procedure punctured a vein in plaintiff's pericardium.¹⁶¹ A Fairfax jury returned a verdict for the plaintiff in the amount of \$2.25 million.¹⁶² The verdict was reduced to the applicable medical malpractice cap of \$1.85 million.¹⁶³

In *Williams v. Jones*, plaintiff alleged that negligent delivery by defendant obstetrician when shoulder dystopia was encountered resulted in brachial/plexus injury and Erb's palsy in her infant.¹⁶⁴ Plaintiff alleged the injury was caused by the application of fundal pressure, rather than suprapubic pressure.¹⁶⁵ Defense experts contended that the injury was caused by contractions, not negligence by the physician.¹⁶⁶ A Norfolk jury returned a verdict for the plaintiff in the amount of \$1.75 million.¹⁶⁷ The Supreme Court of Virginia granted the defendant's petition for appeal on

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Helical Tack Alleged to Cut Vein Inside Pericardium*, VA. MED. L. REP., Jan. 2010, at 7, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-jan2010.pdf>.

161. *Id.*

162. *Id.*

163. *Id.*; see VA. CODE ANN. § 8.01-581.15 (Repl. Vol. 2007 & Cum. Supp. 2010).

164. *Negligence by Obstetrician Alleged in Erb's Palsy Case*, VA. MED. L. REP., May 2009, at 9, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-May-2009.pdf>.

165. *Id.*

166. *Id.*

167. *Id.*

March 15, 2010, oral argument was heard in September of 2010, and the court's opinion is pending.¹⁶⁸

A Richmond jury returned a \$1.07 million verdict for the plaintiff in a case arising out of alleged failure to timely diagnose laryngeal cancer, which later spread to plaintiff's lungs.¹⁶⁹ Plaintiff's decedent, a smoker, allegedly complained of ear pain and sore throat for more than a year, but defendant ear, nose, and throat specialists failed to perform a fiberoptic exam.¹⁷⁰ The defense contended that a mirror exam alone met the standard of care, and that detection at that time would not have prevented her death.¹⁷¹

Several noteworthy defense verdicts were also returned in medical malpractice cases in 2009. In *Core v. Anesthesiology Defendants*, a Fairfax County jury returned a defense verdict in response to plaintiff's demand for \$10 million in a case involving the death of a twenty-nine-year-old woman who developed a hematoma in her neck after undergoing thyroid surgery.¹⁷² The swelling compromised her airway, causing difficulty breathing, so an anesthesiologist was called.¹⁷³ He called a surgeon after determining intubation would be very difficult.¹⁷⁴ When she went into respiratory arrest, he attempted to intubate her but failed, and she suffered hypoxic brain injury.¹⁷⁵ She was later declared brain dead, and life support was removed.¹⁷⁶ Plaintiff alleged the anesthesiologist should not have waited for a surgeon to intubate the patient, and the defense contended that waiting to attempt intu-

168. *Jones v. Williams ex rel Williams*, No. 091745 (Va. appeal granted Mar. 15, 2010), available at <http://www.courts.state.va.us/courts/scv/appeals/091745.html>. The issues on appeal are whether "[t]he trial court erred in finding that plaintiff presented competent corroboration evidence and in denying defendant's motions to strike based on the Dead Man's Statute issue" and whether "[t]he trial court erred in deciding, as a matter of law, that [the nurse's] testimony was corroborated and in refusing defendant's proposed jury instruction on the Dead Man's Statute." *Id.*

169. *Lack of Proper Test Said to Result in Death from Cancer*, VA. MED. L. REP., Nov. 2009, at 7, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-nov-2009.pdf>. The parties' names are confidential. *Id.*

170. *Id.*

171. *See id.*

172. *Million-Dollar Med-Mal Defense Verdicts of 2009*, VA. MED. L. REP., Mar. 2010, at 10, available at <http://valawyersweekly.com/wp-files/pdf/vmlr-march-2010.pdf>.

173. *Id.*

174. *Id.*

175. *See id.*

176. *Id.*

bation was a reasonable decision because a surgeon could perform a tracheotomy if needed.¹⁷⁷

In a Fredericksburg City Circuit Court case, the jury returned a defense verdict in the face of the plaintiff's \$4 million demand in a case involving the death of an eighty-five-year-old woman following gallbladder surgery.¹⁷⁸ The surgeon planned to perform the surgery laparoscopically but, when he encountered dense adhesions, he changed to open surgery.¹⁷⁹ The patient had intermittent nausea and pain post-operatively, and she became confused and hypotensive shortly after passage of a nasogastric ("NG") tube to address a persistent intestinal blockage.¹⁸⁰ She was transferred to the intensive care unit, where she developed acute respiratory distress syndrome ("ARDS") and sepsis and died.¹⁸¹ Plaintiff alleged that a perforation during the surgery caused the patient's post-operative complications and death, but the defense contended that ARDS and death resulted from aspiration when the NG tube was passed, not from the surgery.¹⁸²

In a confidentially reported case from the Richmond Circuit Court, a jury returned a defense verdict in a brachial plexus injury case.¹⁸³ Plaintiff sought \$5 million for permanent disability to her child, and she alleged that, when she delivered her infant, the defendant "obstetrician breached the standard of care by not recognizing that the mother was at increased risk for shoulder dystocia" and by not offering her a cesarean section because of her delivery history, the estimated fetal weight, her obesity, and gestational diabetes.¹⁸⁴ Plaintiff's expert also testified that the obstetrician negligently pulled the baby's head, causing injury during delivery.¹⁸⁵ The defense contended that there was no increased risk of dystocia, and that the delivery was handled appropriately.¹⁸⁶

177. *Id.*

178. *Id.* The parties' names are confidential. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

Another Richmond Circuit Court jury returned a defense verdict in a case involving the death of a sixty-nine-year-old man following surgery for a broken femur.¹⁸⁷ Plaintiff alleged that the defendants—a surgeon, a hospitalist, and an anesthesiologist—failed to properly communicate about the patient’s pre-operative vomiting, and that they should have consulted a gastrointestinal specialist.¹⁸⁸ Defense experts testified that the defendants responded appropriately in light of the information available to them about the patient.¹⁸⁹ A factual issue arose regarding the application of cricoid pressure by the anesthesiologist, which became a matter for the jury to resolve.¹⁹⁰ The plaintiff sought \$3 million, and the jury returned a verdict in favor of the defendants.¹⁹¹

V. BOARD OF MEDICINE ACTIVITY

Increasingly over the past few years, Department of Health Professions (“DHP”) investigations seem to follow on the heels of, or sometimes precede, medical malpractice litigation. DHP, which is comprised of the various licensing boards,¹⁹² investigates complaints through its Enforcement Division.¹⁹³ Following the Enforcement Division’s initial investigation, the findings and evidence are summarized in an investigative report, which is sent to the appropriate board for a probable cause determination.¹⁹⁴ If probable cause is found by the board to investigate further, the investigation proceeds within the board and may involve an informal factfinding conference or a formal hearing.¹⁹⁵ According to statistics published by DHP, its three most active boards are the Board of Medicine, Board of Nurse Aides, and Board of Nursing.¹⁹⁶

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *See Va. Dep’t of Health Professions*, VIRGINIA.GOV, <http://www.dhp.state.va.us/> (last visited Oct. 30, 2010).

193. *Va. Dep’t of Health Professions Enforcement Division*, VIRGINIA.GOV, <http://www.dhp.state.va.us/Enforcement/default.htm> (last visited Oct. 30, 2010).

194. *See* Department of Health Professions Enforcement Division, *The Disciplinary Process for Licensed Health Professionals*, VIRGINIA.GOV, http://www.dhp.state.va.us/Enforcement/enf_DisciplineProcess.htm (last visited Oct. 30, 2010).

195. *Id.*

196. Department of Health Professions Cases Closed, Open and Received, Reports for

In fiscal year (“FY”) 2010, the Board of Medicine received 1680 cases.¹⁹⁷ This is approximately 100 more cases than it received in FY 2009.¹⁹⁸ The same is true for the Board of Nurse Aides, which received 650 cases this FY,¹⁹⁹ as compared to 596 in FY 2009,²⁰⁰ and the Board of Nursing, which has received 1480 cases this FY,²⁰¹ an increase of 110 as compared to FY 2009.²⁰² It is unknown at this time whether these increases in case volume at the Boards are a result of increasing public awareness of the complaint process within the DHP, or whether the number of complaints has increased with the number of licensees. Additionally, the Boards’ increased numbers may be due to their recent efficiency efforts, which have culminated in 80.7% of cases completed within target time frames for FY 2010, a significant increase from 72.7% in FY 2009.²⁰³ Regardless of the reason, however, DHP and board investigations are increasingly becoming an important aspect of the defense of a medical malpractice case.

DHP also publishes statistics regarding the outcome of its boards’ investigations. For the Board of Medicine, in FY 2010, approximately 16% of cases resulted in a finding of violation, 32% resulted in a finding of no violation, 50% are undetermined, and 2% resulted in the issuance of a confidential consent agreement.²⁰⁴

Fiscal Year 2010 Fourth Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q4/2-4CasesRecdOpenClosed6-30-10.pdf> (last visited Oct. 30, 2010).

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. Department of Health Professions Rate of Compliance with Established Case Standards, Reports for Fiscal Year 2010 Fourth Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q4/1CaseStdRpt6-30-10.pdf> (last visited Oct. 30, 2010).

204. Department of Health Professions Charges Showing Category and Disciplinary Action, Reports for Fiscal Year 2010 First Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q1/6ChgCategory&FindXDate9-30-09.pdf> (last visited Oct. 30, 2010) [hereinafter First Quarter Charges]; Department of Health Professions Charges Showing Category and Disciplinary Action, Reports for Fiscal Year 2010 Second Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q2/6ChgCategoryFindXDate12-31-09.pdf> (last visited Oct. 30, 2010) [hereinafter Second Quarter Charges]; Department of Health Professions Charges Showing Category and Disciplinary Action, Reports for Fiscal Year 2010 Third Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q3/6ChgCategory&FindXDate3-31-10.pdf> (last visited Oct. 30, 2010) [hereinafter Third Quarter Charges]; Department of Health Professions Charges Showing Category & Disciplinary Action, Reports for Fiscal Year 2010 Fourth Quarter, VIRGINIA.GOV, <http://www.dhp.state.va.us/about/stats/2010Q4/6ChgCategory&FindXDate6-30-10.pdf> (last visited Oct. 30, 2010) [hereinafter Fourth Quarter Charges].

The statistics for the Board of Nurse Aides are similar, with 33% of cases ending in findings of violation, 30% ending in findings of no violation, 34% are undetermined, and 3% resulted in the issuance of a confidential consent agreement.²⁰⁵ For the Board of Nursing, 40% resulted in a finding of violation, 35% resulted in no violation findings, 23% are undetermined, and 2% ended with confidential consent agreements.²⁰⁶ In the cases in which sanctions are issued, those sanctions may include terms and conditions on a provider's license, probation, fine, reprimand and censure, suspension, or revocation of the provider's license.²⁰⁷

VI. CONCLUSION

The statutory limitation on damages in medical malpractice cases remains perhaps the most meaningful, and controversial, "tort reform" measure in this area of Virginia law. The last of the annual statutory increases in the cap occurred on July 1, 2008, when the cap was increased to its current level of \$2 million.²⁰⁸ In recent years, both sides of the malpractice litigation bar have contemplated that the General Assembly might revisit or revise the cap, which could unquestionably be the most significant medical malpractice liability legal development in recent years. In the summer of 2009, at the request of Senator Henry Marsh and Delegate Dave Albo, the Virginia Trial Lawyers Association and the Virginia Hospital and Healthcare Association were asked to meet with the goal of defining opportunities for improving Virginia's medical liability system in a manner that preserves access to care while providing for fair compensation when appropriate.²⁰⁹

205. First Quarter Charges, *supra* note 204, at 4; Second Quarter Charges, *supra* note 204, at 4; Third Quarter Charges, *supra* note 204, at 4; Fourth Quarter Charges, *supra* note 204, at 4.

206. First Quarter Charges, *supra* note 204, at 6; Second Quarter Charges, *supra* note 204, at 6; Third Quarter Charges, *supra* note 204, at 6; Fourth Quarter Charges, *supra* note 204, at 6.

207. Department of Health Professions Enforcement Division, *supra* note 194.

208. See Act of Mar. 14, 2001, ch. 211, 2001 Va. Acts 176 (codified as amended at VA. CODE ANN. § 8.01-581.15 (Supp. 2001)). The Act provided:

The maximum recovery limit of \$1.5 million shall increase on July 1, 2000, and each July 1 thereafter by \$50,000 per year; however, the annual increase on July 1, 2007, and the annual increase on July 1, 2008, shall be \$75,000 per year The July 1, 2008 increase shall be the final annual increase.

Id.

209. See MED. SOC'Y OF VA., 2009 LEGISLATIVE WRAP-UP 6, available at <http://>

In the 2010 session, medical liability legislation was not a significant issue. The uncertainty regarding the pending national health care reform likely provided incentive to maintain the status quo in Virginia. Any legislative amendment to the cap would seem to be an easier political initiative if those stakeholders reach accord. If not, we can expect a heated legislative battle on this issue.