

## Immunities

# The Virginia Birth-Related Neurological Injury Compensation Program: A Lifetime of Care?

by Ann LaCroix Jones

The Virginia Birth-Related Neurological Injury Compensation Act was enacted in 1987 at the proposal of the Medical Society of Virginia amidst mounting fears that major medical malpractice insurers would not renew obstetrical malpractice insurance within the Commonwealth.

The Act became effective January 1, 1988. It bars traditional tort claims arising out of the birth of profoundly injured infants who have been delivered by “participating physicians” or in “participating hospitals.” As a result, participating physicians and hospitals avoid the prospect of obstetrical negligence litigation, in exchange for reduced malpractice insurance premiums, a yearly assessment, quality review of claims filed, and agreeing to provide care to indigent patients. Neurologically devastated infants are provided lifelong benefits without the need to prove that their injuries were caused by medical negligence, in exchange for the traditional right to recover for pain, suffering, disfigurement and mental anguish.

The Act created the Virginia Birth-Related Neurological Injury Compensation Program (the “Program”) and was set up to provide no-fault benefits in a manner similar to the Workers’ Compensation scheme, to provide quick and easy access to eligible infants and their families, without protracted litigation and the associated costs, providing a multitude of lifelong benefits to neurologically devastated infants, while at the same time solving a perceived obstetrical insurance “crisis” in the Commonwealth. Program benefits are intended to be an exclusive remedy for qualified infants and their parents, personal representatives and next of kin for all claims derivative of the infant’s injuries.<sup>1</sup> Non-participating hospitals, non-participating physicians and program participants who intentionally or willfully cause injury may be sued.<sup>2</sup>

The Program is governed by a nine-member Board of Directors appointed by the Governor and made up of six citizen representatives and one representative for each of the following groups: participating physicians, participating hospitals, and liability carriers. As of December 31, 2006, 18 years after the Act went into effect, approximately \$64,395,071 had been paid out in claims

benefits.<sup>3</sup> As of April 30, 2008, 196 Petitions had been filed, 137 infants had been awarded benefits, 109 Program beneficiaries were still living, and seven cases were pending.

“**Birth-Related Neurological Injury.**” To come under the purview of the Act, an infant must have sustained a “birth-related neurological injury” and been delivered at a “participating hospital” or by a “participating physician.” An infant has a “birth-related neurological injury” if the infant meets the following criteria:<sup>4</sup>

- (1) **Location of Injury:** The infant has an injury to the brain or spinal cord;
- (2) **Cause of Injury:** The injury was caused by deprivation of oxygen or mechanical injury;
- (3) **Time of Injury:** The injury occurred in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital
- (4) **Nature of Injury:** The injury has rendered the infant permanently motorically disabled and
  - (i) Developmentally disabled or
  - (ii) For infants sufficiently developed to be cognitively evaluated, cognitively disabled.
- (5) **Quantum of Injury:** The disability shall render the infant to be permanently in need of assistance in all activities of daily living.

The definition of “birth-related neurological injury” **expressly excludes:**

- (1) Infants who are not “live births”
- (2) Infants whose disabilities or death are caused by
  - (i) genetic abnormality
  - (ii) congenital abnormality
  - (iii) degenerative neurological disease, or
  - (iv) maternal substance abuse

### Presumptions

Once the Commission is satisfied that the infant meets criteria for the location, cause and nature of the injury, the infant

is entitled to a **rebuttable presumption** that he has a “birth-related neurological injury.” This is a presumption that the infant’s injury occurred during the statutory time period and caused the requisite quantum of damage. Anyone who contests this presumption has the burden of proving that the injuries are not a “birth-related neurological injury.” This is a “Morgan theory” presumption, which shifts “both the burden of production and the burden of persuasion on the factual issue in question to the party against whom the presumption operates.”<sup>5</sup>

The Birth Act’s burden-shifting presumption is akin to the heart and lung presumption of Code §65.2-402(b) of the Workers’ Compensation Act, where there is a statutory presumption of occupational disability. The heart and lung presumption requires proof of timing in order to obtain a presumption on causation, whereas the Birth Act requires the reverse, proof of causation in order to get a presumption on timing and magnitude of injury. Once causation is established and a presumption of timing is invoked, the party opposing the presumption must prove to a reasonable degree of medical probability both: (1) that the injury did not occur during the statutory period; and (2) the non-birth related cause of injury. Failure of either prong of this two-part test is fatal to overcoming the presumption.<sup>6</sup>

#### **Second statutory rebuttable presumption.**

Few people realize that there is a second statutory rebuttable presumption in the Birth Act. That is a **presumption of fetal distress** in cases where the hospital of birth **fails to provide fetal heart monitor tapes** properly requested under the terms of the Act.<sup>7</sup> Upon written notification from the legal representative of an injured infant indicating that he intends to file a petition under the Act, the hospital of birth must promptly deliver to the representative all available medical records relating to the infant.<sup>8</sup> Fetal heart monitor strips are considered part of the medical records relating to an infant who allegedly suffered a birth-related neurological injury.<sup>9</sup> Failure to provide these records will result in a presumption of fetal distress. For this reason, it is wise to include in any medical records request to a hospital seeking to obtain records of the mother and/or the infant for whom a claim under the Act may be filed, a statement giving notice that this request for medical records is being made in order to facilitate the filing of a claim under the Virginia Birth-Related Neurological Injury Act on behalf of an injured infant.

In addition to the two statutory presumptions contained in the Act, the Court of Appeals and the Commission have recognized that the **common law spoliation of evidence presumption** is applicable to claims under the Act. At least one child in the Program obtained an award of benefits after obtaining a presumption that umbilical cord blood was acidotic as a result of a participating physician’s

failure to preserve umbilical cord blood for pH analysis after birth.<sup>10</sup>

There is **no presumption** that an infant who dies shortly after birth as a result of oxygen deprivation during labor is entitled to the benefits of the Act. “Death is the cessation of life, not a measure of disability.”<sup>11</sup> The Court of Appeals has held that it is a non-sequitur to assert that a disability – as that term is specifically defined and qualified in the statute – always precedes death or is subsumed by it. Though an injury may be an anatomical antecedent to death, the same cannot be said of the statutorily-defined disability required by the Act. There is no per se rule equating death with disability. For that reason, in cases where an infant dies shortly after birth, where there has been little time to perform tests and evaluations of the infant’s condition, parties may have difficulty establishing the elements of the Act.<sup>12</sup>

#### **Common misconceptions regarding “birth-related neurological injury”**

A lot of doctors and lawyers have misconceptions about what children the legislature intended to cover under the Act. These misperceptions have made their way into many of the Commission opinions by way of expert testimony and legal arguments. A few of the most common misconceptions are worthy of note.

The most prevalent is the misconception that **pre-mature infants** are somehow excluded from coverage under the Act. In fact, the Code expressly lists the type of injuries and infants excluded. Infants who were born prematurely are not listed. Beware of expert reports indicating that an infant’s injuries were “caused by” prematurity. Prematurity is a state of being born early, not a disease process. Premature infants may be more vulnerable to oxygen deprivation during labor, delivery and resuscitation because of their developmental immaturity, but that does not disqualify them from benefits. Year after year the General Assembly has expressly refused to impose weight limitations on infants eligible for benefits (infants of lower weight are of lower gestational age).<sup>13</sup> Currently, about one-third of the infants in the Program are premature infants. You need not back off representing an infant under the Act due to his or her prematurity.

Another misconception is that only **certain types of oxygen deprivation** are covered by the Act. Common arguments in opposition to a claim are that only oxygen deprivation which occurs *by virtue of the process* of labor, delivery, or resuscitation processes are covered by the Act, or that “oxygen deprivation” under the Act is defined as “an hypoxic event of asphyxia to multiple organs.” The Commission has expressly, and repeatedly rejected these arguments.<sup>14</sup> In fact, there is no definition of “oxygen deprivation” in the Code. The Code refers to oxygen deprivation that occurs *during* labor, delivery and resuscitation, *not as a result of it*.

Another common misconception is that **injuries which have their onset prior to the onset of labor** and delivery are not covered by the Act. However, the case law establishes that so long as the injurious oxygen-depriving condition continued throughout the labor, delivery and resuscitation, the infant qualifies for benefits. The fact that an infant was compromised (even seriously) prior to the commencement of the statutory period, does not take a child outside of the purview of the Act. Persuasive evidence that the injury was complete prior to the inception of the statutory period is required to overcome the presumption in an infant's favor.<sup>15</sup>

### Changes to the definition of "birth-related neurological injury"

The definition of a "birth-related neurological injury" has had two substantive changes since the adoption of the Act. In 1990, the *nature of the injury* element changed. Prior to 1990, the nature of the injury had to render an infant "nonambulatory, aphasic and incontinent," a much more stringent requirement. Practitioners should beware of early case law discussing the criteria for eligibility which utilize the old definition. In 2003, another substantive change to the definition was made, this time to the *timing element* of a "birth-related neurological injury." In order to qualify for benefits, infants born prior to July 1, 2003 must have been injured during the course of labor, delivery or "resuscitation in the immediate post-delivery period." Infants born after July 1, 2003, must have been injured during the course of labor, delivery or "resuscitation necessitated by deprivation of oxygen or mechanical injury that occurred in the course of labor and delivery." Knowing the definition of a "birth-related neurological injury" on the date of your client's birth may make a difference in the outcome of the case.

### Participating providers

Qualification as a "participating hospital" or "participating physician" is voluntary and is accomplished by the physician or hospital:

- (1) Being licensed in Virginia
- (2) Paying a yearly assessment to the Birth-Related Neurological Injury Fund ("Fund"),
- (3) Agreeing to be subject to quality review for each claim that is filed involving that physician/hospital, and
- (4) Agreeing to provide medical care to indigent patients.<sup>16</sup>

For healthcare providers seeking tort immunity for injuries occurring after April 1, 2000, the term "participating physician" includes a partnership, corporation, professional corporation, professional limited liability company or other entity through which the participating physician practices.<sup>17</sup> For any injury occurring prior to April 1, 2000, there is no tort immunity for partnerships, corporations, professional corporations and professional limited

liability companies.<sup>18</sup>

You can learn whether your client was delivered by a "participating physician" or in a "participating hospital" by issuing a Freedom of Information Act Request to the Birth-Related Neurological Injury Compensation Program ("Program") and giving the name of the delivering physician, the hospital and date of the birth, or by checking the Program's web page: [www.vabirthinjury.com](http://www.vabirthinjury.com). I recommend that you check the web page and then issue a FOIA request seeking copies of the relevant Participating Physician Agreement and Participating Hospital Agreement. Those participating provider agreements are routinely received as evidence and proof of "participation" status at hearings to determine eligibility for benefits. Also, a hospital or physician cannot claim the benefits of the Act until 30 days following joining the Program as a "participant."<sup>19</sup> For that reason, knowing the date "participation" began for any calendar year, will help you determine whether the healthcare provider was a participant on the date of your client's birth.

### Forum and Statute of Limitations

The forum for resolution of a Birth Act claim is the **Workers' Compensation Commission** ("Commission").<sup>20</sup> Claims must be brought within **10 years** of the infant's birth.<sup>21</sup> The filing of a claim under the Act tolls the statute of limitations with respect to any civil action that may be brought on behalf of an injured infant, and the time the claim is pending is not computed as part of the period within which a civil action may be brought.<sup>22</sup>

### Initiating a Claim Under the Act

A claim can be initiated in either of two ways, by the filing of a Petition by an infant's legal representative ("Claimant"), or by virtue of a Motion for Referral from circuit court by a participating physician or hospital being sued for medical malpractice pursuant to Virginia Code §8.01-273.1.

### Filing a Claim

A Claimant may initiate a claim by the filing of **an original and nine copies** of a Petition, along with a \$15 filing fee, with the Workers' Compensation Commission in Richmond.<sup>23</sup> Upon filing, the claim will be forwarded to a Deputy Commissioner to whom you will be directed to make all subsequent filings. The requirements of the contents of the Petition are set forth in Virginia Code §38.2-5004, and include: identification of the name and address of the infant, his representative, the delivering physician and hospital of birth, the date of birth, a description of the disability for which a claim is made and a brief statement of the facts and circumstances surrounding the injury giving rise to the claim. The Code requires production of many records along with the Petition. To avoid delay, at a minimum, Claimants should provide with the Petition: the obstetrical/prenatal record relating to

the pregnancy, the records of the labor and delivery of the infant; the records relating to the initial hospitalization of the infant; such other records as are relevant to diagnosis and determination of the injury/disability (head imaging studies, EEG reports, pediatric neurology records and assessments, developmental assessments); and a report from the infant's treating neurologist or other primary healthcare provider setting forth the infant's condition and limitations at the time of filing. For infants who are in school, inclusion of the infant's Individual Education Plan (IEP) can be an invaluable source for documentation of the infant's functional limitations (i.e., inability to perform the activities of daily living).

### Referral from Circuit Court

Participating physicians and hospitals who wish to transfer medical malpractice actions from the circuit courts to the Commission for determination of an infant's qualification for the Program must do so in accordance with Virginia Code §8.01-273.1, which requires a motion for referral to be filed within 120 days of the date of the filing of the grounds of defense. Within 30 days of the entry of an order of referral, the Circuit Court must file with the Commission a copy of the Complaint and any responsive pleadings by the parties. All parties to the civil action are entitled to participate before the Commission upon filing a notice of appearance with the Clerk of the Commission within 21 days after receipt of the transmittal letter to the Clerk of the Circuit Court. The party who sought referral is responsible for providing the Commission with an original and five copies of the following: appropriate assessments, evaluations, and prognoses and such other records obtained during discovery and reasonably necessary for the determination of whether the infant has suffered a birth-related neurological injury. The moving party is entitled to be reimbursed for all copying costs upon entry of an award of benefits.

### Department of Health Review of Claims

Upon the filing of the Petition, the Commission will forward a copy of the Petition and its attachments to the Department of Health Professions. Thereafter, the Board of Medicine is required to evaluate the claim to determine if the injury was caused or aggravated by substandard care on the part of a *physician*.<sup>24</sup> The Department of Health is required to evaluate the claim to determine if the injury was caused or aggravated by substandard care on the part of the *hospital*.<sup>25</sup> The Department of Health Professions' reviews do not bear in *any* way on the infant's eligibility for benefits under the Act. The Birth Act is a no-fault Program and the issue of whether the care provided was substandard is irrelevant to a determination of whether an infant qualifies for benefits. The review by the Department of Health was simply a safeguard put into

place by the General Assembly when it removed catastrophically injured infants from the tort system, which usually identifies and ferrets out substandard care providers.

Just as a Claimant's filing of a Petition at the Commission will initiate a review of the healthcare providers by the Department of Health Professions, so too will a medical malpractice defendant's referral of a medical negligence claim to the Commission under Virginia Code §8.01-273.1. A defense lawyer who does not explain that serious consequence to a malpractice defendant *prior* to having a claim moved from Circuit Court to the Commission, may find himself as a defendant in a legal malpractice claim if the Department of Health Professions takes action against his client's license. Usually defense counsel is hired by an insurance carrier who has a financial incentive to have a case waylaid or terminated in the Commission, rather than settled or tried to verdict in Circuit Court. A malpractice defendant's financial interests are more closely tied to the viability of his license.

### Disinterested Panel of Physicians

Shortly after the filing of a Petition, the file will be referred to one of the three medical schools in the Commonwealth for review by a panel of three impartial physicians (**the "Panel"**), from the fields of obstetrics, pediatrics, pediatric neurology, neonatology, physical medicine and rehabilitation, or any other specialty particularly appropriate to the facts of a particular case.<sup>26</sup> Effective July 1, 2008, no more than one panel member may be from the field of obstetrics. The panel is required to provide a detailed report to the Commission as to whether or not a child meets each of the elements of a birth-related neurological injury, giving the basis for their opinions. The report must be filed with the Commission within 60 days of the filing of the Petition, and by statute, must be provided to counsel of record at the same time it is filed.<sup>27</sup> As a practical matter, parties rarely receive the report at the time it is filed, and sometimes do not receive it at all unless they go looking for it. As the time for the issuance of the panel report comes due, our office makes a practice of sending a letter to the panel chair (with copies to the Commission and opposing counsel) asking that they provide the claimant's copy of the report via facsimile. Most panels will comply with this request. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing of the matter.<sup>28</sup> The Commission must consider, but is not bound by the recommendations of the panel.<sup>29</sup>

Though one would think that a report by a panel of three disinterested physicians from academic institutions would carry weight with the Commission, historically, the panel reports have not, for various reasons. First, until July 1, 2008, when the law changed forbidding more than one obstetrician from sitting on a panel at a time, the panels were histori-

cally made up exclusively of obstetricians. Litigants who presented well-reasoned evidence from pediatric neurologists, neonatologists, and pediatric neuro-radiologists and other pediatric specialists were easily able to convince Commissioners that their opinions on neonatal brain injury should carry more weight than the opinions of obstetricians, who do not traditionally treat or diagnose neonatal brain injuries. Also, until July 1, 2008, the panel physicians were not paid for the time they spent reviewing files or rendering opinions. As a result, often the reports were short, poorly reasoned, with little or no explanation for the opinions rendered. Though the 2008 change in the law allowing payment to the physicians for their efforts, and requiring inclusion of pediatric experts on the panel should provide for more well-rounded panel opinions on eligibility, another factor may continue to frustrate the usefulness of these reports.

In 2004, obstetricians from the disinterested panels got together with the Chairman of the Virginia Section of the American College of Obstetricians and Gynecologists (ACOG) (a past member of the Board of Directors of the Program) and created a form check list for the evaluation of Birth Act claims for the stated purpose of making eligibility determinations more uniform. However, “*the form*” created does not track the elements of a “birth-related neurological injury” as set forth in the Virginia Code, and in fact implies a much more narrow definition for qualification for benefits. Instead of tracking the language of Virginia’s law, *the form* tracks criteria published by ACOG in its “Green Book,” the flagship of its 2003 tort reform platform.

By way of example, *the form* implies that certain things are necessary for a “birth-related neurological injury” to exist, such as certain umbilical cord blood gas values, certain Apgar scores, the presence of a “sentinel event” during labor, certain fetal heart monitor findings, which are simply not required by Virginia law. *The form* implies that certain things exclude an infant from benefits (such as prematurity, onset of injury prior to the commencement of labor and the infectious processes) which are not listed as exclusions in the Code and which have expressly been rejected as exclusionary items by both the Commission and the Court of Appeals. At the same time, *the form* ignores items that the Code says exclude an infant from benefits (still birth, maternal drug use, genetic abnormalities). While the Code requires an injury to a single organ, either the brain or the spinal cord, *the form* implies that multi-organ injury is necessary for an award of benefits. While the Code requires an injury that causes permanent motor dysfunction and either developmental delays or cognitive impairments, *the form* implies that spastic quadriplegia or dyskinetic cerebral palsy are necessary to establish a right to benefits. In fact, very few infants who have been admitted into the Program meet the requirements of *the form*.

In 2004, the panel chairs wrote to the Commission asking for Commission approval of *the form* and asking the Commission to require use of *the form* by all experts who evaluate claims under the Act. The Commission declined. Later that year, the Governor’s Work Group on Rural Obstetrical Care also declined an invitation to endorse *the form*. In 2006, the Program proposed legislative changes to the Act that would have codified the items on *the form* as part of the definition of a “birth-related neurological injury.” Additionally, that legislation would have required all evaluators involved in a case under the Act to utilize *the form* in rendering opinions in a case and explain any opinions given in departure from those suggested by use of *the form*. Despite a heavy lobbying effort by professional lobbyists paid out of Program funds, that legislation was rejected by the General Assembly.<sup>30</sup> Though the legislation failed, the panels are still utilizing *the form* to evaluate cases.

An entire article could be devoted to the history of *the form*, its legal and medical deficiencies, and the problems associated with its use. That type of detail certainly exceeds the intended scope of this article. However, practitioners representing infants under the Act should beware that a careful review of the panel report, compared with a copy of *the form* and the statutory definition of a “birth-related neurological injury” is important. Only a handful of the Deputy Commissioners have been exposed to the problems of *the form*, and how its use can distort, and in some instances render useless, the opinions of the disinterested panels. A lawyer facing a negative panel report should be prepared to thoroughly enlighten the trier of fact on the contents of the form and how its contents do not track the law. The Commission has a copy of *the form* and should be able to produce a copy pursuant to a Freedom of Information Act Request.<sup>31</sup>

### Responsive Pleadings

The Program is represented by the Office of the Attorney General.<sup>32</sup> The Program has 10 days after the filing of the panel report in which to file a response and submit relevant written information relating to the issues of whether the injury is a “birth-related neurological injury.”<sup>33</sup> The “relevant written information” required to be filed with the response usually takes the form of expert reports. Typically, if the Program’s experts and the panel physicians have concluded the infant qualifies for benefits, the claim will be accepted at this stage through an agreed order. However, if the claim is contested, a hearing will be scheduled.

### Discovery

Parties seeking discovery must apply to the Commission for permission to serve interrogatories or take depositions, setting forth the materiality of the information requested. Costs associated with discovery are taxed as expenses incurred in connec-

tion with the filing of a claim.<sup>34</sup> Effective July 1, 2008, litigants under the Act have a statutory right to depose witnesses from whom evidence is likely to be elicited at the hearing.<sup>35</sup> Because deadlines under the Act are short, filing a motion to conduct discovery shortly after the Petition is filed seeking responses on the date the Program's responsive pleadings are due is prudent. Waiting to learn the Program's position prior to initiating discovery leaves little time (no more than 90 days) to move for permission to conduct discovery, receive responses, conduct discovery depositions and obtain appropriate evidence for the hearing in the event the Program chooses to contest the claim. Too often counsel for claimants are left without meaningful information about the opposition to their claims until shortly before the hearing. Filing discovery early allows for proper preparation for hearing.

### Legal Research

It is not easy, but is very important **to obtain opinions from previous hearings in Birth Act cases.** Because many of the medical issues present in a case have been present in cases previously determined, prior cases are not just a wealth of information on the legal issues, but the medical issues, as well. For example, what is "deprivation of oxygen?" Does it include both hypoxic and ischemic insults? What impact does severe prematurity or obvious long-standing (pre-labor) insult have on an infant's chances of acceptance into the Program? What does "labor" mean? What is meant by "the immediate post-delivery period?" What is a "reasonable attorney's fee" or an acceptable cost of prosecuting the claim? These issues have been addressed, if not resolved, in previous claims.

Another valuable benefit to reading earlier cases is gaining information on experts who will give evidence in the case. The Program and the disinterested panels tend to utilize the same physician evaluators over and over. Review of prior cases will often disclose prior opinions of a medical expert who will be giving evidence in your case, and assist in preparation for cross-examination. Furthermore, the Program has been a party to each case under the Act. For most of the history of its existence, the Program has been represented by the Office of the Attorney General. Your opponent will know what has been decided in each case that has preceded yours. You do not want to be the only one in the courtroom who does not know.

Unfortunately, the vast majority of Birth Act cases are not indexed in any reporter or digest to stream-line research efforts. Cases that have been appealed to the Court of Appeals or Virginia Supreme Court can be obtained from traditional sources. In Commission cases that have not been appealed to higher courts – which make up the bulk of the opinions available – word-searching on the Commission's opinion web page is the only way to obtain the opinions ([www.vwc.state.va.us](http://www.vwc.state.va.us)). Regret-

tably, there are no head notes telling counsel what issues are contained in an opinion. A lawyer must plow through an entire opinion to see if any useful information or precedent is contained therein. Most opinions exceed 20 pages in length and are intensely medically complicated. However, the exercise is well worth the effort in a case that is likely worth millions of dollars to a profoundly injured infant. Your efforts in locating important case law may be significantly streamlined by contacting counsel who have previously handled cases under the Act.

### Hearings

Hearings shall be held no sooner than 15 days and no later than 90 days after the filing of the Program's Response.<sup>36</sup> Some Deputy Commissioners will permit these deadlines to be extended upon the agreement of counsel, and others will not. Hearings are usually held at the office of the Commission closest to the place of the infant's birth, unless another location is better for the parties or counsel. Generally, but not always, a Deputy Commissioner within that venue will be assigned the case. A word to the wise: If the Deputy Commissioner assigned to your case is not from the venue of the child's birth and will have to travel to conduct the hearing, don't make him or her drive the distance only to learn upon arrival that the parties have decided to rely on the written record and will present no other evidence.

In preparing to write this article, I sought input from the Commission regarding any suggestions for practitioners filing claims under the Act. The response was an encouragement for counsel to communicate directly with each other during the course of the claim in order to narrow issues for hearing.

Birth Act hearings are quite different from the formal medical malpractice trials that most Claimant's counsel are used to. Often the Deputy Commissioners will not permit an opening statement, and there may be no closing argument either. Sometimes there is no rule on witnesses (all doctors who will be testifying sit in for the whole hearing so that they CAN hear what was said by the others and comment thereon). The rules of evidence are relaxed. Medical records, written physician reports and published treatises will be received into evidence without a live witness to authenticate them. Effective July 1, 2008, parties have a statutory right to cross-examine witnesses from whom evidence is elicited.<sup>37</sup> There should be no need for a Court Reporter, because the Commission has its own recording equipment.

At the hearing, the Commission shall determine:<sup>38</sup>

- (1) Whether the injuries alleged are the result of a "birth-related neurological injury." (Hopefully you will know in advance of the hearing who will bear the burden of proof on this issue).
- (2) Whether obstetrical services were provided by a "participating physician" at the time

- of the birth;
- (3) Whether the birth occurred in a participating hospital;
- (4) What award is appropriate.

In planning to present evidence at the hearing, do not go to the expense of preparing and/or presenting a life care plan or economic projection of future needs. Typically, the Commission does not even address the amount of an award in the eligibility hearing. Instead, eligibility is determined and if the infant is entitled to benefits, the Commission's award orders the Program to pay all covered benefits on behalf of the infant. Then the claimants deal directly with the Program employees for reimbursements of covered benefits. The lawyers and the Commission are only involved where a benefits dispute arises between the parties.

Usually within a few weeks of the hearing, you and your client can expect to receive the Commissioner's opinion on eligibility in the mail. You can expect to wait longer in particularly complicated cases. Rehearing may be had by the Full Commission upon application within 20 days of the date of the determination or award.<sup>39</sup> Appeals from the Full Commission lie with the Court of Appeals in accordance with the Rules of the Supreme Court of Virginia.<sup>40</sup>

**Awards of benefits** under the Act include payment of four types of benefits: medical benefits, wage replacement, fees and costs associated with filing a claim, and a one-time death benefit for infants who die within 180 days of birth.<sup>41</sup> The Program is a payor of last resort, meaning it does not take over payment of expenses or benefits that an infant receives from collateral sources, such as Medicaid Medicare, other state or federal programs, prepaid health insurance plans, HMOs, or other private insurance.<sup>42</sup> Expenses are paid as they are incurred, rather than in lump sum.<sup>43</sup>

### Medical Benefits

The Code provides for payment of reasonable and necessary expenses of medical, hospital, rehabilitative, therapeutic, nursing, attendant, residential and custodial care and services, medications, supplies, special equipment and facilities and related travel. As of July 1, 2008, the Code was amended to expressly provide for reimbursement for nursing and attendant care that is provided by a relative or legal guardian of a Program beneficiary so long as that care is beyond the scope of child care duties and services normally and gratuitously provided by family members to uninjured children.<sup>44</sup> In addition to the obvious benefits (medical expenses, therapies, equipment and ramps), infants in the Program receive wheelchair accessible vans and have substantial housing modifications made for them, including additions to the home for handicap-accessible bedrooms, with large bathrooms and walk-in closets to accommodate their sizeable equipment. Those whose families rent rather than own, receive rental supplements. Children in the Program receive quali-

fied attendant care in their homes (giving parents and other care givers needed respite), and often enjoy the therapies not typically covered by health insurance.

### Income Benefits

From ages 18 to 65 infants in the Program receive an amount equal to 50 percent of the average weekly wage in the Commonwealth in the private, nonfarm sector.<sup>45</sup> In 2008, Program wage replacement benefit is \$21,840.

### Death Benefit

A one-time benefit of up to \$100,000 is available to the parents or legal guardians of infants who die within 180 days of birth. In order to receive the death benefit, the infant must have been otherwise eligible for Program funds, have been born on or after July 1, 2003 and died within 180 days of birth. Prior to making an award, the Commission is required to conduct a hearing to determine if such an award is appropriate, and if so, the appropriate amount to be awarded after hearing evidence of the family's sorrow, mental anguish, solace and grief associated with the death of the infant.<sup>46</sup>

### Fees and Costs

An important benefit of admission into the Program is payment of the reasonable expenses incurred in connection with filing the claim, including reasonable attorney's fees.<sup>47</sup> In addition to fees for representation during the initial eligibility determination, fees for legal representation of admitted claimants against the Program during benefits disputes which occasionally arise is also available.<sup>48</sup> Attorneys fees and costs must be approved and awarded by the Commission.

After an eligibility award, claimant's counsel will be instructed to file evidence necessary for determination of an appropriate award of fees and costs. The Program is permitted to respond and object to the monies sought, and rulings are generally based on written submissions of the parties. Fees are paid on a contingent hourly basis, as opposed to a percentage factor. The number of hours worked, the geographic area and the experience of the lawyer applying for fees weigh heavily in determinations of awards.<sup>49</sup> Document your time wisely as you go, it will enable the Deputy Commissioner to pay you for the hours you have spent. Since activities and expenses involved in a review for a medical malpractice claim and a review of a claim under the Act are often necessarily intertwined, you will not be foreclosed payment for time or expenses associated with a medical malpractice claim, if they can fairly be attributed to preparation for both claims.<sup>50</sup> Do not be put off by the Program's objection to payment of two members of a firm meeting, consulting or acting together. The Commission has authorized payment for time spent by both actors, so long as it is conservatively requested.<sup>51</sup> Finally, the Commission has

awarded fees for time spent obtaining amendments to the law and communicating with members of the General Assembly on an claimant's behalf.<sup>52</sup>

Payment of attorneys fees and reimbursement of costs is the Program benefit for which there has been the most litigation. However, the frequency and ferocity with which fees and costs have been opposed by the Program slowed dramatically in 2006, after the Court of Appeals made it clear that fees and costs would be awarded for time spent litigating the reasonableness of fees and costs.<sup>53</sup>

## Conclusion

Whether the Act has met its legislative goals is a matter of increasing debate among its many stakeholders. In a state with a cap on medical malpractice awards, a practical question for practitioners representing children who are impacted by this legislation is the determination of whether it is in the child's best interest to fight to prove that the child is or is not entitled to the benefits of the Program. The average benefit of an infant admitted into the Program is approximately \$2.29 million, present value,<sup>54</sup> slightly more than is available under the 2008 medical malpractice cap of \$2 million. However, benefits paid on behalf of individual beneficiaries are widely variable depending on the beneficiaries' particular injuries and needs. Importantly, unlike medical malpractice awards, benefits available to an infant accepted into the Program are uncapped. In the end, benefits paid on behalf of some children in the Program greatly exceed the \$2.29 million present value estimate (i.e. children needing 24-hour nursing care), while others are unlikely to ever reach the \$2.29 million estimate (those who die early in life, or who do not require much nursing care).

Only a handful of infants have a choice whether to seek the benefits of the Act or to pursue a medical malpractice action.<sup>55</sup> In order to determine whether your client would receive more under the Act or in a traditional medical negligence claim, you need to consider a number of things. First, has the statute of limitations (2 years) run on the mother's claim for emotional distress over giving birth to an injured infant? If not, the potential recovery in a malpractice case is double the relevant medical malpractice cap, making a malpractice case twice as attractive. How likely is a medical malpractice claim to succeed? What is the life expectancy of the infant? What medical expenses have been incurred to date or are likely to be incurred in the future? Were they paid by a collateral source with a lien on future recoveries? What are the likely attorneys fees and costs of a medical malpractice case? After payment of liens, attorneys fees and costs, what is the likely net to the client?

Another factor to consider is the Program's fiscal condition and financial longevity, which has recently been called into question. The Program is funded by yearly assessments to participating physicians,

participating hospitals, the general physician population, and liability carriers in the Commonwealth. Unfortunately, faulty actuarial assumptions led to a perception that the Program was over-funded in its early years, when it was actually under-funded. For this reason, over the course of many years, the Program failed to collect more than \$109 million in potential assessments.<sup>56</sup> In 2000, the problems with the actuarial assumptions were identified and the Program was declared actuarially unsound, meaning its projected obligations exceeded its projected assets.

Since that time, assessments to the four funding sources have resumed, and slightly increased. As of December 31, 2007, the Program had assets of \$227.1 million, and a projected deficit of \$127.6 million.<sup>57</sup> The Program is expected to be able to pay its obligations for at least the next 20 years under the current assessment scheme.<sup>58</sup> However, in 2008, the General Assembly amended the Code to allow the Program to utilize a different method of actuarial accounting of its projected future obligations. The new method of accounting is purportedly based on data more closely related to the actual expenses likely to be incurred by beneficiaries of the Program. This change in accounting alone is expected to reduce the projected deficit by up to 40 percent.

Though reports of the Program's actuarial unsoundness are sobering and require careful consideration, a matter of perspective is in order. The Program has been declared "unsound" since the year 2000. At that time, the Program was expected to be able to pay its obligations for another 20 years. Eight years later, the Program is still "unsound," yet it has over \$227.1 million in assets, growing every year, and is still projected to be able to meet its obligations for the next 20 years. With adjustments in the accounting method at hand, it is very likely that next year's projections will be much brighter. The General Assembly has shown an interest in keeping the Program viable. Though there is little incentive to pass legislation to fix the whole problem now, each year legislators have shown a willingness to keep an eye on the Program and make small changes to keep its financial situation from worsening.

When all is said and done, whether the Birth Act is a good thing or has met its goals depends on your perspective. Participating physicians and hospitals can choose to avoid catastrophic malpractice litigation for a relatively minor yearly fee. Attorneys who represent infants under the Act get less in hourly fees than their contingent fee medical malpractice contemporaries. Qualified infants who are not victims of malpractice benefit greatly and obviously get more. However, with the oldest beneficiaries less than 20 years old, it is probably still too early to say whether infants who are the victims of malpractice are better or worse off with the Act, even in a state with capped malpractice awards.

## Endnotes

1. Virginia Code §38.2-5002(B). The Act is the exclusive remedy for a mother's own claim for emotional distress over giving birth to an injured infant, but not for a mother's claim for physical injury to herself which is distinct from the injury to the infant. *Cooper v. Adler*, 44 Va. App. 268, 604 S.E.2d 747 (2004); *In Re: Nina Scott*, VWC B-07-05 (Commission, 11/20/07); *In Re: Robert Chad Lowery*, VWC B-04-09 (Commission, 3/31/06).
2. Virginia Code Section 38.2-5002(C).
3. Virginia Birth-Related Neurological Injury Compensation Program 2007 Annual Report at page 19.
4. Virginia Code §38.2-5001.
5. *Virginia Birth-Related Neurological Injury Compensation Program v. Young*, 34 Va. App. 306, 541 S.E. 2d 298 (2001).
6. *Coffey v. Virginia Birth-Related Neurological Injury Compensation Program*, 37 Va. App. 390, 558 S.E.2d 563 (2002).
7. Virginia Code §38.2-5008(A)(1)(b).
8. Virginia Code §38.2-5004(E).
9. Virginia Code §38.2-5004(F).
10. *See Wolfe v. Virginia Birth-Related Neurological Injury Compensation Program*, 40 Va. App. 565, 580 S.E.2d 467 (2003) and the subsequent rulings in *In Re: Taylor Hope Wolfe*, VWC B-01-02 (11/02/04).
11. *Central Virginia Obstetrics & Gynecology Associates, et al. v. Whitfield-Smith*, 42 Va. App. 264, 590 S.E.2d 631 (2004).
12. *See Central Virginia Obstetrics & Gynecology Associates, et al. v. Whitfield-Smith*, 42 Va. App. 264, 590 S.E.2d 631 (2004); *Inova v. Yost*, 2007 Va. App. Lexis 293.
13. In 2004, legislation placing a birth weight limit of 2000 grams was proposed and defeated. (House Bill 1407, and Senate Bill 687) In 2005, legislation placing a birth-weight limit of 1800 was proposed and defeated. (Senate Bill 1323) In 2006, legislation excluding prematurity without definition by birth weight, was proposed and defeated. (House Bill 416, Senate Bill 643)
14. *In Re: Cody Arven*, VWC B-06-10 (10/4/07) at pages 2-5; *In Re: Elijah Johnson*, VWC B-04-03 (5/17/05) at page 20, aff'd *Virginia Birth-Related Neurological Injury Compensation Program v. Long*, Record 1407-05-04 (1/10/06)
15. *See In re: Trevor Ellington*, B-00-24, 8/29/01 (Although injury began prior to arrival at the hospital, absence of evidence proving that injury was complete by that time rendered the infant eligible for benefits); *In Re: Jamie Marie Wells*, B-90-2, 2/5/92 (statutory presumption in infant's favor not overcome where the medical evidence established that the injury caused by oxygen deprivation commenced prior to the hospitalization but continued through the birthing process); *see also In Re: Lily Kate Haggart*, B-98-5, 9/15/00; *In re Atticus Bailey*, B-95-14 (3/18/96); *In Re Claire Marie Horne*, B-95-5 (9/26/95); *Program v. Young*, 34 Va. App. 306, 541 S.E.2d 298 (2001).
16. Virginia Code §38.2-5001.
17. *See* 2000 amendments to §38.2-5001 (effective April 1, 2000). The legislature's change in the law was a speedy response to the March 3, 2000 decision *Fruiterman v. Waziri*, 259 Va. 540; 525 S.E.2d 552 (2000).
18. *See Berner v. Mills*, 265 Va. 408, 579 S.E.2d 159 (2003).
19. Virginia Code §38.2-5020(A).
20. Virginia Code §38.2-5003
21. Virginia Code §38.2-5013.
22. Virginia Code §38.2-5005.
23. I understand that the Commission is in the process of converting to a paperless facility, though it is not clear how long the change over will take. Prior to filing a claim under the Act, it would be wise to call the Clerk of the Commission in order to be clear on how many copies of the relevant paperwork must be filed.
24. Virginia Code §38.2-5004(B).
25. Virginia Code §38.2-5004(C).
26. Virginia Code §38.2-5008(B).
27. Virginia Code §38.2-5008(C).
28. I am not aware of any case in which a panel member actually has attended a hearing.
29. Virginia Code §38.2-5008(C).
30. The failed pieces of legislation were sponsored by Delegate Tata in House Bill 416, and Senator Watkins in Senate Bill 643.
31. A request for a copy of three documents is in order: (1) March 10, 2004 letter from Drs. Abuhamad, Herbert, Partridge and Seeds to the Commission; (2) "Panel Evaluation of Medical Records Of Claimant For Compensation Under the Virginia Birth-Related Neurological Injury Compensation Program" Form; (3) April 21, 2004 letter of Commissioners Tarr, Diamond and Dudley responding to Drs. Abuhamad, Herbert, Partridge and Seeds.
32. Virginia Code §38.2-5002.1.
33. Virginia Code §38.2-5004(D).
34. Virginia Code §38.2-5007.
35. Virginia Code §38.2-5008.1.
36. Virginia Code §38.2-5006.
37. Virginia Code §38.2-5008.1.
38. Virginia Code §38.2-5008(A).
39. Virginia Code §38.2-5010.
40. Virginia Code §38.2-5011.
41. Virginia Code §38.2-5009(A)(1)-(3) and §38.2-5009.1.
42. Virginia Code §38.2-5009(A)(1)(a)-(d).
43. Virginia Code §38.2-5009(A)(1).
44. Virginia Code §38.2-5009(A)(1).
45. Virginia Code §38.2-5009(A)(2).
46. Virginia Code §38.2-5009.1.
47. Virginia Code §38.2-5009(A)(3).
48. *Spicer v. Virginia Birth-Related Neurological Injury Compensation Program*, 48 Va. App. 613, 633 S.E. 2d 732 (2006); *See also Robert Hastings*, VWC B-93-2 and James Kaelin, VWC B-94-2 (1/31/97) at page 7 ("The Program maintains that the award of attorney's fees is limited to entry of the initial award, but the Commission feels that such a reading of this provision is too restricted. It is apparent that the General Assembly wished to ensure that certain services and expenses would be the Program's responsibility throughout the petitioner's lifetime. Generally, in awarding such benefits, no specific services are at issue, but it is completely logical that the services and expenses outlined under

§38.2-5009 would be the subject of future petitions/claims. Thus, we conclude that such a dispute about the service and expenses awarded would continue to constitute a claim under Chapter 50, Virginia Birth-Related Neurological Injury Compensation Act and would be covered by paragraph four.”).

49. *In Re: Shayla Pham*, B-04-10 (Commission, 3/25/05), aff’d by the Court of Appeals in Records No. 0969-05-4 (11/1/05); *In Re: Taylor Hope Wolfe*, B-01-02 (Commission, 11/16/05)
50. *In Re: Claire Marie Horne*, B-95-5 (5/1/96).
51. *In Re: Joseph Phelps*, B-98-11 (4/11/00).
52. *In Re: Sara Kelly Duncan*, VWC B-97-10 (2/11/00); *In Re: Robert Hastings*, VWC B-93-2 (1/31/97).
53. *Spicer v. Virginia Birth-Related Neurological Injury Compensation Program*, 48 Va. App. 613, 633 S.E. 2d 732 (2006).
54. Virginia Birth-Related Neurological Injury Compensation Program 2007 Annual Report at page 25.
55. Those infants born in a participating hospital, but not delivered by a participating physician, can choose to sue the physician for any malpractice rendered by the physician. Alternatively, they can choose to file a Petition for Benefits under the Act. Infants delivered by a participating physician, but not in a participating hospital can choose to sue the hospital for malpractice rendered by hospital employees. Conversely, they can choose to file a Petition for Benefits under the Act.
56. See House Document 11 (2006), *A Study to Establish an Economically Balanced Approach for Funding the Birth-Related Neurological Injury Compensation Fund* at pages 30-33.
57. Virginia Birth-Related Neurological Injury Compensation Program Comprehensive Annual Financial Report For Years Ended December 31, 2007 and 2006 (4/18/08) at page 4.
58. Virginia Birth-Related Neurological Injury Compensation Program 2007 Annual Report at page 13.



*Ann LaCroix Jones concentrates her law practice in areas of civil litigation with a focus on cases with medically complex injuries and issues. Ms. Jones has a special interest in cases involving cerebral palsy and other profound injuries occurring to infants at the time of birth. Since 1998, she has won admission for 31 children into Virginia's Birth Related Neurological Injury Compensation Program. Ms. Jones graduated magna cum laude from James Madison University where she earned a Bachelor of Science in Business Administration in 1987. She earned her law degree from T.C. Williams School of Law in 1990. Following graduation from law school, Ms. Jones served two years as a Judicial Law Clerk in the Fairfax County Circuit Court before entering the private practice of law. Ms. Jones is a partner in the law office of Jones & Rostant, PC, in Fairfax.*