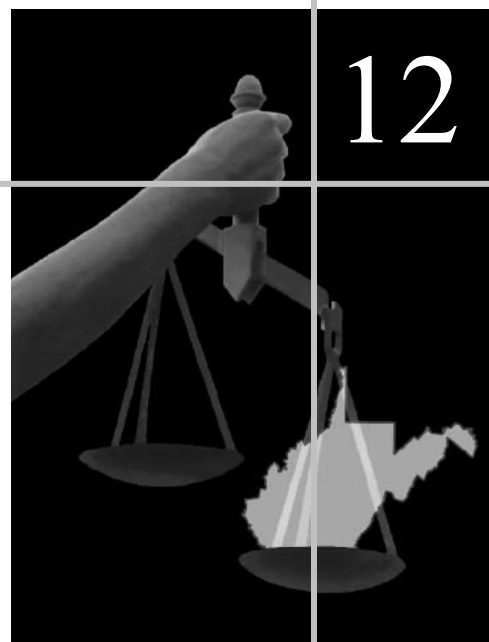


# CHAPTER 12



## MEDICAL LIABILITY REFORM IN WEST VIRGINIA: IS IT WORKING? WILL IT LAST?

*by Evan H. Jenkins and Juliet A. Terry*



# 12

## MEDICAL LIABILITY REFORM IN WEST VIRGINIA: IS IT WORKING? WILL IT LAST?

*Evan H. Jenkins and Juliet A. Terry*

Medical professional liability in West Virginia has had a tortured existence, particularly in the last two decades. Since the creation of the Medical Professional Liability Act in 1986, health care providers and lawyers have been at war on where to draw the line between stemming excessive, costly litigation and keeping the courthouse doors open for legitimately injured patients. Compounding this protracted dilemma is the insurance industry, which is affected not just by claims and litigation but also market forces.

This chapter first reviews what led to the 2001 (H.B. 601) and 2003 (H.B. 2122) reforms, then uses the best available data to determine whether the reforms succeeded in achieving their intended purpose or if the critics of reform were accurate in their claim the reforms would have no positive impact.

This chapter includes:

- Reports containing data on the number of medical liability lawsuits that are filed in each of the state's 55 counties on a monthly basis for the last eight years showing the impact of the reforms on lawsuit frequency;
- Data compiled by the West Virginia Insurance Commission for the last eight years tracking a key indicator of an insurance carrier's financial performance;
- Rate filing data tracking changes in the premium rates charged both before the reforms were enacted and after; and
- Licensure statistics dating back more than 10 years from the West Virginia Board of Medicine showing the number of newly licensed West Virginia physicians.

The final section of this chapter is devoted to a review of decisions by the West Virginia State Supreme Court of Appeals on the constitutionality of the various components of the Medical Professional Liability Act.

## THE ROAD TO REFORM

Suing doctors for medical negligence is not a particularly novel concept. Decades ago, the late West Virginia lawyer Hale J. Posten predicted malpractice lawsuits would become more common. In a 1935 West Virginia Lawyer Quarterly article, Posten foretold of an evolution unfolding: “As the practice of medicine in its various branches tends to become a business rather than a personal relation, and the paternal position of the family physician fades into the limbo of forgotten things, it is likely that actions against doctors for their acts of negligence in the exercise of their art will become more, rather than less, frequent.”<sup>1</sup>

Over the years, the health care delivery system has changed dramatically with many factors such as government regulation and insurance payor restrictions coming between the traditional doctor-patient relationship. Posten was more correct than he could have realized when predicting more lawsuits against physicians. While the law on medical malpractice litigation dates back to 19<sup>th</sup> century English common law, the last few decades have seen significant attention paid by states to medical liability.<sup>2</sup> When an insurance crisis hit the country in the 1980s, one of the cost drivers identified was medical liability litigation, and West Virginia lawmakers created the Medical Professional Liability Act. The MPLA was not a barrier to litigation — it provided structure with some limitations. Ohio County Circuit Court Judge Arthur M. Recht recalled the legislation during a newspaper interview in 2000. “The Medical Professional Liability Act of 1986 was a piece of legislation that responded to concerns in the health care community. It created a highly structured framework for the handling and disposing of medical and professional liability,” Recht said.<sup>3</sup>

Years after passage of the MPLA, however, it became clear to the medical community that the availability and affordability of medical liability insurance remained a problem in West Virginia. The cost for insurance began skyrocketing in the late 1990s and early years of this decade, but the medical and legal communities could not agree on why rates were spiking. The warring sides blamed an uptick in medical malpractice litigation and related costs or insurance industry mismanagement and profiteering among the many possible causes. What cannot be denied, however, is that insurance companies were paying far more in claims than they anticipated.

From 1993 to 2007 in West Virginia, insurance carriers paid out more than \$500 million in medical liability lawsuit settlements, with the average amount exceeding \$200,000 per claim.<sup>4</sup> In the past 15 years, more than \$40 million was awarded in court judgments, and in each of 20 cases, juries awarded more than \$1 million to plaintiffs.<sup>5</sup>

In West Virginia, malpractice carriers tracked by the National Association of Independent Insurers (now the Property Casualty Insurance Association of America) posted combined ratios ranging from about 122 percent to as high as 160 percent in the 1990s,

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<sup>1</sup> Posten, Hale J. “The Law of Medical Malpractice in West Virginia.” 41 W.Va. L.Q. 35 (1935), as quoted in “Simplifying the Law in Medical Malpractice: The Use of Practice Guidelines as the Standard of Care in Medical Malpractice Litigation,” by Sam McConkey IV, W.Va. L. Rev. 491 (Winter 1995).

<sup>2</sup> Budetti, Peter P. and Teresa Waters. “Medical Malpractice Law in the States.” Henry J. Kaiser Family Foundation, May 2005.

<sup>3</sup> Terry, Juliet A. “Health Care Goes to Court.” Wheeling News-Register, May 14, 2000.

<sup>4</sup> West Virginia Insurance Commission 5 percent Market Share report, November 2008.

<sup>5</sup> Ibid.

meaning carriers were not earning enough in premiums to cover losses.<sup>6</sup> This kind of financial performance led to rate increases in West Virginia approved by the Insurance Commission because they met state law requirements as adequate to cover liabilities without being discriminatory, unjust or artificially high.<sup>7</sup>

By the end of the 20<sup>th</sup> century, the issue hit the state Capitol, but before taking action, lawmakers challenged the insurance industry to document their justification for the premium rate increases. The insurance companies claimed the crisis was being driven by the state's litigious environment and that state lawmakers needed to enact legislation to reform West Virginia's civil justice system. Reform opponents claimed the insurance carriers' claims were driven by corporate greed or mismanagement coupled with low return on investment and suggested the crisis could best be resolved through tighter restrictions and more regulations on the insurance industry.

Regardless of the true culprit behind the steeply rising rates, however, the availability and affordability of medical liability insurance became more than merely challenging. The number of companies selling this line of insurance dwindled, and their rates became cost prohibitive, forcing some doctors to limit the scope of their practices to leave out higher risk components such as delivering babies. Other physicians pulled up the stakes completely and left West Virginia for regions where insurance was less expensive.

Information from the West Virginia Board of Medicine validated claims that physicians were leaving the state. In addition, state law requires all indemnity payments from lawsuit settlements or verdicts be reported to the physician's licensing board. This information was useful in validating the claim settlement and judgment data reported by the insurance companies to the Insurance Commission.

Policymakers concluded the affordability and availability crisis was being driven in large part by the state's litigious environment, which caused the financial performance of the insurance carriers selling medical liability coverage to deteriorate, forcing them to raise premium rates significantly or stop selling this line of insurance altogether. The high rates and/or limited insurance availability made West Virginia an unattractive place to practice medicine, thus affecting the physician resource available to care for West Virginia patients.

By 2001, the U.S. Department of Health and Human Services identified 50 West Virginia counties as wholly or partly designated as medically underserved areas and found health professional shortage areas in each of the state's 55 counties.<sup>8</sup> Some communities were left with no physicians trained to deliver babies. Others had no neurosurgeons, meaning all serious head trauma injury cases had to be transported to another hospital, delaying urgently needed treatment and displacing patients and family members from their communities.

Continued concerns about doctors' ability to find and afford liability insurance fueled an expansion to the Medical Professional Liability Act in 2001. Those changes were not a panacea, however, and in early 2003, the spotlight continued to shine brightly on the need for more dramatic medical liability reform, and the Legislature responded with a sweeping overhaul of the MPLA.

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<sup>6</sup> A combined ratio measures the profitability of an insurer. Expressed as a percentage, it measures what an insurer must pay to cover claims and expenses per dollar of earned premium. Essentially, a combined ratio of 100 percent indicates a break-even point. Anything beyond 100 percent indicates a loss.

<sup>7</sup> West Virginia Insurance Commission 5 percent Market Share report, November 2004.

<sup>8</sup> West Virginia Department of Health and Human Resources. "Burden of Cardiovascular Disease in West Virginia." July 2001.

In total, the Legislature enacted a series of reforms in 2001 and 2003 that took the 1986 Medical Professional Liability Act and brought it into the 21<sup>st</sup> century.<sup>9</sup> The reforms were designed specifically to address this insurance affordability and availability crisis that impacted West Virginia patients' access to care. Lawmakers approved tax credits to help offset the high insurance rates. The state's own governmental insurance program, the Board of Risk and Insurance Management (BRIM) was directed to begin selling medical liability insurance coverage to non-governmental, private practicing physicians. Following a period of mounting losses in the state's own insurance program, the 2003 reforms directed the closure of the expanded BRIM program and created, with a significant state subsidy, a physician-led mutual insurance program to provide insurance coverage for physicians.

The statutorily created West Virginia Mutual Insurance Co. now insures more than three-quarters of the physicians who purchase private sector insurance in West Virginia. By design the company is led by a board that is made up of a majority of West Virginia practicing physicians. Its structure as a mutual insurance company means that each policyholder has an ownership interest. To date, through the board's leadership efforts and an experienced professional management team, the company has built a strong operation that serves as the foundation of the medical liability insurance marketplace in West Virginia.

The elements of the 2001 and 2003 reforms that were debated most hotly centered on changes to the state's civil justice system and on how lawsuits alleging negligence against physicians and other health care providers would be handled in state courts.

The 2001 reform legislation, for example, added a new requirement designed to weed out meritless lawsuits by requiring that a screening certificate of merit be obtained from an independent, qualified health care provider who reviewed the facts of the case and believed a breach in the standard of care may have occurred. A notice of intent to sue and the certificate of merit must be served on the physician before a lawsuit was filed to show that the claim may be legitimate and give the parties an opportunity to reach a settlement.

The 2003 reforms included a provision that prohibited a patient from using the court system to obtain double recovery (collateral source) for the same injury and another provision limited a physician's financial exposure only to his or her percentage of fault (several liability) determined by a jury. The Legislature also reduced from \$1 million to \$250,000 the cap on the amount a jury could award for noneconomic damages and imposed a new \$500,000 total damages cap in certain cases relating to trauma care. These and other civil justice reform provisions contained in the 2001 and 2003 legislation were designed to impact both insurance affordability and availability.

As alluded to above, it is a massive understatement to say the policy discussion and legislative debate over the passage of both sets of reforms were heated. Reform advocates said the actions were necessary to preserve access to health care by bringing fairness and balance to the court system. Critics claimed the changes amounted to "special rights" for doctors and would limit or restrict a patient's rights to have a medical negligence claim fully adjudicated. Central to the critics' opposition to many of the reforms enacted was their belief that the changes would not result in lower insurance rates or improved access to care.

Have the reforms worked? Several key measures indicate the MPLA is functioning as it was intended. The question remains, however, whether the latest incarnation of the MPLA will withstand constitutional scrutiny. When asked to decide the constitutionality of various provisions of the Medical Professional Liability Act, justices of the West Virginia Supreme

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<sup>9</sup> W.Va. Code, 55-7B.

Court of Appeals have shown their stripes over the years and made it clear how they feel about certain portions of the act. But much of the case law on medical malpractice dates back to a Court makeup that no longer exists, so predicting how the current or future Court will view the reforms is difficult.

One of the most controversial components of the Medical Professional Liability Act dates back to when it first was created in 1986 — the imposition of a \$1 million limit on noneconomic damages arising from a malpractice lawsuit.<sup>10</sup> Since its enactment, the “cap” on pain and suffering, as many have termed it, has generated volumes of praise and criticism. The Supreme Court first upheld the cap in 1991 in *Robinson v. Charleston Area Medical Center*.<sup>11</sup> Several years later, the Supreme Court heard a new challenge to the cap in *Verba v. Ghaphery*.<sup>12</sup> Like in *Robinson*, the challenge in *Verba* attacked the cap’s constitutionality on equal protection grounds. While under intense scrutiny, the Supreme Court upheld the noneconomic damage cap in December 2000, affirming its holdings in *Robinson*.

Two of the most controversial changes made in 2003 involved reducing the noneconomic damage cap down to \$250,000 and imposing a \$500,000 total cap on damages stemming from trauma care rendered in an emergency situation.<sup>13</sup> The constitutionality of those two changes has yet to be decided in the courts, but some of the 2001 reforms already have made their way to the Supreme Court. Although the justices have refused so far to address the constitutionality of the new pre-suit requirements, the majority has indicated a willingness to throw procedural requirements aside if they prevent a plaintiff from bringing a lawsuit. Former Justice Elliott E. “Spike” Maynard, in fact, warned that the majority opinion in one case “may result in the complete gutting of a portion of the 2001 medical malpractice reforms.”<sup>14</sup>

## MEASURING PROGRESS

### LAWSUIT FILINGS

Liability insurance rates are impacted heavily by three factors: claim frequency (number of suits filed), severity (average size of settlements and jury awards) and “shock losses” (judgments exceeding \$1 million). Prior to 2001, medical liability insurance companies conducting business in multiple states, including West Virginia, reported that while severity and shock losses were on par in West Virginia compared to other states, they did see a significantly higher rate in the number of suits filed per insured in West Virginia.

In an effort to weed out meritless lawsuits some believed were being filed in the state, the 2001 medical liability reform legislation included a requirement that, with few exceptions,

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<sup>10</sup> The language of W. Va. Code, 55-7B-8, as amended in 1986: “In any medical professional liability action brought against a health care provider, the maximum amount recoverable as damages for noneconomic loss shall not exceed one million dollars and the jury may be so instructed.”

<sup>11</sup> *Robinson v. Charleston Area Medical Center Inc.* 186 W.Va. 720, 414 S.E.2d 877 (W.Va.1991).

<sup>12</sup> *Estate of Marjorie Verba v. Ghaphery, M.D.* 543 S.E.2d 347 (W.Va. 2000).

<sup>13</sup> W.Va. Code, 55-7B-8 and 55-7B-9c (2003).

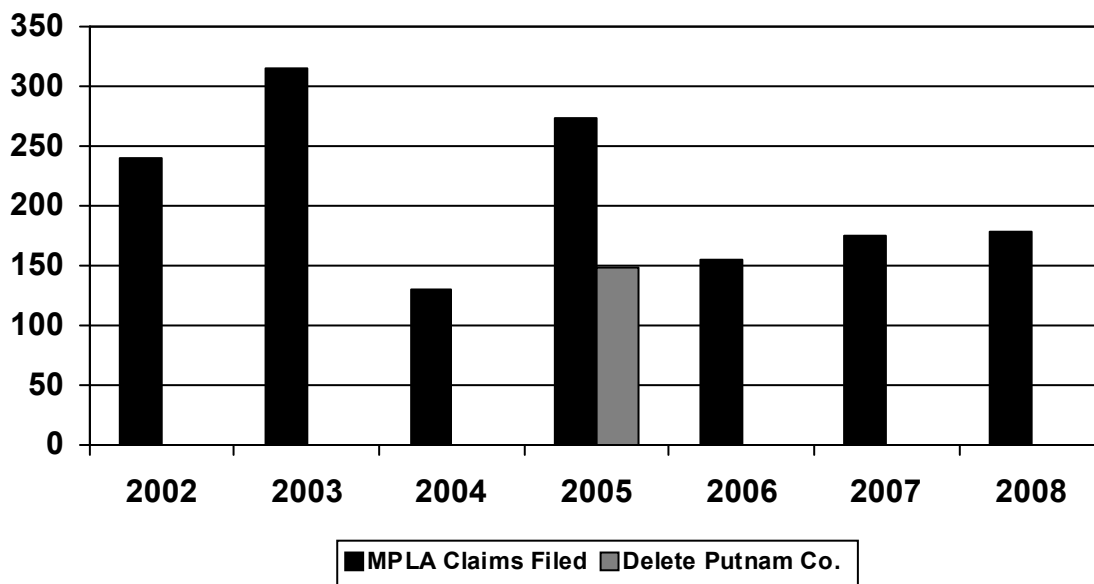
<sup>14</sup> *Hinchman v. Gillette.* 618 S.E.2d 387 (W.Va. 2005) (Maynard, concurring in part and dissenting in part, filed July 11, 2005).

any medical liability suit filed must contain a certificate of merit from an independent medical expert indicating that there is evidence that medical negligence may have occurred.

Another reform measure contained in the 2001 legislation was a \$165 increase in the filing fee on any suit against a health care provider alleging medical negligence under the Medical Professional Liability Act. The extra filing fee is collected by the circuit clerk of the county where the lawsuit is filed and forwarded monthly to the West Virginia State Treasurer for deposit in the Medical Liability Fund.

The State Treasurer's collection report provides a clear picture of claim filing activity in every county throughout the state on a monthly basis and a way to document the impact of the 2001 and 2003 reforms on lawsuit filing frequency in West Virginia.

Figure 12.1: Medical Liability Lawsuit Filings<sup>15</sup>



In 2002 and 2003, MPLA claim filings against health care providers in West Virginia were 239 (11 months of filing data) and 315 respectively. Following the full implementation of the 2001 and 2003 reforms, medical liability lawsuit saw a sharp decline beginning in 2004 with an annual total of only 130, a 59 percent drop from the prior year total. Filing totals for 2005 were 273, significantly higher than the 2004 total; however, much of the increase from the prior year can be attributed to the lawsuits filed in one county (Putnam County) relating to a specific health care provider. Reducing the annual statewide total by the claim filings in Putnam County shows the 2005 filing total of 147 is in line with the 2004 historic low number. From 2006 to 2008, the claim filing report shows continued low annual totals (154, 174 and 178, respectively).

In addition to the drop in lawsuit filings, a 2006 annual report by the Insurance Commission on the medical liability insurance marketplace documented a rise in the number of claims being dismissed, attributing these positive trends also to the pre-filing certificate of

<sup>15</sup> Medical Liability Fund 2002-2008 West Virginia State Treasurer's Office Reported by Month Collected, as reported in the West Virginia Insurance Commission 5 percent Market Share report, November 2008.

merit requirement. The Insurance Commission's report stated: "We believe that this screening process [pre-filing certificate of merit] explains the sharp and maintained rise in the percentage of dismissals seen beginning in 2002. Additionally, in 2002, we have seen a sharp drop in the percentage of claims settled. ... Overall, the number of claims filed has ... decline[d] over 50%."<sup>16</sup>

#### *INSURANCE COMPANY FINANCIAL PERFORMANCE*

While there was little public sympathy for the poor financial performance reported by the insurance companies in the late 1990s, the public did become engaged when physicians were driven out of state or out of practice because of skyrocketing insurance premium rates. Double-digit premium rate hikes year after year were needed to make up for the companies' mounting losses.

An important indicator of a carrier's financial performance is its combined ratio. This number is reported as a percentage of each premium dollar the insurer spends on claims and expenses and does not include any return on investment. A decrease in the ratio means financial results are improving; an increase means that they are deteriorating. When the ratio is over 100 percent, the insurer has an underwriting loss. An easy way to understand this ratio is to consider that if a carrier receives \$1 in premium and pays out \$1 in claims and expenses, the carrier has a 100 percent direct combined ratio.

The West Virginia Insurance Commissioner collects this information from the insurance companies doing business in the state and issues a report annually that tracks the direct combined ratio. The report indicates a 165 percent direct combined ratio for 1999 in West Virginia, meaning that for every dollar collected in premium, the carriers paid out \$1.65 in claims and expense. It is not difficult to understand why carriers began increasing premium rates in the late 1990s to cover the mounting underwriting losses. The carrier's poor financial performance was also a deterrent to new carriers wanting to start doing business in West Virginia.

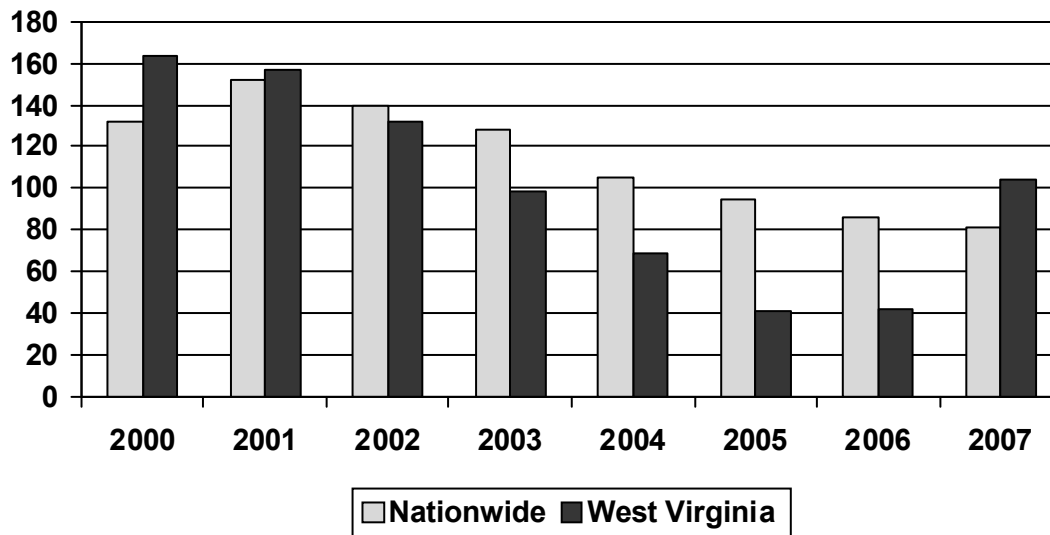
Following the passage of the 2001 and 2003 reforms, the direct combined ratio showed steady improvement moving from significant underwriting losses to underwriting profits in recent years. Another significant observation is how the carrier's financial performance was much worse in West Virginia compared to national averages prior to the reforms but now demonstrates better performance here than in other states.

A slip in the carriers' reported financial performance in 2007 was pointed out as a possible anomaly in the November 2008 report. Two companies left the West Virginia insurance market that year, and their financial performance for 2007 skewed the overall market performance, according to the Insurance Commission. The report said that absent those two companies, the "West Virginia market would have more closely reflected the experience of the countrywide market in 2007, were it not for those exits and the great impact that it created upon these percentages for our relatively small market."

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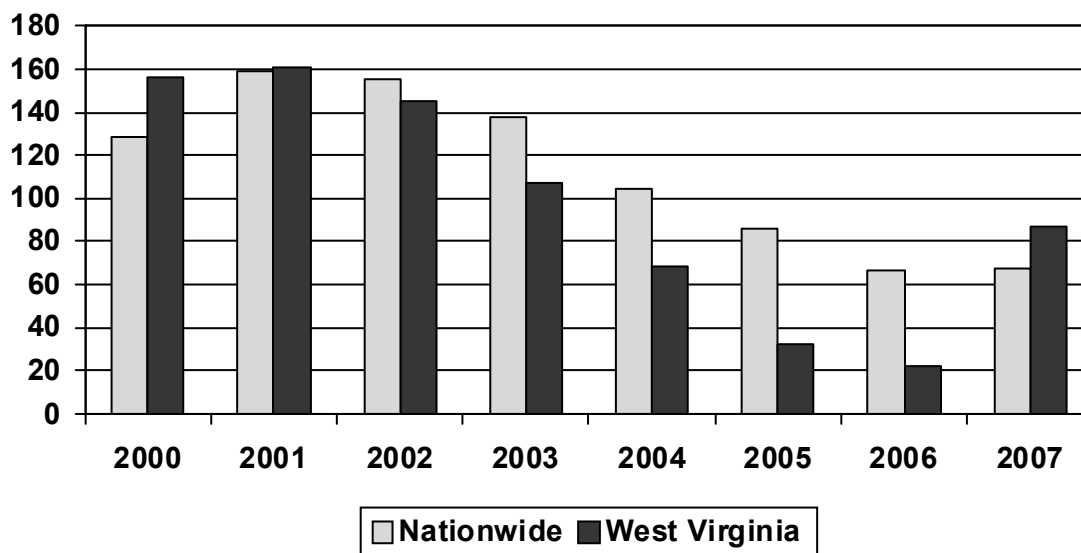
<sup>16</sup> West Virginia Insurance Commission 5 percent Market Share Report, November 2006.

Figure 12.2: Direct Combined Ratio,  
Nationwide and West Virginia<sup>17</sup>



Another measure of insurance carriers' financial performance is the direct operating ratio, which further reflects dividends paid and investment gains and losses.

Figure 12.3: Direct Operating Ratio,  
Nationwide and West Virginia<sup>18</sup>



<sup>17</sup> West Virginia Insurance Commission 5 percent Market Share report, November 2008. Direct combined ratios do not take into consideration reinsurance recoveries or payments for reinsurance coverage.

<sup>18</sup> Ibid.

Again, the exit of two companies in 2007 skewed direct operating ratio results for that year, but overall, the chart above demonstrates that after accounting for dividends and investment gain, medical malpractice produced an operating profit in West Virginia annually from 2004 to 2007. Averaging financial performance from 2000 to 2007, the industry posted a total direct operating ratio of 98.9 percent; in West Virginia, carriers combine for a total direct operating ratio of 85.7 percent, meaning the medical liability insurance industry remains profitable overall in West Virginia and specifically more profitable than that of the countrywide average.<sup>19</sup>

The improved financial performance reflects the impact the 2001 and 2003 reforms have had on the state's civil justice system. The 50 percent drop in medical liability lawsuit filings in recent years, due in large part to the certificate of merit requirements, coupled with the other civil justice reform measures can be credited for a reduction in the carriers' claims expense.

#### *PREMIUM RATE REDUCTIONS*

Carriers have responded to their improved financial performance in West Virginia by reducing physician premium rates.

Figure 12.4: Annual Premium Base Rate  
Change in Percentage<sup>20</sup>

	Effective Date	Percent Requested	Percent Granted
<b>West Virginia Mutual Insurance Co.</b>	1/1/2009	0	0
	3/1/2008	-0.01	-0.01
82.15 percent WV market share	1/1/2008	0	0
	1/1/2007	-15	-15
	1/1/2006	-5	-5
	1/1/2005	10.2	10.2
	7/1/2004	initial filing	initial filing
<b>Woodbrook Casualty Insurance Co.</b>	11/1/2008	-8.3	-8.3
	11/1/2007	-10.7	-10.7
	10/20/2006	-2.8	-2.8
(formerly Medical Assurance of WV Inc.)	10/20/2005	-1.1	-1.1
7.63 percent WV market share	10/20/2004	18.5	14.5
	10/3/2003	17.3	13
	7/1/2002	23	16
	9/14/2001	30	18
	8/1/2000	35	35

<sup>19</sup> West Virginia Insurance Commission 5 percent Market Share report, November 2008.

<sup>20</sup> Ibid.

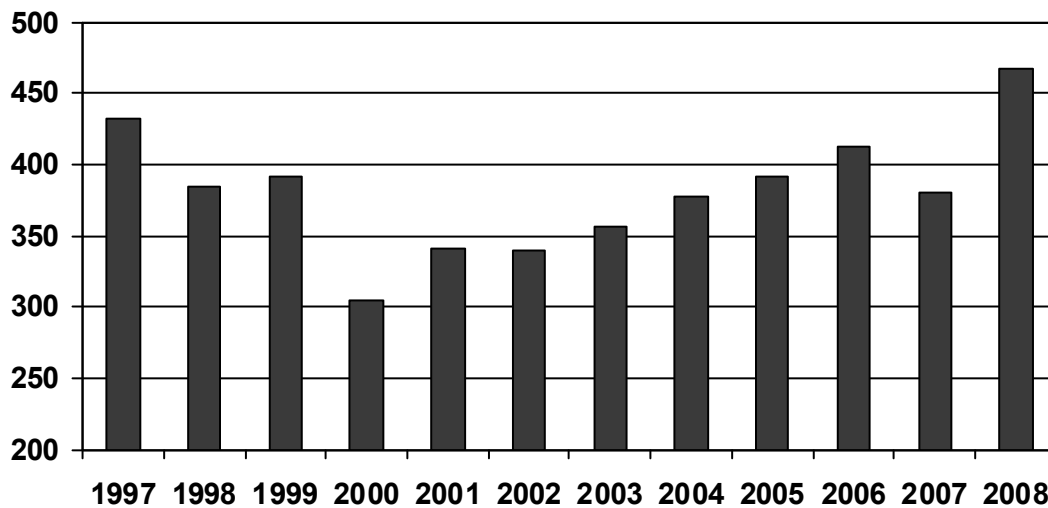
The state's largest carrier, the West Virginia Mutual Insurance Company, has more than 82 percent of the market. Just 18 months after its initial rate filing it reduced rates in January, 2006 by 5 percent. The Mutual reduced rates again the following year by another 15 percent. In addition to these base rate reductions, the carrier has instituted a number of credits available to physicians that can reduce the actual premium rate by an additional 15 to 20 percent. In total, premium rates charged by the Mutual, depending on the physician practice specialty, have dropped 25 to 45 percent in just the last few years.

The state's second largest carrier, Woodbrook Casualty Insurance Co., reported since October, 2005 four consecutive premium rate cuts totaling over 22 percent.<sup>21</sup> According to Insurance Commission records, Woodbrook's annual rate reductions the last few years have had the net effect of lowering medical liability insurance rates to the equivalent of what they were in 2002-2003.<sup>22</sup>

#### *IMPROVED ACCESS TO CARE*

A more stable liability system and lower premium rates have brought a renewed sense of optimism and improved outlook on the attractiveness of practicing medicine in West Virginia. Data from the West Virginia Board of Medicine clearly demonstrates a turnaround in the number of physicians seeking licensure to practice medicine in the state.

Figure 12.5: Annual Total of Newly Licensed Physicians by the West Virginia Board of Medicine<sup>23</sup>



Between 1997 and 2001, West Virginia physicians experienced the full brunt of the insurance affordability and availability crisis. The West Virginia Board of Medicine reported

<sup>21</sup> West Virginia Insurance Commission 5 percent Market Share report, November 2008.

<sup>22</sup> Ibid.

<sup>23</sup> West Virginia Board of Medicine.

a significant decrease in the number of new licenses issued between 1997 and 2000 from 433 to 305, a 30 percent drop.

As mentioned earlier, much of West Virginia is designated by federal criteria as medically underserved, meaning the state can ill afford to have an environment that causes physicians to shy away from licensure. Physicians in other states recognized West Virginia's negative practice environment as well. The nation's largest physician membership organization, the American Medical Association, surveyed the medical liability environment in all 50 states and several years ago designated West Virginia as one of the few "crisis" states.

Thankfully, that perception is changing. Data show that beginning in 2001 and continuing through 2008, the trend in physicians seeking licensure in West Virginia has grown steadily. Final totals for licensure activity from the West Virginia Board of Medicine show that 2008 was the highest number of new licenses issued on record at 467.

Additional confirmation of the improved environment are many anecdotal reports from medical practice administrators and hospital-based physician recruiters who say attracting physicians into practice in West Virginia has seen significant improvement. What does this mean for the average West Virginian? Increased access to care. In 2001, almost every county had at least one recognized health care professional shortage area, according to the U.S. Department of Health and Human Services. Today, 11 West Virginia counties no longer have health care professional shortages in primary care.<sup>24</sup>

These objective measures demonstrate the legislative reforms in 2001 and 2003 have achieved their goals of addressing the underlying factors that jeopardized access to care in West Virginia. The number of suits filed has dropped dramatically. Insurance companies have seen a significant improvement in their financial performance and as a result cut the premiums they charge physicians for coverage by as much as 45 percent. The availability of insurance at lower rates and coupled with a more stable litigation environment has made West Virginia a more attractive place to practice medicine. Physicians are seeking licensure in the state, and that enables patients to have greater access to care.

A critical question, however, is will the positive results last? Plaintiff lawyers who fought against the passage of H.B. 601 (2001) and H.B. 2122 (2003) are working actively to have both laws undone through the judicial system. To date, their repeated efforts have succeeded in getting the West Virginia Supreme Court of Appeals to strike down several of the reforms minor provisions. No clear decisions, however, have been issued by the Court on the more substantive components of the 2001 and 2003 reforms. So the question remains on whether the Court will allow the reforms to stand or strike them down, likely putting West Virginia back in crisis and jeopardizing access to care.

## JUDICIAL REVIEW OF THE MPLA

### *CONSTITUTIONAL ISSUES AFFECTING NONECONOMIC DAMAGE CAP*

The noneconomic damage cap has generated some of the most heated arguments among the various provisions of the Medical Professional Liability Act that have come under fire in the

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<sup>24</sup> U.S. Department of Health and Human Services, <http://hpsafind.hrsa.gov/HPSASearch.aspx>.

past two decades. Insurance and medical community representatives have said noneconomic damages are for things such as pain and suffering — damages that are impossible to calculate and therefore should be limited within reason so juries cannot use them in lieu of punitive damages. Plaintiffs' lawyers, in contrast, have said limiting jury awards goes against due process and equal protection provisions of the Constitution, because it treats patients differently than other victims of negligence.

In *Robinson v. Charleston Area Medical Center* (1991) and again in *Verba v. Ghaphery* (2000), the West Virginia Supreme Court of Appeals examined the cap on a variety of constitutional grounds: separation of powers, equal protection, due process, right to trial by jury, open court and certain remedy clauses and the special act clause.

### *Verba v. Ghaphery*<sup>25</sup>

In 1996, Marjorie Verba died following complications from anti-reflux surgery performed by Dr. David Ghaphery. At trial in Ohio County Circuit Court, the jury awarded Verba's heirs \$300,000 for physical pain, mental pain and loss of enjoyment of life; \$21,000 for medical and funeral bills; and \$2.5 million to the beneficiaries of Verba's estate under the wrongful death statute. The trial judge later reduced the total judgment to \$1.02 million because of the \$1 million limit on noneconomic damages imposed by the MPLA (1986).

On appeal, Verba's attorneys argued the cap was unconstitutional for many of the reasons enumerated above. But in upholding the cap, the Supreme Court said legal concerns were not the only issues to consider: "Where economic rights are concerned, we look to see whether the classification is a rational one based on social, economic, historic or geographic factors, whether it bears a reasonable relationship to a proper governmental purpose, and whether all persons within the class are treated equally. Where such classification is rational and bears the requisite reasonable relationship, the statute does not violate Section 10 of Article III of the West Virginia Constitution, which is our equal protection clause."<sup>26</sup> A rational basis test is the least demanding method for interpreting whether a statute is constitutional. It requires justices only to identify a nexus between the objective of a statute and the means chosen to achieve it.<sup>27</sup>

Addressing the separation of powers issue, the Supreme Court said the Legislature properly exercised its authority in setting the cap and, more importantly, has the authority to change the cap. The court said it cannot "sit as a superlegislature [sic] to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines."<sup>28</sup> The bottom line, the court said, is that the Legislature can change the common law.

The *per curiam* decision was far from unanimous, however, as former Justices Warren McGraw and Larry Starcher dissented. Justice Robin Jean Davis also dissented in part.

In her separate opinion, Davis said the "majority correctly found that the Legislature did not offend our constitution by exercising its authority to impose a one million dollar cap on noneconomic damages in medical malpractice cases. Furthermore, I adhere to the principle that it is the Legislature's 'right and public responsibility to formulate tort or liability

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<sup>25</sup> *Verba v. Ghaphery* (W.Va. 2000).

<sup>26</sup> *Ibid*, syllabus point 2.

<sup>27</sup> Black's Law Dictionary, (6<sup>th</sup> edition, 1990).

<sup>28</sup> *Verba v. Ghaphery* (2000).

legislation.” But Davis said the \$1 million cap becomes invalid because in present-day dollars at the time, \$1 million was worth \$648,147, according to plaintiffs’ arguments; therefore, Davis said it does not fulfill the legislative intent set in 1986.<sup>29</sup>

Justice McGraw dissented for a different reason. He said the noneconomic damage cap “denies equal protection by discriminating among tort victims in such a way as to deny recovery to the most egregiously injured.”<sup>30</sup> McGraw said the Supreme Court should not have reviewed the noneconomic damage cap using a rational basis test, but rather via intermediate scrutiny. Using this method, courts determine whether a challenged statute is substantially related to an important state interest.<sup>31</sup> McGraw said an intermediate scrutiny analysis would prove the cap does not pass constitutional muster despite what the Legislature intended, because “there is no logically supportable reason why the most severely injured malpractice victims should be singled out to pay for social relief to medical tortfeasors and their insurers.”<sup>32</sup>

In the same vein, Justice Starcher echoed McGraw’s comments, stating the cap limits the ability of medical malpractice victims to collect full damages while other victims of other kinds of negligence are not limited. “Why should hospitals get more protection for their carelessness than I do as a driver or homeowner?” Starcher questioned.<sup>33</sup>

Whatever shaky majority the Supreme Court had in issuing its *Verba* decision, however, the justices renewed the constitutionality of the cap after granting a rehearing for the case in 2001. They decided once again to uphold the lower court’s decision. This time, Davis and former Justice Elliott E. “Spike” Maynard concurred in full — no partial dissents. The majority upheld the cap based on the separation of powers doctrine and, once again applying a rational basis test, the Supreme Court said limiting noneconomic damages “bears a reasonable relationship to a proper government purpose...”<sup>34</sup>

With three separate majority opinions upholding legislative fiat when it comes to limiting damages that are impossible to calculate finitely, it would appear the new cap may stand up to constitutional scrutiny. The Court long has recognized that a higher standard applies when considering the constitutionality of legislation: “...(C)ourts must exercise due restraint, in recognition of the principle of the separation of powers in government... Every reasonable construction must be resorted to by the courts in order to sustain constitutionality, and any reasonable doubt must be resolved in favor of the constitutionality of the legislative enactment in question. ... In considering the constitutionality of an act of the legislature, the negation of legislative power must appear beyond reasonable doubt.”<sup>35</sup>

Will today’s Supreme Court — with only two members remaining from when the *Verba* case was decided — view the lower noneconomic damage cap in the same way? No one can predict the future, obviously, and no case has made it to the Supreme Court of Appeals that squarely takes on the constitutionality of the 2003 MPLA noneconomic damage cap. When that case finally arrives, the arguments against the cap no doubt will be asserted.

In the end, West Virginia’s health care system is faring far better today than it was seven or eight years ago, as are medical liability insurance carriers in West Virginia. Without

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<sup>29</sup> Ibid (Davis concurring in part, dissenting in part, filed Dec. 15, 2000).

<sup>30</sup> Ibid, (McGraw dissenting, filed Jan. 16, 2001).

<sup>31</sup> Black’s Law Dictionary, 6<sup>th</sup> edition.

<sup>32</sup> *Verba v. Ghaphery* (McGraw dissent).

<sup>33</sup> *Verba v. Ghaphery* (Starcher dissenting, filed Jan. 16, 2001).

<sup>34</sup> *Verba v. Ghaphery*. 552 S.E.2d 406 (W.Va. 2001), syllabus point 2.

<sup>35</sup> Ibid.

the reforms, however, who knows what would have become of access to care by West Virginia patients.

For now, absent a new, compelling state interest to the contrary, the Supreme Court is likely to remain consistent with precedent regarding the Legislature's ability to set the noneconomic damage cap. Even with Davis' posture on how inflation erodes the value of the cap, the Supreme refrained from trying to require the Legislature to increase the \$1 million cap to reflect inflationary erosion in its value from 1986 to 2000. "Just as it was within the Legislature's proper exercise of its authority in initially setting the cap, it is similarly up to the legislature to make any amendments to that legislation."<sup>36</sup>

It should not offend the Supreme Court's view on constitutionality if lawmakers reduce the cap to \$250,000 using the same reasoning that was applied when setting the \$1 million cap. The legislative findings in the 2003 incarnation of the MPLA, while similar to those stated in 1986, reflected the new reality of the current access to care crisis. Clear legislative intent remained, and lawmakers made sure to reflect some of the criticisms levied against the cap during the *Verba* case and in discussions leading up to passage of the amended MPLA in 2003. The new cap starts at \$250,000 but provides for an escalation up to \$500,000 depending on the severity of injury and up to 50 percent increase to account for inflation.<sup>37</sup>

Furthermore, to make certain doctors are insured adequately, the noneconomic damage cap disappears if the physician does not have at least \$1 million in liability coverage. The Legislature made its intentions clear. They responded to the needs of physicians to improve the affordability and availability of medical liability insurance so doctors would be available to care for West Virginians. The doctors, in turn, must carry adequate insurance so injured patients will be compensated. As the Supreme Court said in *Verba*, it is up to the Legislature — not the courts — to determine whether its legislation meets the desired goal.

## TREATMENT OF THE 2001 AND 2003 MPLA PROVISIONS

Several cases have made their way to the Supreme Court that involve the 2001 reforms, but few, if any, have dealt substantively with the changes made in 2003. What's more, the high court has refrained from making a constitutional analysis of many of the substantive changes made to the MPLA.

The 2001 changes to the MPLA required, among other things, that plaintiffs send a pre-suit notification to the defendant with a screening certificate of merit at least 30 days before a medical negligence lawsuit can be filed.<sup>38</sup> The 2001 reforms also imposed a 12-member jury requirement in which a nine-member majority constituted a verdict.<sup>39</sup> Those three requirements have not survived legal challenges well, although only one has been stricken on constitutional grounds.

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<sup>36</sup> *Verba v. Ghaphery* (2000).

<sup>37</sup> 55-7B-8 (2003).

<sup>38</sup> W. Va. Code 55-7B-6 (2001).

<sup>39</sup> W. Va. Code 55-7B-6d (2001).

***Boggs v. Camden-Clark***

In 2004, the Supreme Court reversed a lower court dismissal of a malpractice lawsuit in *Boggs v. Camden-Clark*.<sup>40</sup> Hilda Boggs slipped and broke her ankle while at work in 2001. Her injury required surgery, and during anesthesia, she stopped breathing and went into cardiac arrest. She later died. Her husband filed a lawsuit that accused Camden-Clark and others of failing to adhere to the standard of care plus other non-medical allegations including an alleged cover-up and spoliation of evidence.

The first time Boggs filed suit, the summons and complaint were not served within 120 days of filing, so the court dismissed the case. The second time he filed suit, the court again dismissed the complaint, finding that Boggs failed to comply with the 30-day notice period before filing the lawsuit in accordance with the 2001 MPLA. That action forced Boggs to file his lawsuit a third time, and by this point, enough time had elapsed that the lawsuit would fall under the 2003 MPLA, which had the lower noneconomic damage cap. In the second dismissal, the lower court rejected all of Boggs' claims, even those that were not medical malpractice, and denied his motion for leave to amend his original complaint under Rule 15 of the West Virginia Rules of Civil Procedure.<sup>41</sup>

On appeal, the Supreme Court said it did not find it necessary to question the MPLA's constitutionality. Its standard of review, therefore, was abuse of discretion. Under this standard, an action generally is presumed to be valid and is affirmed if it is founded on a rational basis and has no clear error that indicates the decision was arbitrary, capricious or constitutes an abuse of discretion.<sup>42</sup>

The Court identified clear error in *Boggs*. "Though we reject the appellant's request that we consider the constitutionality of the entire MPLA scheme, we agree with his contention that the lower court was wrong to deny him leave to amend his complaint."<sup>43</sup> The Court said Rule 15 states a party can amend his complaint by leave of the court or by written consent of the opposing party, and "leave shall be freely given when justice so requires."<sup>44</sup> Even though Boggs' notice of intent to sue was sent 27 days — not 30 days — before he filed suit, the majority said the courts cannot allow a procedural device such as the pre-suit notification requirement to prevent a case from being decided on its merits. In *Boggs*, the actual medical negligence claims had yet to be litigated, and the lower court's refusal to allow the plaintiff to amend his complaint was an error, the Supreme Court said. The Court ordered the lower court to reinstate Boggs' non-medical claims and allow him to amend his complaint and proceed with the case under the 2001 MPLA, not the 2003 version of the act.

In a dissenting opinion, however, Justice Maynard said the majority had gone against the plain reading of the 2001 MPLA. Boggs' notice was served 27 days before he filed suit, not the statutorily required 30 days. Just six days before the *Boggs* decision was rendered, the Supreme Court had ruled in *Miller v. Stone* (2004) upholding a circuit court ruling that said a complaint could not be filed until 30 days after the filing of the certificate of merit.<sup>45</sup> Maynard said the 2001 MPLA is clear, and the Supreme Court should have upheld the dismissal of

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<sup>40</sup> *Bernard Boggs, as administrator of the estate of Hilda Boggs v. Camden-Clark Memorial Hospital*. 609 S.E.2d 917 (W.Va. 2004).

<sup>41</sup> *Ibid.*

<sup>42</sup> Black's Law Dictionary, 6<sup>th</sup> edition.

<sup>43</sup> *Boggs v. Camden-Clark* (2004).

<sup>44</sup> West Virginia Rules of Civil Procedure, Rule 15.

<sup>45</sup> *State ex rel. Miller v. Stone*, 216 W. Va. 379, 607 S.E.2d 485 (2004).

Boggs' claim. Forcing him to re-file his case and have it adjudicated under the 2003 MPLA would not have been any injustice to his claims.<sup>46</sup> Interested parties such as the West Virginia State Medical Association said even though the plaintiff prevailed on appeal, the fact that the Supreme Court did not strike down the MPLA or even entertain a constitutional analysis was a positive step in changing West Virginia's medical liability landscape.

### ***Louk v. Cormier***

The 2001 MPLA did not fare so well in 2005, however, when the Supreme Court ruled in *Louk v. Cormier* that the 12-member jury provision was "enacted in violation of the Separation of Powers Clause, Article V, §1 of the West Virginia Constitution, insofar as the statute addresses procedural litigation matters that are regulated exclusively by this Court pursuant to the Rule-Making Clause, Article VIII, §3 of the West Virginia Constitution. Consequently, W.Va. Code §55-7B-6d, in its entirety, is unconstitutional and unenforceable."<sup>47</sup>

Rita Louk sued her surgeon, Dr. Serge Cormier, after a 2000 hysterectomy that resulted in perforation of Louk's cecum, which caused her assorted health problems and required an additional exploratory surgery. Louk filed a medical malpractice lawsuit against Cormier in 2002. At trial before a 12-person jury, 10 of the 12 jurors returned a verdict in favor of Cormier. Under the 2001 MPLA, only nine jurors were needed to constitute a majority. Louk then filed a post-trial motion seeking a new trial, arguing the non-unanimous verdict instruction authorized by a provision in the 2001 MPLA was unconstitutional. The circuit court denied her petition, and Louk appealed to the Supreme Court.

In a 4-1 verdict, the Supreme Court addressed Louk's separation of powers and rule-making argument.<sup>48</sup> The Court historically has invalidated statutes that conflicted with rules promulgated by the Supreme Court, and *Louk v. Cormier* was no different. The high court agreed with Louk that the 2001 MPLA's non-unanimous verdict provision conflicts with Rule 48 of the West Virginia Rules of Civil Procedure, which "provides only one method by which a jury may return a non-unanimous verdict, i.e., through a stipulation by the parties. ... The non-unanimous verdict provision ... has stripped litigants of a right granted to them by this Court under our constitutional authority. The Legislature cannot remove that which was not in its power to give."<sup>49</sup> The Supreme Court reversed the lower court and ordered a new trial, renewing the previous rule that medical malpractice cases were to be decided by a unanimous six-member jury.

Justice Maynard's dissent illustrated his displeasure with the majority: "By ruling that this Court, simply by its own judge-made rules, can strike down a statute passed by the entire legislature is sobering indeed!"<sup>50</sup> He said the majority not only had invalidated important MPLA provisions, but it also showed how the Supreme Court has the power to invalidate any part of the MPLA simply by saying the statute conflicts with an existing court rule.

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<sup>46</sup> *Boggs v. Camden-Clark* (2004) (Maynard dissenting, filed Dec. 8, 2004).

<sup>47</sup> *Louk v. Cormier*. 622 S.E.2d 788 (W.Va. 2005), syllabus point 3.

<sup>48</sup> The Rule-Making Clause of Article VIII, section 3, provides, in relevant part, that the Supreme Court "shall have power to promulgate rules for all cases and proceedings, civil and criminal, for all of the courts of the state relating to writs, warrants, process practice and procedure, which shall have the force and effect of law."

<sup>49</sup> *Louk v. Cormier* (2005).

<sup>50</sup> *Ibid*, (Maynard dissenting, filed July 11, 2005).

***Hinchman v. Gillette***

Regardless of Maynard's disagreement with the majority, the trend of chipping away at the 2001 MPLA continued in 2005 when the Supreme Court ruled in *Hinchman v. Gillette* that failing to follow strictly the pre-suit filing requirements cannot prevent a person from bringing a claim. Paul Hinchman died in 2003 after sedation for a biopsy surgery, and his wife sued the nurse, doctors and hospital for wrongful death due to medical negligence. The circuit court dismissed Hinchman's claims on the grounds the pre-suit notice of claim and certificate of merit were legally defective and deficient.

In reversing the lower court, however, the Supreme Court ruled "the purposes of requiring a pre-suit notice of claim and screening certificate of merit are (1) to prevent the making and filing of frivolous medical malpractice claims and lawsuits; and (2) to promote the pre-suit resolution of non-frivolous medical malpractice claims. The requirement of a pre-suit notice of claim and screening certificate of merit is not intended to restrict or deny citizens' access to the courts."<sup>51</sup>

Although the Court declined the chance to take up the constitutionality of the pre-suit requirements, the majority found certain details of Hinchman's claims that gave the justices reason to find fault with a strict application of the 2001 MPLA pre-suit requirements. The defendants had the opportunity to make known what the problems with Hinchman's notice and certificate of merit were, rather than waiting to move for a dismissal of the lawsuit. "...[A] principal consideration before a court reviewing a claim of insufficiency of notice or certificate should be whether a party challenging or defending the sufficiency of a notice and certificate has demonstrated a good faith and reasonable effort to further the statutory purposes."<sup>52</sup>

Those statutory purposes are enumerated in the MPLA as providing a chance for the opposing parties to mediate and possibly resolve their dispute before a lawsuit is filed. Since none of the defendants made the notice and certificate defects known in a timely manner, the Supreme Court said their silence constituted a waiver of that chance to mediate, and it also prevented the plaintiff from correcting the mistakes. "Whatever technical insufficiencies the appellant's notice and certificate in the instant case arguably have had, it strains common sense to assert that the notice and certificate support any contention that the appellant's claims were frivolous."<sup>53</sup>

While the majority opinion did not make a constitutional argument against those provisions of the 2001 MPLA, Justice Davis' detailed concurrence made it clear where she stands on the issue. She concurred in the result, but she said the majority opinion should have reversed the case on different grounds. Davis said she believes the certificate of merit requirement violates the separation of powers/rule-making clauses and the certain remedy clauses of the West Virginia Constitution.<sup>54</sup>

Davis used the court's findings in *Louk* to explain the conflict between the MPLA and Rule 48 (non-unanimous jury instruction). She said a constitutionally delegated power vested in one branch of government, in this case the judiciary, cannot be infringed upon by another, the legislature. "Promulgation of rules governing litigation in the courts of this state rests

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<sup>51</sup> *Hinchman v. Gillette*. 618 S.E.2d 387 (W.Va. 2005), syllabus point 2.

<sup>52</sup> *Ibid*, syllabus point 6.

<sup>53</sup> *Ibid*, footnote 6.

<sup>54</sup> *Ibid*, (Davis concurring, filed July 8, 2005).

exclusively with this Court.”<sup>55</sup> She said the certificate of merit is a procedural law, and only the Supreme Court has the authority to set litigation procedures.

Maynard voiced his disagreement once again, this time sounding a warning bell to the medical community in the first sentence of his dissent in *Hinchman v. Gillette*: “The majority opinion may result in the complete gutting of a portion of the 2001 medical malpractice reforms.”<sup>56</sup> Maynard said the MPLA is clear, and if a plaintiff fails to provide a certificate of merit in the manner prescribed by statute, the circuit court is correct to dismiss the case immediately. “The majority’s reversal and remand indicates to me that the statute requiring pre-certificates of merit may be rendered essentially meaningless,” Maynard said, adding that plaintiffs will have no motivation to be thorough with their certificates now, and the goals for requiring them may not be met.

In contrast to Davis, Maynard said he believes those requirements of the 2001 MPLA are constitutional and do not infringe on the Supreme Court’s rulemaking power or the separation of powers doctrine. “Our Rules of Civil Procedure ‘govern the procedure in all trial courts of record in all actions, suits, or other judicial proceedings of a civil nature.’ According to Rule of Civil Procedure 3(a), ‘(a) civil action is commenced by filing a complaint with the court.’” Thus, Maynard said, the Supreme Court rules do not govern a pre-filing certificate of merit because the certificate is filed before the lawsuit actually is filed. “Hence (it) is a legitimate addition to the substantive law of this State.”<sup>57</sup>

## THE MPLA LANDSCAPE IN 2005 AND BEYOND

Since 2005, the Supreme Court has had the opportunity to underscore its position on pre-suit notification, certificate of merit and 12-member jury requirements from the 2001 MPLA.

In November 2005, the Supreme Court affirmed its holdings from the *Boggs* and *Hinchman* decisions in *Gray v. Mena*.<sup>58</sup> In March 2006, the court again affirmed *Hinchman* in *Roy v. D’Amato*, and made similar findings in *Elmore v. Triad Hospitals* and *Davis v. Mound View*.<sup>59,60</sup>

In June 2006 the court affirmed its findings in *Louk* in *Richmond v. Levin*.<sup>61,62</sup> In the *Richmond* case, in fact, the Supreme Court not only reaffirmed that the 12-member jury requirement and non-unanimous verdict were unconstitutional, it allowed that opinion to apply retroactively to any medical malpractice case that was pending when the *Louk* opinion was released and that later resulted in a non-unanimous verdict. Any case that meets that description now may be retried.

When deciding how far the MPLA reaches, the Supreme Court has defined who or what falls under the protections. In *Phillips v. Larry’s Pharmacy* (2007), the Court ruled that pharmacies are not health care providers under the definition in the MPLA. In doing so, the

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<sup>55</sup> *Ibid.*

<sup>56</sup> *Ibid.*, (Maynard concurring in part and dissenting in part, filed July 11, 2005).

<sup>57</sup> *Ibid.*

<sup>58</sup> *Gray v. Mena*. 625 S.E.2d 326 (W.Va. 2006).

<sup>59</sup> *Elmore v. Triad Hospitals*. 640 S.E.2d 217 (W.Va. 2006).

<sup>60</sup> *Davis v. Mound View Health Care Inc.* 640 S.E.2d 91 (W.Va. 2006).

<sup>61</sup> *Roy v. D’Amato*. 629 S.E.2d 751 (W.Va. 2006).

<sup>62</sup> *Richmond v. Levin*. 637 S.E.2d 610 (W.Va. 2006).

Court neutered the language “including, but not limited to” in the definition of health care provider and said only entities specifically listed are covered.<sup>63</sup>

The *Boggs* and *Gray* decisions about the pre-suit filing requirements were clarified further in 2007 in *Blankenship v. Ethicon*.<sup>64</sup> In this opinion, the Court said the MPLA applies to any tort or breach of contract claim based on health care services rendered, even if those claims are not initially filed under the MPLA. Intentional acts, however, are not covered by the Act. Even more recently, the *per curiam* opinion in *Westmoreland v. Vaidya* underscored the Court’s posture in *Hinchman*, *Gray* and *Blankenship* regarding pre-suit filing requirements, making it clear that a required notification and certificate of merit cannot prevent a plaintiff from bringing a medical malpractice claim.<sup>65</sup>

## CONCLUSION

West Virginia’s health care delivery system always will be challenged by the state’s economic condition, its topography and a host of other factors that are difficult for policymakers to address. But when the system was pushed to the breaking point several years ago because physicians could not find or afford medical liability insurance coverage, lawmakers were able to take action, and the results thus far show success.

The medical community sees improvement in how insurance carriers are performing, claims statistics, the rate of physician licensure in the state and insurance rate filings. As a result, access to health care professionals has improved in West Virginia, but all of this progress could vanish if the Supreme Court strikes down major provisions of the Medical Professional Liability Act.

The Supreme Court already has stricken one of the 2001 MPLA provisions as unconstitutional — the 12-member jury with a non-unanimous verdict. The court also has weakened substantially the pre-suit notification and screening certificate of merit requirements, favoring the plaintiff’s right to bring a cause of action over the legislative intent of whittling down frivolous lawsuits.

The \$250,000 noneconomic damage cap has not yet been decided in the high court, and while case law indicates the cap may have a fair chance at passing constitutional muster, the future does not look so bright for some of the other procedural requirements of the MPLA. In several cases now, the Supreme Court has said procedural details cannot take precedent over a person’s right to seek a remedy in court. Whether that trend carries over into what Justice Maynard cautioned against — a gutting of the MPLA — remains to be seen. The medical liability environment is improving, but ultimately, the West Virginia Supreme Court of Appeals will write the final chapter in this ever-evolving saga.

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<sup>63</sup> *Phillips v. Larry’s Drive-In Pharmacy Inc.* 647 S.E.2d 920(W.Va. 2007).

<sup>64</sup> *Blankenship v. Ethicon*, 656 S.E.2d 451 (W.Va., 2007).

<sup>65</sup> *Westmoreland v. Vaidya*, 664 S.E.2d 90 (W.Va. 2008).

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