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Annual Survey of Virginia Law: Health Care Law

Steven D. Gravely

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HEALTH CARE LAW

Steven D. Gravely*

I. OVERVIEW AND INTRODUCTION

The health care industry, known for its dynamics and constant change, lived up to its reputation throughout 1987 and early 1988. Continuing concern for the cost of hospital and physician services, availability of adequate health care services for the elderly, and the impact of the AIDS virus on health care delivery contributed to make this period a tumultuous one for the health care industry nationwide. Virginia was not spared the tumult. This article focuses on key legislative, regulatory, and judicial events of the past year, and evaluates their impact on the business of providing health care in the Commonwealth.¹

II. CERTIFICATE OF PUBLIC NEED

The Certificate of Public Need (CON) statute² creates a regulatory framework through which substantial capital expenditures associated with the provision of health care services must be approved by the State Health Commissioner. Simply stated, the CON statute requires administrative agency approval of any "project"³ undertaken by a "medical care facility."⁴ A party wishing to

* Associate, Mezzullo, McCandlish & Framme, P.C. Mr. Gravely specializes in health care law and litigation; B.A., 1977, College of William and Mary; M.H.A., 1980, Medical College of Virginia; J.D., 1983, T.C. Williams School of Law, University of Richmond.

1. Developments in the area of medical malpractice and tort reform are dealt with in another portion of the Annual Survey of Virginia Law. See Schockemoehl, *Medical Negligence: Annual Survey of Virginia Law*, 22 U. RICH. L. REV. 717 (1988).

2. VA. CODE ANN. §§ 32.1-102.1 to -122.4 (Repl. Vol. 1985 & Cum. Supp. 1988). The CON law is administered by the State Department of Health pursuant to the statute and extensive regulations promulgated by the State Board of Health. See RULES AND REGULATIONS OF THE BOARD OF HEALTH, COMMONWEALTH OF VIRGINIA, VIRGINIA MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED (effective January 22, 1986) [hereinafter CON REGULATIONS] 2 Va. Regs. Reg. 702 (1985).

3. "Project" is defined to include the introduction of a new health care service which has not been provided during the past twelve months or a capital expenditure in excess of \$600,000 the purpose of which is to add hospital beds, acquire equipment or facilities. VA. CODE ANN. § 32.1-102.1 (Repl. Vol. 1985).

4. "Medical Care Facility" is broadly defined to include virtually any facility in which health care services are provided. Physicians' offices are specifically excluded from this defi-

undertake a project subject to CON review must submit a written application to the State Department of Health. If necessary, administrative hearings are held to permit the applicant an opportunity to justify the need for the project.⁵ The State Health Commissioner is authorized to seek an injunction against any medical care facility which undertakes a project without first obtaining either certificate of need approval or exemption from the process.⁶

The process of obtaining a certificate of need has long been intensely adversarial, with competitors bidding for regulatory approval to provide services. Judicial challenges to CON decisions are frequent. During 1987 and early 1988, the courts continued to grapple with legal challenges to CON administrative decisions. In addition, the Virginia General Assembly saw substantial activity during the 1988 session relative to CON issues.

A. *Legislative Activity*

The Governor's Commission on Medical Care Facilities Certificate of Public Need report, issued December 1, 1987, was the culmination of an extensive study of Virginia's CON system.⁷ The

tion except where the physicians' office is attempting to acquire equipment on behalf of a hospital or other medical care facility which would otherwise be subject to CON review. Clinical laboratories are also excluded from this definition if they are independent of physicians' offices and hospitals and certified as independent laboratories under Title XVIII of the Social Security Act. *Id.*

5. The administrative procedures applicable to filing for a certificate of need are set out in § 32.1-102.6. VA. CODE ANN. § 32.1-102.6 (Repl. Vol. 1985). *See also* CON REGULATIONS, 2 Va. Regs. Reg. 709-711 (parts VI and VII).

6. The Code specifically authorizes the Commissioner, the State Board of Health or the Attorney General to request the appropriate circuit court to issue an injunction against any "project which is constructed, undertaken or commenced without a certificate or to enjoin the admission of patients to the project or to enjoin the provision of services through the project." VA. CODE ANN. § 32.1-102.8 (Repl. Vol. 1985).

7. The purpose of the CON study commission was to evaluate the continued necessity of CON review and to suggest reforms to the system. The CON study commission was created by the Governor in 1986 as an adjunct to a study of indigent health care issues commissioned by the 1986 General Assembly. *See* S.J. Res. 32, 1986 Va. Acts 2070 (continued by S.J. Res. 151, 1987 Va. Acts 1822). "Indigent care" refers to the provision of health care services for individuals who are "medically indigent." In addition to the unemployed, the term "medical indigence" includes a large number of working individuals who are not eligible to participate in health insurance programs and who, for a variety of reasons, are unable to afford needed health care. Some of these patients are covered by the Medicaid program created pursuant to Title XIX of the Social Security Act, administered by the Virginia Department of Medical Assistance. Other persons are without any type of coverage whatsoever. The provision of indigent care, which is either wholly uncompensated or subject to the Medicaid payment restrictions, creates a substantial financial burden on Virginia hospitals. This burden is particularly serious for certain hospitals in the Commonwealth which have a

Commission recommended that the CON system be retained, but that the number and type of projects that qualify for exemption from CON review be dramatically expanded. Only the most significant of capital expenditures, such as the construction of a new hospital or nursing home, would continue to be subject to CON review.

During the 1988 session of the General Assembly, the issue of CON reform became inextricably tied to indigent care concerns.⁸ Modification of CON law became linked with an initiative from the Administrator. This initiative proposed a funding mechanism through Virginia's hospitals and nursing homes designed to stabilize Virginia's Medicaid program.⁹

The Administration's initiative was vigorously opposed by hospital industry representatives and did not obtain sufficient support to carry it forward. The Administration responded by proposing a two-year moratorium on the issuance of any certificate of need by the State Health Commissioner. The Administration's moratorium concept was eventually enacted by the 1988 General Assembly as part of the Appropriations Act (the Act).¹⁰ The version of the Act passed by the General Assembly imposed a one-year moratorium, from July 1, 1988, on the issuance of certificates of public need except in limited circumstances.¹¹

The more significant categories of exemption from the moratorium are: projects necessary for compliance with applicable life safety codes, licensure and certification, or accreditation standards; projects which meet "a clearly demonstrated emergency public health need;" the renovation or replacement of existing equipment necessitated by equipment failure or obsolescence; a project providing "innovative technologies of proven significance" not readily

disproportionately high concentration of Medicaid eligible or other indigent patients.

8. See *supra* note 7.

9. The administration's initiative would have created an initial license application fee of \$250,000 per 100 beds for hospitals and nursing homes, and would have applied to new facilities seeking licensure for the first time. In addition, license renewal fees for all hospitals and nursing homes would have been increased to \$1 per bed per calendar day for nursing homes and \$5 per bed per calendar day for hospitals. The administration proposed that \$1 of the \$5 hospital license renewal fee be placed in a special trust fund for hospital indigent care, with the remainder of the monies raised by license fees placed in the general fund. In addition, the initiative proposed a CON application fee designed to fund the CON program.

10. Act of April 11, 1988, ch. 800, 1988 Va. Acts 1426.

11. *Id.* The language in the Act provides that on or after July 1, 1988, and prior to June 30, 1989, the Commissioner of Health shall not approve or authorize the issuance of any certificate of need except as specifically provided for in the Act.

accessible to citizens of the Commonwealth; and, projects of a "nonclinical nature" such as parking lots.¹² Aside from the exemptions specifically included in the Act, the one-year moratorium is absolute.¹³

The Department of Health has issued guidelines to govern the implementation of the CON moratorium.¹⁴ A memorandum issued by the Department clarified that projects exempt from CON review under part 5 of the CON Regulations were exempt from the moratorium as well.¹⁵ Since the moratorium expires on June 30, 1989, the Department of Health begins review of CON applications again on March 1, 1989, for decision by the State Health Commissioner on or after July 1, 1989.

The problem of indigent care will continue to be studied during the moratorium. A joint subcommittee was created by the 1988 General Assembly to study methods of financing health care for low income persons in Virginia, including long term health care.¹⁶ The efforts of the joint subcommittee will more than likely result in a legislative initiative relating to both CON and indigent care concerns.

12. Other categories of exemption include: projects required to comply with research grants sponsored by the Federal government or biomedical research agencies; projects funded by charitable contributions from donors unaffiliated with the medical care facility, its parent or any subsidiary; projects which clearly demonstrate that they will significantly reduce health care costs through merger, consolidation or reconfiguration; and, projects required by the General Assembly pursuant to the Appropriations Act. *Id.*

13. It is important to note that exemption from the CON moratorium does not assure administrative approval of a project. The applicant must still submit a written application and be reviewed for need against the appropriate health plans and statutory review criteria. *Id.*

14. See Memorandum from Marilyn H. West, Director, Division of Resources Development, Department of Health, April 22, 1988 (regarding implementation of CON moratorium).

15. Pursuant to part five of the CON Regulations, certain types of projects are exempt from CON review although a CON is still required to be issued by the Department. CON REGULATIONS § 5.1, 2 Va. Regs. Reg. 708 (1985). The practical effect of exemption from review means that an applicant can pursue a project without being subject to the administrative review process. Projects exempt from review include those which involve a capital expenditure of less than \$700,000, (except where specialized equipment or services, such as CT scanning, open heart, cardiac cath, or radiation therapy are acquired). In addition, replacements of operational equipment such as nurse call systems, material management, and heating and air conditioning systems are exempt from CON review if they involve a capital expenditure of less than \$1.5 million. *Id.*

16. See H.J. Res. 78, 1988 Va. Acts 2134; S.J. Res. 99, 1988 Va. Acts 2358. The joint subcommittee consists of 17 members, including five members from the House of Delegates, four members from the Senate, six citizen members and two representatives of state agencies.

B. *Judicial Decisions-Scope of Review*

Three recent decisions by the Virginia Court of Appeals regarding judicial review of CON decisions have helped refine the law in Virginia on this point.¹⁷

In *Roanoke Memorial Hospitals v. Kenley*,¹⁸ the court of appeals upheld the State Health Commissioner's decision denying Roanoke Memorial's challenge of a CON award to a competing hospital.¹⁹ In *Roanoke Memorial*, Lewis Gale Hospital, Inc. filed a CON application seeking authority to construct a radiation therapy suite. Roanoke Memorial sought standing to participate in the CON review process as a party demonstrating "good cause."²⁰ The Commissioner issued a CON to Lewis Gale Hospital, contrary to the recommendation of the Southwest Virginia Health Systems Agency Board and the staff of the Department of Health.²¹ The Commissioner also denied Roanoke Memorial's request for standing as a party demonstrating "good cause." Roanoke Memorial objected to the Commissioner's decision and appealed to the circuit court.²²

17. The court of appeals has appellate jurisdiction over administrative agency appeals pursuant to VA. CODE ANN. § 17-116.05 (Repl. Vol. 1988). The Virginia Supreme Court will no longer hear appeals regarding administrative agency decisions, and therefore, the decisions of the court of appeals are controlling authority for these matters.

18. 3 Va. App. 599, 352 S.E.2d 525 (1987).

19. See *id.* at 608-11, 352 S.E.2d at 530-32. Certain parties may seek to participate in the administrative review process of a CON application as "parties demonstrating good cause." See VA. CODE ANN. § 32.1-102.6(E) (Repl. Vol. 1985). "Good cause" means that "(i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health systems agency." *Id.*

20. A party seeking "good cause" standing is entitled to participate in administrative hearings and present evidence in opposition to an application, under current Department of Health procedures. CON REGULATIONS § 9.2(A), 2 Va. Regs. Reg. 713.

21. *Roanoke Memorial*, 3 Va. App. at 601, 352 S.E.2d at 526. The staff of the Department of Resources and Development analyzes each CON application and prepares a staff report. This report is presented to the applicant and other interested persons and serves as a recommendation to the hearing officer that presides over the fact-finding conference. In portions of the Commonwealth where Health Systems Agencies (HSA) still exist, the HSA also makes a recommendation on a project which becomes a part of the administrative record. Following the informal fact-finding conference, the hearing officer makes a formal recommendation to the State Health Commissioner which takes into account the state staff's recommendation and evidence presented at the conference. The State Health Commissioner issues the case decision on the CON application based on this record. See CON REGULATIONS § 7.10, 2 Va. Regs. Reg. 711.

22. *Roanoke Memorial*, 3 Va. App. at 601, 352 S.E.2d at 526. The Commissioner's deci-

Roanoke Memorial contended that the Commissioner had improperly ignored provisions of the State Health Plan (SHP) and the State Medical Facilities Plan (SMFP) in evaluating the Lewis Gale application.²³ According to Roanoke Memorial, both of these plans indicated a lack of need for additional radiation therapy services in the area. Since the record did not reflect a determination by the Commissioner that the provisions of the SHP or the SMFP were not applicable, Roanoke Memorial argued that the Commissioner was obligated to reach a decision consistent with these plans and deny the CON.²⁴ Roanoke Memorial argued that the Commissioner's failure to follow the applicable health plans, or to set them aside, was an abuse of his discretion which constituted an error of law requiring reversal or remand. The circuit court ruled that Roanoke Memorial had failed to demonstrate an error of law on the part of the Commissioner and upheld his decision.²⁵ The court held that the provisions of the applicable health plans were flexible and permitted discretion by the Commissioner in their application.²⁶ The court found substantial evidence in the record to support the Commissioner's interpretation of the health plans and the need for the Lewis Gale project.²⁷

On appeal, Roanoke Memorial asserted that the circuit court had failed to apply the appropriate standard of review to the Commissioner's decision.²⁸ Roanoke Memorial argued that the Commis-

sion regarding a party's request to be granted standing to participate as a party demonstrating "good cause" is a "case decision" as defined under the Virginia Administrative Process Act. VA. CODE ANN. § 9-6.14:4(D) (Repl. Vol. 1985). These case decisions are subject to judicial review. VA. CODE ANN. § 9-6.14:16 (Repl. Vol. 1985). Appeals of administrative decisions are taken to circuit court for initial review. VA. SUP. CT. R. 2A.

23. *Roanoke Memorial Hosp. v. Kenley*, 5 Va. Cir. 277, 280 (Salem County 1985), *aff'd*, 3 Va. App. 599, 352 S.E.2d 525 (1987). The State Health Plan and State Medical Facilities Plan are documents prepared by the State Board of Health. The State Health Plan is a five-year planning document which deals with the health needs of the citizens of the Commonwealth. The State Medical Facilities Plan, which is updated annually by the Board of Health staff, maintains current inventories of health care services as well as numerical projection methodologies by which the need for additional services are evaluated. Pursuant to the provisions of § 32.1-102.3(A) of the Code of Virginia, the Commissioner's decision to issue a certificate of need "shall be consistent with the most recent applicable provisions of the State Health Plan and the State Medical Facilities Plan," unless the Commissioner finds that the provisions of either plan are "inaccurate, outdated, inadequate or otherwise inapplicable." VA. CODE ANN. § 32.1-102.3(A) (Repl. Vol. 1985).

24. *Roanoke Memorial*, 5 Va. Cir. at 279.

25. *Id.*

26. *Id.* at 282.

27. *Id.* at 280-82.

28. *Roanoke Memorial*, 3 Va. App. at 608, 352 S.E.2d at 530. Judicial review of administrative agency decisions is governed by the Virginia Administrative Process Act contained in

sioner's refusal to follow the literal provisions of the applicable plans or, alternatively to set them aside, constituted an error of law subject to de novo review, not a question of fact subject to the substantial evidence standard. The appellate court upheld the trial court's ruling that the Commissioner enjoyed discretion in interpreting the applicable health plans, and that his interpretation in this case was supported by the record.²⁹

The court of appeals also rejected Roanoke Memorial's contention that by evaluating the factual basis for the Commissioner's decision, the circuit court had erroneously substituted its own judgment for that of the Commissioner.³⁰ The appellate court found specifically that the trial court was correct in considering whether, as a matter of law, there was substantial evidence in the record to support the Commissioner's decision. If such substantial evidence existed, the trial court was without authority to overturn that decision, absent a clear error of law. The court held that Roanoke Memorial had failed to prove such error.³¹ The *Roanoke Memorial* decision is consistent with the long line of Virginia decisions granting deference to administrative agency action, and underscores the difficulty of successfully challenging agency decisions.³²

In *Bio-Medical Applications of Arlington, Inc. v. Kenley*,³³ the Virginia Court of Appeals considered the procedures required for the review of CON applications where several parties seek to establish the same or similar services. Bio-Medical submitted a CON application to double the size of its existing kidney dialysis facility in Arlington County. At approximately the same time, five other

VA. CODE ANN. §§ 9-6.14:1 to -6.14:25 (Repl. Vol. 1985 & Cum. Supp. 1988). Section 9-6.14:17 provides that a party complaining of an agency decision shall have the burden of demonstrating an "error of law." "Errors of law" are defined by § 9-6.14:17 to include: (i) accordance with constitutional right; (ii) compliance with statutory authority, jurisdiction limitations, or right; (iii) observance of required procedures; and, (iv) the substantiality of the evidential support in the record for findings of fact.

29. *Roanoke Memorial*, 3 Va. App. at 610, 352 S.E.2d at 531-32.

30. *Id.* at 610, 352 S.E.2d at 530.

31. *Id.* (citing Virginia Real Estate Comm'n v. Bias, 226 Va. 264, 308 S.E.2d 123 (1983)). The substantial evidence standard has been construed by Virginia courts to mean that a reviewing court may reject the factual findings of an administrative agency "only if considering the record as a whole, a reasonable mind would necessarily come to a different conclusion." *Id.* at 269, 308 S.E.2d at 125 (quoting B. MEZINES, ADMINISTRATIVE LAW § 51.01 (1981) (emphasis in original)). The substantial evidence standard represents a considerable barrier to the successful challenge of administrative agency determinations.

32. See, e.g., *Bias*, 226 Va. 264, 308 S.E.2d 123.

33. 4 Va. App. 414, 358 S.E.2d 722 (1987).

CON applications were filed proposing the development of new dialysis facilities and the expansion of existing facilities in Northern Virginia. The regulations in effect at the time allowed all six applications to be evaluated simultaneously.³⁴ The Commission ultimately awarded a CON to another applicant and denied Bio-Medical's application. On appeal, the circuit court affirmed the Commissioner's decision.³⁵

Bio-Medical presented the court of appeals with two assignments of error. First, Bio-Medical argued that it had been denied a comparative hearing with the other applicants and therefore, was deprived of due process.³⁶ Second, there was not substantial evidence in the record to justify the Commissioner's decision.³⁷ The court ruled that the review process followed by the Commissioner was sufficiently comparative to meet the due process standards set forth by the United States Supreme Court in *Ashbacker Radio Corp. v. FCC*.³⁸

The court of appeals distinguished the instant case from *Ashbacker* on the grounds that the Commissioner did not make an award to one of the applicants prior to affording a hearing to the others.³⁹ Rather, all six applications were considered simultaneously by him.⁴⁰ Although the Commissioner issued individual case decisions on each of the applications, the decisions reflected a comparative process in which the relative merits of each project were evaluated in terms of the needs of the Northern Virginia population.⁴¹ The court rejected Bio-Medical's argument that *Ashbacker* required a consolidated comparative hearing among all competing applications and ruled that *Ashbacker* did not impose any particular method for insuring that mutually exclusive applications be

34. *Id.* at 423, 358 S.E.2d at 727. Under current regulations, CON applications for the same or similar services within the same geographic area, which are submitted to the Department of Health for the same review cycle or are submitted within a roughly contemporaneous 30 day period of each other, are deemed to be "competing applications." As competing applications, the projects are automatically reviewed simultaneously and are evaluated on a comparative basis.

35. *Id.* at 416-18, 358 S.E.2d at 724-26.

36. *Id.* at 421, 358 S.E.2d at 726.

37. *Id.* at 426, 358 S.E.2d at 729.

38. 326 U.S. 327 (1945). *Ashbacker* involved a dispute between competing applicants for a license to operate a radio station. The Supreme Court ruled that where two applications for a public license are deemed to be mutually exclusive, a reviewing authority must provide an opportunity for a comparative hearing. *Id.* at 327-28, 333.

39. *Bio-Medical Applications of Arlington, Inc.*, 4 Va. App. at 423, 358 S.E.2d at 727.

40. *Id.* at 423, 358 S.E.2d at 727.

41. *Id.*

given a comparative review.⁴² The court adopted the interpretation of *Ashbacher* advanced by other courts: the *Ashbacher* rule should provide fairness in a comparative consideration, but it must also be applied pragmatically, on a case-by-case basis.⁴³

The court similarly rejected Bio-Medical's argument that there was not substantial evidence in the record to support the Commissioner's denial of its CON application. Citing *State Board of Health v. Godfrey*,⁴⁴ the court reaffirmed that the appropriate inquiry of an administrative agency determination "is limited to whether there was 'substantial evidence in the agency record' to support the decision".⁴⁵ On the basis of the whole record, the *Bio-Medical* court held that there was no evidence in the record which would lead a reasonable mind to necessarily come to a conclusion different than that reached by the Commissioner. Therefore, the trial court properly applied the substantial evidence standard in upholding the Commissioner's decision.⁴⁶

Although factual determinations by an agency are entitled to great deference by the courts,⁴⁷ there is often a question as to whether a particular issue is factual, legal, or a mixed question of fact and law. As a general rule, questions of law are not entitled to any special deference, whereas questions of fact are. In a very recent decision, the Virginia Court of Appeals addressed this issue in upholding the State Health Commissioner's decision to deny a CON certificate to Johnston-Willis Hospital in Richmond, Virginia.⁴⁸

42. *Id.* at 424-25, 358 S.E.2d at 728.

43. *Id.* (citing *Delta Airlines v. Civil Aeronautics Bd.*, 497 F.2d 608, 612-13 (D.C. Cir. 1973), *cert. denied*, 417 U.S. 930 (1974)).

44. 223 Va. 423, 290 S.E.2d 875 (1982).

45. *Bio-Medical Applications of Arlington, Inc.*, 4 Va. App. at 427, 358 S.E.2d at 729 (quoting *State Bd. of Health v. Godfrey*, 223 Va. at 433, 290 S.E.2d at 879-80).

46. *See id.* at 426-29, 358 S.E.2d at 729-30.

47. *See* VA. CODE ANN. § 9-6.14:17 (Repl. Vol. 1985) ([I]n the context of factual issues, the reviewing court shall take due account of the presumption of official regularity."); *see also* *Virginia Real Estate Comm'n v. Bias*, 226 Va. 264, 269, 308 S.E.2d 123, 125 (1983); *Johnston-Willis, Ltd. v. Kenley*, 6 Va. App. 231, 243, 369 S.E.2d 1, 7 (1988) (citing *Hi-Craft v. NLRB*, 660 F.2d 910, 912-15 (3d Cir. 1981)).

48. *Johnston-Willis, Ltd. v. Kenley*, 6 Va. App. 231, 369 S.E.2d 1. The hospital applied for a certificate of need to expand its outpatient surgery program and to add obstetrical beds to its existing facility in Chesterfield County, Virginia. The Board of Directors of the local Health Systems Agency recommended approval of the application in order to correct a perceived maldistribution of obstetrical beds in the Chesterfield County portion of Planning District 15. The State Staff recommended denial of the application on the basis that there was no numerical need for additional obstetrical beds in the planning district, according to

Johnston-Willis challenged the Commissioner's denial of the portion of its CON application seeking to develop an obstetrical service through additional acute care beds. The hospital argued that the Commissioner erred in relying upon the current SMFP since it was inadequate, outdated and failed to take into account the need for beds to be distributed throughout the planning district.⁴⁹ The hospital also challenged the Commissioner's insistence that obstetrical units in other area hospitals should operate at a minimum occupancy prior to approval of additional OB beds.⁵⁰ Finally, the hospital claimed that the Commissioner's denial of its application was not supported by substantial evidence.⁵¹ The trial court reversed the Commissioner's decision to deny Johnston-Willis a CON certificate to reorganize its outpatient surgery program, but affirmed that portion of the Commissioner's decision which denied Johnston-Willis' request to add obstetrics beds.⁵²

The *Johnston-Willis* court cited the longstanding rule that factual determinations made by an administrative agency are entitled to great deference and a presumption of regularity.⁵³ The court discussed at length, however, the distinction between such factual determinations and errors of law which must be vigorously analyzed by a reviewing court.⁵⁴ The court noted that even where there is substantial evidence in the record to support the decision, an agency's determination must be reversed if the reviewing court determines that the agency failed to observe the required procedures or comply with the applicable statutory authority.⁵⁵ The court concluded that the degree of deference, and conversely the rigor of judicial review, is a direct function of the nature of the issue before the court:

the State Medical Facilities Plan. Following an informal fact-finding conference, the Commissioner denied the CON application. *Id.* at 236-41, 369 S.E.2d at 3-6.

49. *Id.* at 254-56, 369 S.E.2d at 13-14.

50. *Id.* at 257, 369 S.E.2d at 15.

51. *Id.* at 262, 369 S.E.2d at 18.

52. *Id.* at 265-67, 369 S.E.2d at 20-21. The circuit court ruled that Johnston Willis had failed to carry its burden that there was not substantial evidence in the record to support the Commissioner's decision to deny the new obstetrical service. The court stated that "the Commissioner's decision was supported by such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* at 267, 369 S.E.2d at 21.

53. *See supra* note 46.

54. 6 Va. App. at 241-46, 369 S.E.2d at 6-9.

55. *See id.* at 246, 369 S.E.2d at 9.

Where the issue is whether there is substantial evidence to support findings of fact, great deference is to be accorded the agency decision. Where the issue falls outside the specialized competence of the agency, such as constitutional and statutory interpretation issues, little deference is required to be accorded the agency decision. Where, however, the issue concerns an agency decision based on the proper application of its expert discretion, the reviewing court will not substitute its own independent judgment for that of the agency but rather will reverse the agency decision only if that decision was arbitrary and capricious. Finally, in reviewing an agency decision, the courts are required to consider the experience and specialized competence of the agency and the purposes of the basic law under which the agency acted.⁵⁶

The court rejected Johnston-Willis' argument that the 1984 SMFP was not properly promulgated pursuant to the Virginia Administrative Process Act and therefore, could not be relied upon by the Commissioner.⁵⁷ The court agreed with Johnston-Willis that the legal validity of its 1984 SMFP was a legal question, and therefore, any decision by the Commissioner regarding the legal status of the 1984 SMFP was not entitled to judicial deference.⁵⁸ However, the court held that the portion of the SMFP upon which the Commissioner had relied was properly promulgated and that any error was harmless.⁵⁹

The court of appeals rejected Johnston-Willis' argument that the Commissioner improperly relied upon federal minimum occupancy standards for existing obstetrical units at area hospitals to deny its application for a new OB service. The court concluded that this was a legal question, but was one which fell within the specialized

56. *Id.*

57. *Id.* at 246-50, 369 S.E.2d at 9-11. Johnston-Willis argued that in 1984, the General Assembly amended and reenacted §§ 32.1-120, -121, and added § 32.1-120.1. The purpose of this action was to transfer the responsibility for the issuance of the State Medial Facilities Plan (SMFP) from the State Board of Health to the Virginia Statewide Health Coordinating Council (VSHCC). The problem with the legislature's action, according to Johnston-Willis, was that the General Assembly failed to insert a savings clause in the 1984 act which would continue to exempt the SMFP from the formal promulgation process required by the APA. The VSHCC did not follow the promulgation procedure outlined in the Virginia Administrative Process Act (VAPA) when it issued the 1984 SMFP. Johnston-Willis argued that since the statutory basis exempting the SMFP from the promulgative process was not included in the 1984 Act, and since the VSHCC failed to follow the promulgation procedure, the Commissioner could not properly rely on the 1984 SMFP. *Id.*

58. *Id.* at 247, 369 S.E.2d at 10.

59. *Id.* at 250, 369 S.E.2d at 11.

competence of the Commissioner.⁶⁰ Therefore, the Commissioner's use of the occupancy standard could be reversed only if it was arbitrary and capricious.⁶¹ The Commissioner's decision to use the occupancy standard was entitled to a presumption of official regularity, and the court refused to find that the Commissioner's use of this standard was beyond the scope of his legal authority.⁶²

The court also rejected Johnston-Willis' argument that the Commissioner erroneously relied upon the SMFP and SHP despite evidence that the plans were inadequate and outdated.⁶³ The court ruled that section 32.1-102.3(a) of the Code of Virginia should not be read to require the Commissioner to disregard the State Plans if any evidence is presented that the Plans are inaccurate, outdated or inadequate. The court stated that the Code provides the Commissioner with discretion to disregard the plans if appropriate evidence is submitted to support such a conclusion.⁶⁴ Finally, the appellate court upheld the lower court's finding that the Commissioner's decision was supported by substantial evidence. It indicated that the Commissioner was entitled to disregard evidence submitted by Johnston-Willis, and the facts supporting the decision were more than adequate to meet the substantial evidence standard.⁶⁵

III. MEDICAL STAFF ISSUES

A. *Hospital Privileges and Disciplinary Proceedings*

Hospitals have an obligation to insure that the quality of care they deliver is of a caliber consistent with accepted medical standards.⁶⁶ The review of physicians' credentials when they apply for

60. *Id.* at 253-54, 369 S.E.2d at 13.

61. *Id.*

62. *Id.* (citing *Virginia Alcoholic Beverage Control Comm'n v. York St. Inn*, 220 Va. 310, 257 S.E.2d 851 (1979)).

63. *Id.* at 257-58, 369 S.E.2d at 15.

64. *Id.* According to the court this was a decision within the specialized competence of the Commissioner and would be upheld absent a showing as having that the decision was arbitrary and capricious and a clear abuse of discretion.

65. *Id.* at 267, 369 S.E.2d at 21; *see also supra* note 51.

66. This duty finds its origin in court decisions holding that hospitals must properly evaluate the ability and competence of physicians on its medical staff and must monitor the quality of care provided within the institution. These common law rules have been included in the accreditation standards with which hospitals must comply in order to be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO is a voluntary organization which monitors the quality of care in hospitals across the country and a hospital receiving JCAHO accreditation is usually deemed to be in compliance

hospital medical staff privileges is one way that hospitals meet this obligation.⁶⁷ The credentialling process may become a focal point for conflict between hospitals and physicians and even between physicians. Courts have adopted varying degrees of involvement in granting, suspending, or terminating medical staff privileges.

The Virginia Supreme Court clarified the law in Virginia in this area, in *Medical Center Hospitals v. Terzis*.⁶⁸ In *Terzis*, the court reversed a lower court's ruling that a question of fact existed as to whether a physician's privileges had been improperly suspended, and dissolved an injunction issued by the lower court which barred the hospital from proceeding with disciplinary action against the physician.⁶⁹ The physician argued that the physician-hospital relationship was governed by the medical staff by-laws which, according to the physician, established a contract between the hospital and its physicians. The supreme court expressly declined to rule on whether the medical staff by-laws did in fact create a contract between the hospital and physician.⁷⁰ The court ruled, however, that even if the by-laws created a contractual relationship, the express language of the by-laws precluded judicial review of the suspension of the physician's privileges.⁷¹

In *dictum*, the supreme court overruled the claim by Dr. Terzis that section 32.1-134.1 of the Virginia Code provided a statutory

with Medicare, "conditions of participation" for reimbursement purposes without the necessity of an independent inspection.

67. A physician must be appointed to a hospital medical staff before he is permitted to treat patients in that hospital. The appointment process typically involves the filing of a written application, personal interviews and an investigation of the physician's credentials. Hospitals are also required to conduct regular "recredentialling" of physicians on the medical staff to assure continued compliance with medical staff membership criteria.

68. 235 Va. 443, 367 S.E.2d 728 (1988).

69. *Id.* The court held that the trial court erred in overruling the hospital's demurrer to the physician's bill of complaint. The bill of complaint challenged the suspension of Dr. Terzis' medical staff privileges by Medical Center Hospital for alleged acts of improper conduct. The trial court issued a temporary injunction preventing enforcement of the suspension order by the hospital. At a subsequent hearing, the court overruled a demurrer filed by the hospital and continued the temporary injunction until a trial could be held on the merits of the physician's claim. The hospital appealed from this interlocutory decree to the Virginia Supreme Court seeking a dissolution of the injunction. *Id.*

70. *Id.* at 445, 367 S.E.2d at 729.

71. *Id.* The medical staff by-laws in this case provided an extensive mechanism for the review and discipline of physicians. Under the Medical Center Hospital's by-laws, physicians were entitled to investigative hearings. Appeals from the investigative bodies could be made to specific hospital committees, and final appeal could be made to the hospital Board of Directors. The by-laws expressly provided, however, that the decision of the Board of Directors was final, as the by-laws expressly precluded judicial review.

right of review of the hospital's suspension of her privileges.⁷² Section 32.1-134.1 of the Code provides in pertinent part that a hospital may not:

[C]urtail, terminate or diminish in any way a physician's professional privileges in such hospital . . . without stating in writing the reason or reasons therefor, a copy of which shall be provided to the physician. If the reason or reasons stated are unrelated to standards of patient care, patient welfare, violation of the rules and regulations of the institution or staff, the objectives or efficient operations of the institution, or the character or competency of the applicant, or misconduct in any hospital, it shall be deemed an improper practice.⁷³

The supreme court expressly rejected the argument that section 32.1-134.1 in any way provided a statutory right of judicial review of decisions made by hospitals regarding medical staff privileges.⁷⁴ Citing its previous decision in *Khoury v. Community Memorial Hospital, Inc.*,⁷⁵ the court held that in the absence of specific provisions which create contractual rights that may be enforced by the courts, the decisions of private hospitals regarding physicians privileges are beyond judicial review.⁷⁶ The court specifically relied on the following language in *Khoury* to support its opinion:

72. *Id.* at 446, 367 S.E.2d at 730.

73. The full text of § 32.1-134.1 provides as follows:

When denial, etc., to duly licensed physician of staff membership or professional privileges improper. It shall be an improper practice for the governing body of a hospital which has twenty-five beds or more and which is required by state law to be licensed to refuse or fail to act within sixty days of a completed application for staff membership or professional privileges or deny or withhold from a duly licensed physician staff membership or professional privileges in such hospital, or to exclude or expel a physician from staff membership in such hospital or curtail, terminate or diminish in any way a physician's professional privileges in such hospital, without stating in writing the reason or reasons therefor, a copy of which shall be provided to the physician. If the reason or reasons stated are unrelated to standards of patient care, patient welfare, violation of the rules and regulations of the institution or staff, the objectives or efficient operations of the institution, or the character or competency of the applicant, or misconduct in any hospital, it shall be deemed an improper practice.

Any physician licensed in this State to practice medicine who is aggrieved by any violation of this section shall have the right to seek an injunction from the circuit court of the city or county in which the hospital alleged to have violated this section is located prohibiting any such further violation. The provisions of this section shall not be deemed to impair or affect any other right or remedy; provided that a violation of this section shall not constitute a violation of the provisions of this article for the purposes of § 32.1-135 (1979, c. 711.)

74. *Terzis*, 235 Va. at 446, 367 S.E.2d at 730.

75. 203 Va. 236, 123 S.E.2d 533 (1962).

76. *Terzis*, 235 Va. at 446-47, 367 S.E.2d at 730. As previously noted, the Court deftly

[W]hen the trustees of a private hospital, in their sound discretion, exclude a doctor from the use of the facilities of the hospital, the courts are without authority to nullify that discretion by injunctive process. There are no constitutional or statutory rights of the doctor, or of his patients who wish to be treated in the hospital by him, which warrant such interference.⁷⁷

The court further ruled that section 32.1-134.1 did not modify its holding in *Khoury* by requiring a hospital to state the reasons in writing for its decision to grant or refuse privileges. The supreme court simply held that under the terms of section 32.1-134.1, if the reason or reasons stated for a disciplinary action are unrelated to the considerations listed in the statute, then an aggrieved physician may be entitled to injunctive relief and judicial review. Absent such an inconsistency, judicial review is foreclosed.⁷⁸ The court held that "[i]n our opinion, *Khoury* articulates a rule of non-intervention in a hospital's internal affairs. . . . The legislature has acquiesced in that ruling by its limited modification of *Khoury*, unambiguously expressed in Code § 32.1-134.1."⁷⁹ In Virginia, therefore, the courts are generally precluded from disturbing the decisions of private hospitals regarding medical staff privileges.⁸⁰

Notwithstanding the limited judicial review of medical staff privilege decisions followed by many courts, individual physicians or groups of physicians may encounter liability under the federal anti-trust statutes.⁸¹ These statutes have been applied to prohibit certain anticompetitive activity in connection with action taken on other physicians' privileges. The United States Supreme Court handed down a landmark decision on this issue in *Patrick v.*

sidestepped the question of whether the medical staff by-laws created sufficient contractual rights to invoke judicial review under *Khoury*.

77. *Id.* at 446, 367 S.E.2d at 730 (quoting *Khoury*, 203 Va. at 245, 123 S.E.2d at 539). Dr. Terzis unsuccessfully attempted to distinguish the Court's holding in *Khoury* on the basis that *Khoury* involved a refusal to grant a physician initial privileges to the hospital, whereas her case involved suspended privileges.

78. *Id.*

79. *Id.* at 446-47, 367 S.E.2d at 730.

80. It is important to understand that nothing in the *Terzis* or *Khoury* decisions governs the right of judicial review regarding medical staff decisions reached by public or quasi-public hospitals. Although there is no direct authority in Virginia on this point, many courts in other jurisdictions have held that public or quasi-public hospitals are susceptible to challenges of adverse privileges decisions on a variety of bases, including constitutional and statutory discrimination grounds.

81. *E.g.*, Sherman Anti-Trust Act, 15 U.S.C. §§ 1-7 (1982).

Burget.⁸² In *Patrick*, the Court, reversing the Ninth Circuit Court of Appeals, held that individual physicians in Astoria, Oregon had violated sections 1 and 2 of the Sherman Act by initiating and participating in peer-review proceedings of hospital privileges in order to reduce competition from the petitioner, Dr. Patrick.⁸³

On appeal from the trial court, the Ninth Circuit reversed a jury verdict in favor of Patrick on the basis that the medical staff peer-review activities used by the Astoria physicians were immune from anti-trust scrutiny under the state action doctrine.⁸⁴ The Ninth Circuit reasoned that since the hospital peer-review activities were within the broad scope of the activities of the State Board of Medicine, they constituted state action for purposes of anti-trust analysis.⁸⁵ In rejecting the Ninth Circuit's reasoning, the Supreme Court held that the "active supervision" requirement of the state action doctrine was not met.⁸⁶ Since state officials were not actively involved in the supervision of the hospital privilege decision, an opportunity was created for individuals to act in their own interest rather than in the interest of the state. This opportunity made the

82. 108 S. Ct. 1658 (1988).

83. *Id.* at 1660-61. Patrick was a surgeon in Astoria, Oregon, a small community in the northwest part of the state. For a brief period of time, Patrick was employed by the largest group practice in the area, the Astoria Clinic. Patrick declined an offer of partnership in the clinic and instead established his own independent practice in competition with Astoria Clinic. Physicians from the Astoria Clinic consistently refused to have professional dealings with Patrick, refused to refer patients to him, and referred patients to surgeons outside of Astoria in order to avoid using his services. In 1979, a partner in the Astoria Clinic complained to the executive committee of the only hospital in Astoria about Patrick's professional competence. The executive committee referred the complaint to the State Board of Medical Examiners whose investigative committee was chaired by another partner in the Astoria Clinic. Initially, the State Board of Medical Examiners issued a letter of reprimand criticizing Patrick. However, this letter was retracted in full when Patrick initiated a judicial appeal of the Board's decision. In 1981, a complaint was filed with the hospital's executive committee by another physician at the Astoria Clinic. This complaint was investigated, and a decision was made to terminate Patrick's hospital privileges on the ground that Patrick's patient care fell below hospital standards. Patrick exhausted his administrative appeals provided in the by-laws, and filed a complaint in federal court. It is significant to note that the chairman of the hospital's ad hoc review committee which heard Patrick's "internal" appeal was also a physician in the Astoria Clinic.

Patrick's complaint alleged violation of §§ 1 and 2 of the Sherman Act on the grounds that the decision to terminate his medical staff privileges was induced by the anti-competitive intent of the Astoria Clinic physicians. The jury returned a verdict in Patrick's favor with damages in the amount of \$650,000. This amount was trebled by the trial court for total damage award of \$1,950,000. *Id.*

84. *Patrick v. Burget*, 800 F.2d 1498, 1505 (9th Cir. 1986).

85. *Id.* at 1505-06.

86. *Patrick*, 108 S. Ct. at 1664.

state action doctrine inapplicable and exposed the activities of the Astoria's physicians to anti-trust scrutiny.⁸⁷

The Court was particularly persuaded by Patrick's arguments that the state, under applicable statutes and judicial decisions, could not effectively supervise the activities of hospital privilege committees.⁸⁸ Oregon, like Virginia, has adopted a "hands off" approach to private hospital medical staff privilege matters. However, this environment can create an unacceptable opportunity for anti-competitive behavior on the part of the physicians, as demonstrated by the physicians in *Patrick*.

The Supreme Court's decision in *Patrick v. Burget* significantly increases the potential liability of participants to medical staff privilege decision-making activities. Physicians, acting as decision-makers in privilege or disciplinary proceedings against other physicians, can now face anti-trust liability when those proceedings are used to gain an unfair competitive advantage. The record in disciplinary proceedings must reflect clearly the impartiality of all physicians involved in the process. Physicians with any potential bias would be well advised to disqualify themselves from deliberations and perhaps from the entire review process. In doing so, maximum protection is afforded against anti-trust liability and charges of bias or improper motive in the disciplinary process.

B. *Exclusive Contracts Between Hospitals and Physicians*

Hospitals frequently develop exclusive contracts with physicians to provide hospital-based medical services such as radiology, pathology and anesthesiology. The use of exclusive contracts has provided a fertile ground for litigation by physician groups denied such exclusive arrangements.⁸⁹ The Fourth Circuit rendered a recent decision in this area of the law in the case of *White v. Rockingham Radiologists*.⁹⁰ Rockingham Memorial Hospital and two other hospitals acquired a computerized tomography (CT) scanner through Shenandoah Shared Hospital Services (SSHS), a shared service company the hospitals jointly owned. Dr. White, a neurologist, sought a contractual arrangement with Rockingham Memorial

87. *Id.* at 1665.

88. *See id.* at 1664 n.6.

89. *See Exclusive Arrangements in Health Care: Moving Toward Freedom from Anti-trust Threat*, 33 FED. B. NEWS & J., No. 8, Oct. 1986.

90. *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98 (4th Cir. 1987).

to interpret all CT "head scans" performed on Rockingham Memorial patients.⁹¹ The contract was ultimately awarded to Rockingham Radiologists, which also performed radiologic services for Rockingham Memorial.⁹²

Dr. White initiated litigation alleging violation of sections 1 and 2 of the Sherman Act.⁹³ The district court granted summary judgment in favor of the defendants finding insufficient evidence to warrant a jury trial.⁹⁴ The Fourth Circuit affirmed on all counts.⁹⁵

The Fourth Circuit agreed with the district court that there was no evidence of conspiracy since it was clear that the hospital's board acted unilaterally in granting the exclusive contract to the radiologists.⁹⁶ It held that there was "no evidence that 'reasonably tends to prove . . . a conscious commitment to a common scheme designed to adhere to an unlawful objective.'"⁹⁷ Absent such evidence, there was no question for the jury concerning a conspiracy to monopolize or group boycott.⁹⁸

The Fourth Circuit similarly rejected White's allegations that the exclusive arrangement for CT scan interpretation constituted an unlawful "tying arrangement" between the hospital and the radiologists.⁹⁹ The district court assumed for purposes of summary judgment that Rockingham Memorial had market power, but re-

91. The CT scanner produces an x-ray type image which must be interpreted by a physician trained to read the films. Radiology is the medical specialty devoted to interpretation of x-ray films and related imaging services.

92. According to the court's opinion, the selection process was hotly contested. Dr. White received approval by the hospital medical staff to interpret head scans. The final decision rested with the hospital's board of directors, which permitted both Dr. White and Rockingham Radiologists to make formal presentations. The board decided to offer exclusive rights to Rockingham Radiologists. *White*, 820 F.2d at 98.

93. Section 1 of the Sherman Act, makes unlawful any "contract, combination . . . or conspiracy, in restraint of trade." Section 2 prohibits monopolization or attempted monopolization. 15 U.S.C. §§ 1-2 (1982).

94. See *White*, 820 F.2d at 100.

95. *Id.* at 98.

96. *Id.* at 103.

97. *Id.* (quoting *Monsanto Co. v. Spray-Rite Serv. Corp.*, 466 U.S. 752, 764 (1984) (quoting *Edward J. Sweeney & Sons, Inc. v. Texas, Inc.*, 637 F.2d 105, 111 (3d Cir. 1980))).

98. *Id.* The court used the same analysis to dismiss White's claim of illegal price fixing, which also requires evidence of concerted activity. Such evidence was absent in this case.

99. A "tying arrangement" is a mechanism through which a party uses its market power to condition the purchase of a desired product on the purchase of a second product. *Id.* Tying agreements become illegal "whenever a party has sufficient economic power with respect to the tying product to appreciably restrain competition . . . for the tied product." *Id.* (quoting *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 5-6 (1958)). There must also be a "not insubstantial" effect on interstate commerce. *Id.*

jected White's "tying" claim due to the absence of evidence of actionable tying by the hospital.¹⁰⁰

On appeal, Dr. White complained that the district court failed to understand his allegations of tying. The Fourth Circuit analyzed both of White's tying arrangement claims. The first theory claimed that the tying product was hospital medical-surgical services and the tied product was CT scanning services. Dr. White's second theory claimed that the tying product consisted of all hospital CT scans, with the tied product being interpretation of those scans.¹⁰¹

The Fourth Circuit rejected the first claim, agreeing with the district court that the hospital had not exploited its market power over inpatient services to induce use of the CT scanner.¹⁰² The court found it particularly significant that physicians, not the hospital, determined when a CT scan was needed and that the hospital did not even own or operate the CT scanner.¹⁰³

The Fourth Circuit, rejecting White's second theory, ruled that the hospital was not "a competitor in the market for the tied product" because it did not receive any portion of the fee paid to the radiologists for CT scan interpretation.¹⁰⁴ The court distinguished the United States Supreme Court's decision in *Jefferson Parish Hospital District No. 2 v. Hyde*¹⁰⁵ on the basis that the hospital and anesthesiologist in that case shared fees for anesthesiological services.¹⁰⁶ The Fourth Circuit held that the hospital's lack of economic interest in the tied product interpretation of CT scans was sufficient to preclude a tying claim under either theory advanced by White.¹⁰⁷

The Fourth Circuit gave short shrift to White's claim that defendants had combined and conspired to monopolize in violation of

100. *Id.*

101. *Id.* at 103-04.

102. *Id.*

103. The court appeared to ignore the fact that the CT scanner was owned and operated by SSHS, an entity owned in part by the hospital. This analysis leaves open the possibility of a different result if a hospital more directly owns and operates the equipment.

104. *White*, 820 F.2d at 104.

105. 466 U.S. 2 (1984).

106. In *Jefferson Parish*, the Supreme Court declined to apply a per se rule of illegality to an exclusive contract between the hospital and an anesthesiologist for anesthesia services. The Court, however, did remand the case for further consideration of the hospital's market power and the effect of the contract on commerce. See *Hyde v. Jefferson Hosp. Dist. No. 2*, 764 F.2d 1139 (5th Cir. 1985).

107. *White*, 820 F.2d at 104.

section 2 of the Sherman Act.¹⁰⁸ The court held that neither the hospital nor SSHS competed with White in the relevant market, the interpretation of CT head scans.¹⁰⁹ In addition, neither party conspired with the radiologists. The Fourth Circuit held that the absence of a competitive interest, and the lack of evidence of a conspiracy precluded a section 2 claim.¹¹⁰

The Fourth Circuit's opinion in *Rockingham Radiologists* is consistent with the increasing body of case law upholding exclusive contracts against anti-trust challenges.¹¹¹ Although factually unique in some respects, it should provide Virginia hospitals with some comfort regarding exclusive contracts with physicians.¹¹²

IV. AIDS RELATED ISSUES

Recent concern over communicable diseases, particularly AIDS,¹¹³ has had a dramatic impact on the changing health care landscape. Because it is fatal and has no known cure, AIDS has caused widespread fear on the part of the general public. Misinformation concerning the origin of the disease, the methods through which it is transmitted, and the means of treatment or lack thereof have further compounded the problem.¹¹⁴

108. The United States Supreme Court has held that a § 2 monopoly claim has two elements: first, the possession of monopoly power in the relevant market; and, second, the deliberate use of that power. *United States v. Grinnell*, 384 U.S. 563, 570-71 (1966). White was unable to satisfy either element. *White*, 820 F.2d at 105.

109. *White*, 820 F.2d at 104-05.

110. *Id.* The Fourth Circuit acknowledged that the radiologists did have a sufficient competitive interest to support a § 2 claim. However, the radiologists lacked monopoly power since the hospital could terminate its contract at will.

111. *See supra* note 88 at 332.

112. The case has not been appealed to the Supreme Court.

113. "AIDS" is the acronym for Acquired Immune Deficiency Syndrome, a condition in which a victim's natural immune system is so weakened that he/she is unable to resist a variety of diseases (so called "opportunistic infections"). AIDS is caused by a virus now commonly referred to as "HIV". The dimensions of the AIDS epidemic are staggering. The number of persons infected with the HIV virus worldwide is unknown, but it is conservatively estimated that 1.5 million Americans have the virus. *See* SURGEON GENERAL'S REPORT ON AIDS (1987).

114. Government agencies are addressing the problem of misinformation through increased education and awareness programs. The Surgeon General, in a mass mailing, sent AIDS informational booklets to homes nationwide. In addition, television commercials describing preventative measures are being shown on prime-time television, and appear in newspapers and other periodicals. The AIDS epidemic has raised a variety of legal issues which are beyond the scope of this article. These issues include employment related decisions, access to health care, mandatory testing and disclosure related issues, product liability for contaminated materials, and insurance coverage issues.

Health care providers face special problems with continued employment of AIDS infected staff, testing of patients, controlling exposure and transmission of the virus through contact with AIDS infected patients, and the management of physicians who have AIDS. Health regulatory agencies and legislators at both the state and federal level have begun to address these issues.

In late 1987, the Department of Labor and the Department of Health and Human Services issued a joint advisory notice establishing standards for protection against occupational exposure to the AIDS and Hepatitis B viruses.¹¹⁵ Under the guidelines, work environments are divided into three basic categories: (i) those jobs that routinely require exposure to blood, body fluids or tissues (Category I); (ii) those jobs that do not usually require such exposure but may require the unplanned performance of Category I tasks (Category II);¹¹⁶ and (iii) those jobs that do not require exposure, or performance of any Category I task (Category III).

According to the guidelines, both Category I and Category II tasks require formal procedures to protect employees from exposure to HBV or HIV.¹¹⁷ Employers must develop standard operating and identification procedures for workers who engage in Category I and II tasks. Employers should also develop, implement and monitor procedures to minimize the chance of exposure or infection by employees.¹¹⁸

Employers should also establish training and education programs to ensure that employees understand the modes of transmission for HBV and AIDS, the methods of protection, the limitations of these methods, and what to do if accidental exposure occurs. Workers should be required to complete these programs prior to

115. DEPARTMENT OF LABOR AND DEPARTMENT OF HEALTH AND HUMAN SERVICES, JOINT ADVISORY NOTICE, PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO HEPATITIS B VIRUS (HBV) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) (October 19, 1987) [hereinafter NOTICE].

116. *Id.* A good example of the employees who would fall into this category are police officers or firefighters.

117. The NOTICE states as follows:

If the employer determines that category I and II tasks do not exist in the workplace, then no specific personal hygiene or protective measures are required. However, these employees should ensure that workers are aware of the risk factors associated with transmission of HBV and HIV so that they can recognize situations which pose increased potential for exposure to HBV or HIV (category I tasks) and know how to avoid or minimize personal risk.

Id. at 7.

118. *Id.*

engaging in any Category I or II tasks.¹¹⁹ The guidelines also urge that work practices be developed on the assumption that all body tissues and blood products are infectious.¹²⁰

The guidelines suggest that, to the extent feasible, the employer should minimize the risk of exposure by implementing procedures that pose the least risk. Wherever possible, he or she should adopt appropriate engineering controls, and should use the most protective equipment available.¹²¹ The employer should also provide and maintain protective clothing for workers who risk exposure to HBV or HIV viruses. Procedures should specify what clothing should be worn for each task. At a minimum, gloves should be worn. The type of equipment provided should vary with the nature of the risk to which the employee is exposed.¹²²

The guidelines also provide that employees who risk exposure be given HBV immunization if they so desire. Employers should also provide, at no charge to the employee, monitoring for HBV and HIV antibodies and medical counseling for any workers who test positive for the antibodies.¹²³

Complex legal issues associated with the AIDS virus are being litigated in courts across the country. As these cases wind their way through the judicial process, a substantial body of law will be developed regarding the rights and responsibilities of employers, health care providers, government agencies, and persons afflicted with the AIDS virus. In the interim, these cases can only provide a glimpse of the emerging body of law in this area.¹²⁴

The Virginia courts are currently dealing with a number of AIDS related cases. These cases involve employees who were either terminated from their employment or placed upon leave of absence

119. *Id.* at 8.

120. The reason for this recommendation is twofold. First, there is a lapse between the time the virus becomes present in the body and the time when testing will disclose the presence of the antibody to the virus. If all fluids are treated as though they were infectious, employees will be protected even though the patient may be in this lapse period. Second, by treating all fluids as infectious, certain patients would not be avoided or isolated for different treatment, thus protecting confidentiality.

121. See NOTICE, *supra* note 115.

122. *Id.* at 9.

123. *Id.*

124. A comprehensive discussion of the cases pending across the country is clearly beyond the scope of this article. Litigation is prevalent in courts across the nation in both the federal and state court level. While much of this litigation involves employment related issues, other matters being litigated involve the right to insurance benefits and medical malpractice actions for AIDS contaminated blood products.

over their objections on the basis of known or suspected AIDS infection.¹²⁵ There is at least one case pending in Virginia in which the plaintiff alleges that she was infected with the AIDS virus during a transfusion of contaminated blood.¹²⁶ It is reasonable to anticipate that the scope and magnitude of litigation involving AIDS related conditions will continue to increase in Virginia and elsewhere.

Virginia's legislators as well as the judiciary have been forced to deal with AIDS related issues. A variety of AIDS related legislation came before the Virginia General Assembly,¹²⁷ which passed the following bills during its 1988 session: a bill requiring any health care facility which transfers a dead body to a funeral service to provide notice if the deceased was known to have an infectious disease transmitted through exposure to body fluids;¹²⁸ a bill requiring that health care facilities and physicians provide information to emergency medical service personnel who are asked to transport persons known to have an infectious disease, or who may have had contact with a person subsequently diagnosed as having an infectious disease;¹²⁹ a bill authorizing physicians to report the identity of patients who test positive for HIV exposure and granting immunity to a reporting physician;¹³⁰ a bill requiring that local health departments provide free care for venereal disease when the care is required by the health department;¹³¹ a bill creating a study com-

125. In *Charles Crowley v. Idelman Telemarketing, Inc.*, No. —, (E.D. Va. 1988), an employee was terminated shortly after notifying his employer that he suffered from AIDS and was not capable of working a full day. In *Wolf v. Tidewater Pizza, Inc.*, No. C87-662 (Norfolk Cir. 1987), an employee was denied recovery under the Virginians with Disabilities Act, Virginia Code §§ 51.01-1 to -46, for his involuntary suspension and subsequent reinstatement with modified work hours due to suspected AIDS infection. The court ruled that since the employee did not have the AIDS disease, he could not be disabled within the contemplation of the Virginia statute. The case is currently on appeal. See also *Chapoton v. Majestic Caterers, Inc.*, No. 87-000688R (Roanoke Cir. 1988), (regarding wrongful termination of a restaurant waiter); *Doe v. Primary Care Corp.*, No. 86-377-A (E.D. Va. 1988) (termination of a physician from a health clinic).

126. See *Jane Doe v. Roanoke Memorial Hosps.*, No. —. (Buena Vista Cir. 1988).

127. Sixteen pieces of legislation related to AIDS were considered by the 1988 session of the General Assembly. Of this total, five were passed, two were killed, and nine were carried over into the next session. It appears that the 1989 General Assembly session will spend a substantial amount of time on the AIDS issue as well.

128. Act of April 20, 1988, ch. 836, 1988 Va. Acts 1668 (amending VA. CODE ANN. §§ 32.1-37.1, 54-260.74:2 (Cum. Supp. 1988)).

129. Act of April 11, 1988, ch. 760, 1988 Va. Acts 1010; Act of April 11, 1988, ch. 789, 1988 Va. Acts 1247 (codified as amended at VA. CODE ANN. § 32.1-116.3 (Cum. Supp. 1988)).

130. Act of March 16, 1988, ch. 130, 1988 Va. Acts 140 (amending VA. CODE ANN. §§ 32.1-36, -38 (Cum. Supp. 1988)).

131. Act of March 31, 1988, ch. 399, 1988 Va. Acts 486 (amending VA. CODE ANN. § 32.1-57 (Cum. Supp. 1988)).

mission to conduct a comprehensive study of AIDS issues, including testing, reporting of test results, confidentiality, Medicaid coverage, prevention and education.¹³²

In addition to the legislation that was passed, a great many bills were carried over to the 1989 session. A provision creating criminal penalties for exposing another to AIDS,¹³³ and legislation that would mandate the testing of various groups of individuals¹³⁴ were carried over into the next session, as was a bill that would require all licensed health care professionals to disclose positive HIV test results to patients, and vice versa.¹³⁵

V. CONCLUSION

The area of health care law continues to be a dynamic and rapidly changing field of practice. The increasing complexities of the health care industry environment as well as the significant public health issues created by the AIDS epidemic are all contributing to a burgeoning body of statutory, administrative and case law in Virginia. This trend will undoubtedly continue into the foreseeable future and will directly affect attorneys in a variety of specialties.

132. H.J. Res. 31, 1988 Sess., 1988 Va. Acts 2107; S.J. Res. 28, 1988 Sess., 1988 Va. Acts 2288.

133. H. 469, Va. General Assembly (1988); Notably another bill making the intentional attempt to expose another to the AIDS virus a felony was killed. H. 674, Va. General Assembly (1988).

134. *E.g.*, H. 470, Va. Gen. Assembly (1988) (requires that prostitutes and convicted intravenous drug users be tested for exposure); H. 675, Va. Gen. Assembly (1988) (requires all Va. residents five years of age or older on July 1, 1989 be tested for HIV exposure); H. 699, Va. Gen. Assembly (1988) (requires that applicants for a marriage license be tested); H. 697, Va. Gen. Assembly (1988) (requires testing of all hospital patients prior to surgery); H. 969, 970, and 971 Va. Gen. Assembly (1988) (requires the testing of prisoners and persons charged with certain crimes).

135. H. 1048, Va. Gen. Assembly (1988).