Annual Survey of Virginia Law: Recent Developments in Medical Malpractice and Health Care Law

Peter M. Mellette
RECENT DEVELOPMENTS IN MEDICAL MALPRACTICE AND HEALTH CARE LAW

Peter M. Mellette*

I. INTRODUCTION

Over the past year, medical malpractice and health care law in the Commonwealth have undergone significant changes. Major case decisions and significant legislative activity, both at the state and federal levels, have altered the playing field for many health care providers, insurers, and consumers.

This survey article touches upon some of these important developments in medical malpractice and health care law. Over the last year, several Supreme Court of Virginia decisions interpreted the Medical Malpractice Act, its application to multiple plaintiffs, and its notice requirements. New state and federal legislation also substantially affected health care facility advertising, admissions, fire safety requirements, and payments. Additionally, a United States Supreme Court decision allowing a pending hospital association suit challenging Virginia's Medicaid provider payment standards to proceed and a Court decision on the "right to die" are among the many precedential federal court decisions during 1990 discussed in this article.

II. STATE COURT DECISIONS AFFECTING VIRGINIA PROVIDERS

A. Medical Malpractice Decisions

1. Rules for Applying the Medical Malpractice Cap

In Bulala v. Boyd, the Supreme Court of Virginia answered a series of questions raised following judgment in an eight-year-old federal court case against a Tazewell County obstetrician. The Fourth Circuit had asked for the court's assistance in determining...
the amount of damages to which the estate of a brain damaged child, now deceased, and the child’s parents were entitled under state law.

The Supreme Court of Virginia decision in Bulala followed a very active 1988-89 year in medical malpractice law, in which the Virginia medical malpractice cap was upheld under both state and federal constitutions. While the 1988-89 decisions provided circuit courts and federal district courts with guidance regarding the application of the medical malpractice cap to multiple defendants, the Supreme Court of Virginia decision on the certified issues in Bulala addressed, for the first time, the rights of multiple plaintiffs to collect damages for medical malpractice actions.

In Bulala, the Supreme Court of Virginia answered the following certified questions of law:

1. Where there are two or more plaintiffs entitled to recover the damages arising from the same act or acts of medical malpractice, does § 8.01-581.15 [of the Code of Virginia (the “Code”)] apply individually to each plaintiff or overall to two or more such plaintiffs? If the statute does apply to all or any combination of plaintiffs’ claims, how is it to be apportioned among them?

2. Does § 8.01-581.15 apply to damages for the infliction of emotional distress arising from some act or acts of medical malpractice?

3. Does § 8.01-581.15 apply to an award of punitive damages for an act or acts of medical malpractice?

4. Does Virginia law allow recovery for the loss of enjoyment of life when death results from an act or acts of medical malpractice?

5. Does Virginia law allow Veronica Boyd [a brain damaged child] to recover damages for her lost earning capacity based upon the evidence presented in this case?


5. See Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989) (reversing a lower court decision that the medical malpractice cap as applied to the case denied plaintiffs’ rights to trial by jury).

6. See Etheridge, 237 Va. at 105-07, 376 S.E.2d at 534-36. In Etheridge, the Virginia Supreme Court held that the cap on damages applied as a whole to all defendants; accordingly, multiple judgments against defendants would be subject to a $1 million cap on all professional liability pursuant to section 8.01-581.15 of the Code.
6. What is the effect, under §§ 8.01-21, 8.01-25, and 8.01-56 [of the Code] of Veronica Boyd’s death after verdict but before judgment in this case?

In response to the first question, the supreme court decided, based on two public policy grounds, that section 8.01-581.15 of the Code and principles of statutory construction required the court to limit the total damages recoverable for injury to a “patient” to the statutory amount, regardless of the number of legal theories upon which the plaintiffs’ claims are based. Pursuant to the court’s rationale in *Bulala*, the father’s claim for emotional distress and the parents’ joint claim for the medical expenses of the child were found to be wholly derivative of the child’s claim and therefore within the child’s cap on damages. In this case, however, the court held that the mother and child were both “patients” within the meaning of the Medical Malpractice Act and entitled to damages within separate statutory caps because the child was born damaged, but alive, as a result of Dr. Bulala’s negligence.

After the Supreme Court of Virginia construed who was entitled to medical malpractice damages, the court’s position on several other certified questions became clear. The court decided that a plaintiff seeking damages for the infliction of emotional distress and punitive damages may do so only as a patient or through a patient derivative claim and then only up to the statutory cap amount. The court also found that Virginia law does not allow recovery for the loss of enjoyment of life as a separately compensa-

---

7. *Bulala*, 239 Va. at 222, 389 S.E.2d at 672.
8. *Id.* at 228, 389 S.E.2d at 675 (noting that a different construction would defeat the ability of the Malpractice Act to “remedy the mischief at which it is directed”).
9. *Id.* at 228, 389 S.E.2d at 675-76.
10. *Id.* at 229-30, 389 S.E.2d at 676. Justices Russell and Poff disagreed with the Court’s implicit recognition that the infant injured during childbirth was both a “person” and “patient” before she was born, in light of the Court’s prior rulings in *Lawrence v. Craven Tire Co.*, 210 Va. 138, 169 S.E.2d 440 (1969) and *Modaber v. Kelley*, 232 Va. 60, 348 S.E.2d 233 (1986) (noting that an unborn child is not a “person” within the meaning of wrongful death and other personal injury statutes and common law rights). *Bulala*, 239 Va. at 235-36, 389 S.E.2d at 679-80. Accordingly, if the child does not live, a different result would ensue under the majority opinion.
11. *Id.* at 230, 389 S.E.2d at 676; *see also* Va. Code Ann. § 8.01-38.1 (Cum. Supp. 1990) (limiting the amount of punitive damages that may be awarded to $350,000); Va. Code Ann. § 8.01-38 (limiting damages in medical malpractice actions against hospitals exempt from tort action under IRC § 501(c)(3) to $1 million or the hospital’s policy limits whichever is less).
ble element of damages in a personal injury case.\textsuperscript{12} Finally, the court decided that the child was not able to recover damages for lost earnings capacity based on the evidence presented at trial. While a plaintiff is not absolutely precluded from recovering damages for lost future earnings by reason of infancy, the evidence used to calculate such loss or diminution must be grounded upon facts specific to the individual. Plaintiff's use of average statistical assumptions was too remote and speculative to meet the court's test.\textsuperscript{13}

2. Rulings Involving the Notice of Medical Malpractice Claim

In a series of decisions this year, the Supreme Court of Virginia ruled that the notice of claim required by the Medical Malpractice Act\textsuperscript{14} is procedural in nature and does not affect a state court's subject matter jurisdiction over a medical malpractice claim under certain circumstances. The court's rulings in \textit{Hudson v. Surgical Specialists, Inc.},\textsuperscript{15} \textit{Morrison v. Bestler},\textsuperscript{16} \textit{Cowan v. Psychiatric Associates, Ltd.},\textsuperscript{17} and \textit{Hewitt v. Virginia Health Services Corp.}\textsuperscript{18} significantly eased the timing and specificity requirements of the notice of claim sent to a physician or other health care provider.

In \textit{Hudson}, the supreme court ruled that the trial court's limitation of evidence to the specific acts of negligence alleged in plaintiff's notice of claim was in error. The court's opinion noted that the notice of claim

is neither a bill of particulars nor a pleading of any other kind. It is not required to contain a summary of the plaintiff's evidence or an exposition of the plaintiff's theories of the case. Its purpose is simply to call the defendant's attention to the identity of the patient, the time of the alleged malpractice, and a description of the alleged acts of malpractice sufficient to enable the defendant to identify the case to which plaintiff is referring.\textsuperscript{19}

\textsuperscript{12} \textit{Bulala}, 239 Va. at 232, 389 S.E.2d at 677 (citing McDougal v. Garber, 73 N.Y.2d 246, 536 N.E.2d 372 (1989)).

\textsuperscript{13} \textit{Id.} at 232, 389 S.E.2d at 677.


\textsuperscript{15} 239 Va. 101, 387 S.E.2d 750 (1990).

\textsuperscript{16} 239 Va. 166, 387 S.E.2d 753 (1990).

\textsuperscript{17} 239 Va. 59, 387 S.E.2d 747 (1990).

\textsuperscript{18} 239 Va. 643, 391 S.E.2d 59 (1990).

\textsuperscript{19} \textit{Hudson}, 239 Va. at 106-07, 387 S.E.2d at 753.
Through its decision, the court thereby minimized the burden upon a plaintiff in a medical malpractice case to perform sufficient investigation prior to filing the notice of claim to identify with particularity the alleged acts of malpractice. As one commentator has noted, this may allow plaintiffs to serve mere summary notices and then change the theories or add new theories of malpractice in any subsequent lawsuit.\textsuperscript{20}

In \textit{Morrison} and \textit{Hewitt}, the Supreme Court of Virginia addressed the timing and service requirements of a notice of claim. The court held in \textit{Morrison} that the filing of a motion for judgment immediately prior to the end of the two year statutory limitations period, the subsequent filing of a notice of claim, the election of a voluntary non-suit, and the refiling of the motion for judgment did not prevent the plaintiff's case from going forward.\textsuperscript{21} In \textit{Hewitt}, the service of a notice of claim by regular mail did not prohibit the case from going forward.\textsuperscript{22}

In \textit{Cowan}, the plaintiff sent a notice of claim to the defendants which met the notice requirements set forth in the Medical Malpractice Act. However, the notice concluded with a statement denying that the Medical Malpractice Act was controlling as to the claims alleged.\textsuperscript{23} The Supreme Court of Virginia overturned the trial court's dismissal of the subsequent suit, filed during the 120-day statute of limitations period following the notice of claim. While the trial court decided that the plaintiff was estopped from relying on the statutory tolling provisions of the Medical Malpractice Act because of her disavowal of its application, the supreme court interpreted the disavowal as an effort to preserve whatever challenge plaintiff might have had to the constitutionality of the Medical Malpractice Act.\textsuperscript{24}

Despite the court's less restrictive interpretation of the substan-

\textsuperscript{20} Opinion, \textit{Virginia Supreme Court Limits Notice Requirements in Medical Malpractice Cases}, 2 (1) J. Civ. Ltr. 108, 110 (1990) (noting that the court's decision may render ineffective and unnecessary statutory provisions at § 8.01-581.2:1 of the Code, which allow a claimant an opportunity to amend the notice to add causes of action).

\textsuperscript{21} \textit{Morrison}, 239 Va. at 173, 387 S.E.2d at 758.

\textsuperscript{22} \textit{Hewitt}, 239 Va. at 644-45, 391 S.E.2d at 60. The court noted that the providers' failure to object to the letter as constituting a notice of claim and to the adequacy of the notice in the trial court prevented the providers from raising those issues on appeal. \textit{Id}.

\textsuperscript{23} \textit{Cowan}, 239 Va. at 61, 387 S.E.2d at 748.

\textsuperscript{24} \textit{Id.} at 61-63, 387 S.E.2d at 748-49. For a discussion of the questions of constitutionality of the Virginia Medical Malpractice Act, see generally Etheridge v. Medical Center Hosps., 237 Va. 87, 376 S.E.2d 525 (1989) and \textit{supra} notes 4 & 6 and accompanying text.
tive filing requirements for a notice of claim, the Supreme Court of Virginia has continued to require plaintiffs seeking damages from alleged medical malpractice to file a notice of claim. In *Gonzalez v. Fairfax Hospital System, Inc.* the court ruled that a plaintiff allegedly injured while receiving treatment as a patient in a hospital was required to file his action in accordance with the terms of the Act, in spite of the plaintiff's claim that the tort action was based upon a theory of "ordinary, traditional negligence." This decision continued a trend of broad readings of the intended scope of the Medical Malpractice Act for alleged torts committed by health care providers.

3. Decisions Involving the Loss of Chance Doctrine

During 1989, a number of Virginia circuit courts ruled on the proper application of the "loss of chance" doctrine in Virginia medical malpractice jurisprudence. This doctrine, as applied in other state and federal court decisions, allows a plaintiff to obtain damages for a misdiagnosis that results in a lost opportunity to cure and treat a particular disease or injury. The source of Virginia authority for the doctrine is *Brown v. Koulibakis,* in which the Supreme Court of Virginia stated that:

> In medical malpractice cases, as in other negligence actions, the plaintiff must establish not only that the defendant violated the applicable standard of care, and was therefore negligent, he must also sustain the burden of showing that the negligent acts constituted a proximate cause of the injury or death. Thus, in a death case, if a defendant physician, by action or inaction, has destroyed any substantial possibility of the patient's survival, such conduct becomes a

26. *Id.* at 309, 389 S.E.2d at 459. The plaintiff's amended motion for judgment alleged that his left toe was "traumatized and lacerated by a screw, screwlike device or other metal object located inside" a whirlpool tub during a physical therapy session. *Id.* at 308, 389 S.E.2d at 458. In its ruling, the court noted that the alleged tort was "based on health care or professional services rendered to a patient" and was rendered by "health care providers," thereby falling within the definitions of malpractice within the Medical Malpractice Act. *Id.* at 310, 389 S.E.2d at 459-60.
27. E.g., Smith v. Teunis, 16 Va. Cir. 135 (Fairfax County 1989) (suggesting that a physician who has an extramarital affair with his patient during treatment may breach his fiduciary obligation to the patient and therefore may be in violation of the Medical Malpractice Act).
28. *See,* e.g., Waffen v. U.S. Dep't of Health and Human Services, 799 F.2d 911 (4th Cir. 1986); Hicks v. United States, 368 F.2d 626 (4th Cir. 1966).
proximate cause of the patient’s death. The law does not require the plaintiff to prove to a certainty that the patient would have lived had he received more prompt diagnosis and treatment for the condition causing the death.30

The language in Brown has been cited by plaintiffs as a basis for finding that Virginia recognizes the loss of chance doctrine as a separate cause of action.

Recent circuit court rulings in Irby v. Richmond Pediatric Associates,31 Nolan v. Tankoos,32 and George v. Kaiser Foundation Health33 have reached different conclusions from the federal judges, rejecting the loss of chance doctrine as a separate cause of action. As the Circuit Court of the City of Richmond reasoned in Irby, the loss of chance doctrine does not provide a separate cause of action. Instead, the doctrine is an evidentiary tool by which a plaintiff can have the issue of proximate cause determined by a jury.34 The court drew an analogy to res ipsa loquitur, which allows the question of negligence to be determined by a jury, and it ruled that neither theory created a separate cause of action.35 In Nolan, the Circuit Court of Loudoun County decided that the loss of chance doctrine did not apply because the alleged malpractice did not result in the death of a patient.36 As the Circuit Court of Fairfax County found in George, the loss of chance doctrine required the plaintiff to show that the defendant’s negligence more probably than not caused her harm, i.e., that the defendant’s actions were the substantial cause.37

In George, the court also addressed issues of abandonment and the length of the physician-patient relationship. As the court indicated, there is an ongoing duty for the physician to continue treatment as long as necessary or to make arrangements for continuing treatment.38 However, as the Circuit Court of Rockbridge County ruled in McDaniel v. St. Clair,39 the duty of care is continuing, but

30. Id. at 532, 331 S.E.2d at 446.
31. 16 Va. Cir. 383 (Richmond 1989).
32. 17 Va. Cir. 168 (London County 1989).
33. 15 Va. Cir. 327 (Fairfax County 1989).
34. Irby, 16 Va. Cir. at 388-89.
35. Id.
37. George, 15 Va. Cir. at 334.
38. Id. at 335.
39. 18 Va. Cir. 470 (Rockbridge County 1990).
only until the statutory limitations period expires. More specifically, the court held that no claim can be brought against a physician for negligent prescribing practices when the physician had no control over the medication refills.40

B. Other State Court Decisions Involving Health Care Providers

1. Development Issues

Although the certificate of public need ("COPN")42 review process was substantially deregulated by the 1989 General Assembly,42 the COPN law continues to be a source of provider litigation. In Tidewater Psychiatric Institute, Inc. ("TPI") v. Buttery,43 the Court of Appeals of Virginia affirmed the Commissioner of Health's decision to deny standing to a competing psychiatric hospital as part of the Commissioner's decision to approve a psychiatric hospital application in Virginia Beach. The court ruled that the Commissioner's standing decision met the Virginia Real Estate Commission v. Bias44 reasonableness standard for agency case decisions.45

The appeals court began its review by stating that the right to appeal an administrative case decision depends upon party status. The court noted that TPI was not a party to the underlying case decision on the competing hospital application. Nonetheless, the court reasoned that TPI could claim party status to the Commissioner of Health's final order denying TPI permission to intervene. Thus, the appeals court found that TPI had a right to appeal, but

40. Id. at 476-77.
44. 226 Va. 264, 308 S.E.2d 123 (1983) (holding that an administrative agency's decision should be reversed "only if, considering the record as a whole, a reasonable mind would necessarily come to a different conclusion." (citing B. MEZINES, ADMINISTRATIVE LAW § 51.01 (1981))). See also Johnston-Willis Ltd. v. Kenley, 6 Va. App. 231, 369 S.E.2d 1 (1988) (applying Bias standard to a COPN case decision).
only the issue of TPI's standing, not the underlying COPN decision.\textsuperscript{46}

In its review of another COPN case decision, the Circuit Court of Arlington County affirmed the Commissioner’s decision that, in spite of deregulation, operating room tables in ambulatory surgery centers and, by implication, in hospitals, are still subject to COPN review.\textsuperscript{47} In reaching its decision, the circuit court adopted the Commissioner’s earlier finding that an additional operating room is the functional equivalent of an increase in the total number of “beds” in an ambulatory surgery center, and that the COPN issued to Fairfax Surgical Center “was, and is, a document of continuing force which must be reviewed when modifications are sought” to a licensed facility.\textsuperscript{48}

The Commissioner’s underlying decision was reached prior to the COPN deregulation. Accordingly, treatment of an ambulatory surgery table or inpatient operating room table as analogous to an inpatient bed and therefore subject to review may carry less force today than when the Health Commissioner decided the case on April 26, 1988. While ambulatory surgery centers remain subject to COPN review, as of July 1, 1991 hospital beds and ambulatory surgery center operating rooms will no longer be subject to COPN review at all.\textsuperscript{49}

2. Medical Staff Issues

During the last year, at least one Virginia court has refused to interfere in a private hospital’s medical staff appointment decisions, following the lead of the Supreme Court of Virginia’s 1988

\textsuperscript{46} TPI, 8 Va. App. at 386, 382 S.E.2d at 291-92. In practice, this type of standing allowed TPI to argue the merits of the case as part of its grounds for claiming standing. \textit{Id.}


decision in Medical Center Hospitals v. Terzis.\textsuperscript{60} In the Circuit Court of the City of Norfolk case of Amarasinge v. Sentara Hospitals,\textsuperscript{61} the court found that Dr. Amarasinge’s failure to note his loss of privileges at another hospital in his Sentara reapplication for privileges fell within one of the statutory grounds for denial of staff privileges at the hospital.\textsuperscript{62} In its ruling, the Norfolk circuit court specifically found that the hospitals’ corporate and medical staff bylaws did not constitute a contract between Dr. Amarasinge and Sentara Hospitals.\textsuperscript{63}

III. 1990 General Assembly Legislation

A. Psychiatric Treatment Legislation

1. Changes in Treatment Practices

The 1990 General Assembly enacted significant legislation affecting psychiatric treatment practices and procedures and referral relationships between hospitals and physicians in general. The 1990 legislation followed the recommendations of two study committees established by a resolution during the 1988 and 1989 General Assembly sessions.\textsuperscript{64} The flurry of psychiatric treatment practice leg-
islation during the 1990 General Assembly session was prompted in part by legislative concerns that psychiatric professionals, psychiatric facilities, and private review agents have been responding to incentives that increase the cost of patient care and which may affect the quality of such care.55

The treatment practice legislation includes prohibitions on payments for referrals of all patients, based on existing authority in the Medicare and Medicaid programs.56 The new law delegates to the Board of Health, the Board of Mental Health, Mental Retardation, and Substance Abuse Services, and the Board of Medicine the responsibility of adopting regulations consistent with the anti-referral legislation.57 Although the legislation does not include specific penalties for violations, penalties already exist in other sections of the Health Code58 and the Professions Code59 as incentive to providers and practitioners to comply with the anti-referral legislation in cases involving patients who are not eligible for Medicare or Medicaid.60 The Joint Subcommittee recommended anti-
referral legislation as a result of isolated reports that psychiatric facilities paid employees of psychiatric hotline services commissions for referrals of patients to psychiatric facilities.\textsuperscript{61}

Another bill aimed at psychiatric hospital providers in particular will regulate psychiatric facility advertising for the first time.\textsuperscript{62} The new law authorizes the Board of Mental Health, Mental Retardation and Substance Abuse Services to establish regulations designed to prohibit advertisements from containing false and misleading information or false and misleading representations as to the fees charged for services.\textsuperscript{63} Such legislation resulted from complaints by legislators and those testifying before the committee that existing psychiatric provider advertisements were somehow lacking in taste and veracity, and that consumers were unsure of where to go to resolve their complaints.\textsuperscript{64}

Additional legislation endorsed by the Joint Subcommittee and approved by the General Assembly should benefit providers who are dealing with a utilization review process that has grown more complex and costly. The new legislation requires companies performing utilization review to register with and obtain certification from the State Corporation Commission if they intend to do business in Virginia.\textsuperscript{65} The Virginia statute, based upon an existing Maryland statute regulating private review agents,\textsuperscript{66} establishes a

\textsuperscript{61} S. Doc. No. 41, supra note 54, at 7; see also Cornish, The New Psychiatry of Care, Daily Press/The Times-Herald, October 30, 1989, at Supp. 13, 22 (describing allegations raised before the Joint Subcommittee by a former Tidewater Psychiatric Institute employee concerning benefits given hotline workers and medical staff members for patient referrals and bonuses for increasing the patient census given to other employees).


\textsuperscript{63} Id.

\textsuperscript{64} Sen. Doc. No. 41, supra note 54, at 5; see also Cornish, supra note 61, at Supp. 13, 22 (discussing reaction to “scare tactics” employed in some psychiatric facility advertising).

\textsuperscript{65} VA. CODE ANN. §§ 38.2-4214, 38.2-4319, 38.2-5300 to -5303 (Int. Supp. 1990).

\textsuperscript{66} See MD. HEALTH GEN. CODE ANN. §§ 19-1301 to -1303 (1990). The Maryland statute applies to review by non-hospital affiliated entities and requires disclosure of standards used by private review agents in evaluating hospital care. The Act also provides for penalties and for judicial review to persons aggrieved by private review agent decisions. Id. §§ 19-1312 to -1313. The Joint Subcommittee of the Virginia General Assembly that studied psychiatric treatment practices recommended a statute with provisions similar to the Maryland statute. See S. Doc. No. 41, supra note 54, at 6, Attachment H.

The statute adopted by the General Assembly does not provide for judicial review explicitly; instead, it states that a private right of action will not accrue to persons affected by the statute as a result of the statute's enactment. See VA. CODE ANN. § 38.2-5308 (Int. Supp.
series of requirements as prerequisites to certification of private review agents which are not health maintenance organizations, 67 or health insurers, hospital service corporations, or preferred provider organizations that perform reviews on their own subscribers or patients. 68 In addition, the statute excludes from registration requirements all private review agents contracting with the Medicare program 69 and private review agents engaged by pension plans otherwise exempt from regulation under the Employee Retirement Income Security Act 70 through a State Corporation Commission waiver. 71 The private review agent legislation establishes other requirements for the State Corporation Commission approval of private review agent certification 72 and includes a provision assuring

---

67. For a definition of a health maintenance organization, see VA. CODE ANN. § 38.2-4300 (Int. Supp. 1990).
68. Id. § 38.2-5300 (defining “private review agent”).
72. See id. § 38.2-5302. The certification statute requires that private review agents pay a filing fee, and include in an application the following minimum standards and any additional standards established by regulation:
   1. A description of the procedures to be used in evaluating proposed or delivered hospital, medical or other health care services;
   2. The procedures by which patients or providers may seek reconsideration determinations by private review agents;
   3. The type and qualifications of the personnel either employed or under contract to perform the utilization review;
   4. Procedures and policies which ensure that patient-specific medical records and information shall be kept strictly confidential except as authorized by the patient or by regulations adopted pursuant to [the private review agent] chapter; and
   5. Assurances that reviewers be readily accessible by telephone to patients and providers at least 40 hours per week during normal business hours.

Id. The State Corporation Commission must promulgate regulations which include the following requirements:

1. Minimum qualifications to perform review;
private review agent access to and confidentiality of patient-specific medical records and information.\[73\]

2. Admission of Minors Legislation

The Virginia General Assembly also enacted sweeping legislation modifying the psychiatric admissions process for minors.\[74\] The General Assembly passed the admissions practice legislation in apparent response to concerns that prior Virginia law governing admission of minors to psychiatric facilities\[75\] was not being uniformly applied in the state owned and private psychiatric facilities.\[76\] Proponents of the legislation also argued that minors differ in their capacity to consent to voluntary psychiatric treatment and that the interest of parents in seeking psychiatric treatment for their minor children may not always be coincidental with the best interests of the children.\[77\]

The psychiatric admission of minors legislation codified a slightly modified version of pre-existing non-judicial and judicial processes for the admission of minors to psychiatric facilities. The non-judicial process applies to any minor under fourteen years of age, whether he objects to the admission or not, and to any minor over fourteen years of age who consents jointly with his parents or who is incapable of consenting but does not object.\[78\] The primary difference between prior voluntary admission practices and the non-judicial process mandated by the 1990 statute is that a voluntary admission now requires an independent clinical evaluation of the minor which supports the parents’ and admitting practitioner’s

---

2. Procedures which require the private review agent to provide the attending physician an opportunity to consult with a physician advisor prior to issuance of a final denial in any case in which there is an initial recommendation to deny coverage;
3. Guidelines regarding access to and confidentiality of patient-specific medical records and information; and
4. Setting the amount of application fees required by this chapter, which shall be sufficient to pay for the administrative costs of regulation. . . .

*Id.* § 38.2-5309. The legislation also includes an administrative appeal process for private review agents denied a registration certificate. *Id.* § 38.2-5305.

73. *Id.* § 38.2-5307.
77. *Id.*
The minor who voluntarily agrees to treatment but later objects must be discharged within forty-eight hours unless a parent or other person petitions the local juvenile and domestic relations court for involuntary admission. The new voluntary admission law also sets a statutory timeframe for the initiation of a treatment plan for the minor and requires re-evaluation of the minor after ninety days of inpatient treatment.

The judicial process authorized by the new statute depends on whether the minor or his parents object to inpatient psychiatric treatment. The law establishes specific procedures for parental admission of objecting minors fourteen years of age or older and for other involuntary admissions where a parent of an objecting minor also objects or is unavailable. In authorizing either type of admission, the juvenile and domestic relations judge or a special justice must find, based upon the report of a qualified evaluator or the community services board, (1) that there is no less restrictive al-
ternative available, (2) that the minor presents a danger to himself or others to the extent that severe injury is likely to result as evidenced by recent threats or conduct, (3) that the minor is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusional thinking or by significant impairment of functioning in hydration, nutrition, self-protection, or self-control, and (4) that the minor is in need of inpatient treatment and is likely to benefit from such treatment. An initial hearing to consider the minor's unconsenting or involuntary admission must take place within twenty-four hours unless a legal representative of the minor requests an extension of up to seventy-two hours. The statute also provides for emergency treatment of minors through the use of a temporary detaining order prior to an involuntary commitment hearing.

B. Provider Licensure Legislation

One of the most celebrated pieces of legislation during the 1990 General Assembly session was the new requirement for sprinklers in nursing home buildings and smoke detectors in home-for-adult buildings. Additional legislation affecting nursing homes and home-for-adult facilities include changes in the COPN law which extend the moratorium on approval of additional nursing home


Pursuant to separate legislation passed by the 1990 General Assembly, the community services boards are required to assist in the evaluation of persons taken into temporary judicial or police custody for emergency evaluation of the need for inpatient psychiatric hospitalization. See id. § 37.1-67.1 (Cum. Supp. 1990); see sources cited infra note 88.

86. Id. §§ 16.1-339(B), -345.
87. Id. § 16.1-339.
88. Id. § 16.1-340 (referring to § 37.1-67.1). The 1990 General Assembly adopted several changes to the involuntary commitment statutes, including a procedure for temporary custody for evaluation of the need for inpatient hospitalization pending judicial and clinical review of the need for a temporary detention order. Id. § 37.1-67.1. The General Assembly also enacted revisions to the detention order timing requirements and the hearing requirements for subsequent commitment orders. Id. §§ 37.1-67.1, -67.3.

90. See id. § 36-99.5:1 (Cum. Supp. 1990). Home-for-adult facilities are defined by law and licensed by the Department of Social Services to provide for maintenance or care of aged, infirm or disabled adults who are generally ambulatory upon initial residence at the facility. See id. §§ 63.1-172, -174.1, -175 (Repl. Vol. 1987).
1990 MEDICAL MALPRACTICE

beds through June 30, 1991, allow exceptions to the moratorium on nursing home bed approvals for home-for-adult facilities, and allow replacement of existing nursing home facilities to be constructed at offsite locations under certain circumstances. These changes in the Commissioner of Health's COPN authority are interim in nature. The Commission on Health Care for All Virginians is currently examining issues related to the COPN program, including its continued future. Other legislative resolutions provide the Commission with a list of additional issues to study.

C. AIDS Legislation

The flurry of recent legislation concerning the human immunodeficiency virus ("HIV") continued in the 1990 General Assembly. The General Assembly passed three laws affecting the HIV infected population including a law which permits testing of convicted prostitutes for HIV infection with or without consent and a series of amendments to the 1989 HIV test confidentiality statute. A third statute establishes a new procedure for isolation

91. Id. § 32.1-102.3:2 (Cum. Supp. 1990). For a discussion of the reasons behind the current moratorium on approval of additional nursing home beds, see Marshall, supra note 42, at 697-700; Gravely, supra note 50, at 668-70.
92. Va. Code Ann. § 32.1-102.3:2. These exceptions would be granted to facilities which accept specialty, heavy-care patients, such as AIDS, ventilator-dependent and head/spinal cord injury patients, and which convert no more than thirty beds to serve these patients. Id. For information on the licensure requirements of nursing home facilities, see id. §§ 32.1-125 to -137 (Repl. Vol. 1985 & Cum. Supp. 1990).
93. See id. § 32.1-102.3:2 (allowing offsite replacement of existing facilities at locations within the same city or county and within reasonable proximity to the current site when replacement on the current site is proven infeasible).
94. See Commission on Health Care for All Virginians, S.J. Res. 118, Va. Gen. Assembly, 1990 Sess. (1990). The Commission also has the mandate to study ways to minimize the number of uninsured Virginians, to preserve access to acute care services in isolated areas of the Commonwealth, to provide for equitable allocation of state funds for health care, and to expand the availability of various types and levels of services to elderly Virginians for long term care. The Commission also has the authority to investigate a number of health insurance and Medicaid issues, including eligibility for insurance and Medicaid payments and reimbursement for various provider services. For discussion of a recent United States Supreme Court case addressing state requirements for Medicaid payments to hospitals and nursing homes, see infra notes 167-72 and accompanying text.
97. See id. §§ 32.1-36.1, 32.1-88 (limiting any duty of disclosure).
of persons with communicable diseases.\textsuperscript{98}

The isolation statute allows the Commissioner of Health to petition a general district court in the county or city in which a person with a communicable disease resides for an isolation order.\textsuperscript{99} Such orders are appropriate where persons with communicable diseases are engaging in "at-risk behavior," defined by statute as "engaging in acts which a person, who has been informed that he is infected with a communicable disease, knows may infect other persons without taking appropriate precautions to protect the health of the other persons."\textsuperscript{100}

If a court finds that isolation of a person with a communicable disease is necessary to protect the public health,\textsuperscript{101} the court may order isolation of the person in the person's home, another's residence, or an institution.\textsuperscript{102} The general district court's isolation order is valid for no more than 120 days and may be enforced through the use of electronic monitoring devices.\textsuperscript{103} The order may also require the person with the communicable disease to participate in counseling and education programs.\textsuperscript{104}

Prior to the issuance of an isolation order by a general district court, the Commissioner may seek a temporary detaining order for up to forty-eight hours.\textsuperscript{105} Isolation orders are subject to review de novo by a circuit court and must be heard on a priority basis.\textsuperscript{106}

D. \textit{Medical Records and Reports}

Actions by the 1990 General Assembly assisted patients in their efforts to obtain medical records from health care providers other

\textsuperscript{98} See id. §§ 32.1-48.01 to -04.
\textsuperscript{99} Id. § 32.1-48.03.
\textsuperscript{100} Id. § 32.1-48.01.
\textsuperscript{101} This requires the court to find that the following conditions are met:
- 1. The person is infected with a communicable disease.
- 2. The person is engaging in at-risk behavior.
- 3. The person has demonstrated an intentional disregard for the health of the public by engaging in behavior which has placed others at risk for infection.
- 4. There is no other reasonable alternative means of reducing the risk to public health.
\textsuperscript{102} Id. § 32.1-48.04(B).
\textsuperscript{103} Id. § 32.1-48.04(C).
\textsuperscript{104} Id.
\textsuperscript{105} Id. § 32.1-48.03(B). The 48 hour detention order may be extended to up to 96 hours if the specified detention period terminates on a Saturday, Sunday, or legal holiday. Id.
\textsuperscript{106} Id. § 32.1-48.04(D).
than hospitals and physicians. One law established the rights of patients to subpoena copies of medical records from all health care providers, as that term is defined in the Medical Malpractice Act. Companion legislation also set a reasonable charge limit for photocopies of subpoenaed health care provider records at fifty cents per page and established a search fee not to exceed fifteen dollars for hospitals.

Another 1990 General Assembly law stipulates that any requesting patient must be given an itemized statement of the charges for services rendered by a health care provider, regardless of whether a bill for services has been or will be submitted to any third party payor. Additional changes also allow parties in disputes with insurance companies access to medical reports or records by statute.

E. Medical Treatment Directives

The 1990 General Assembly made minor revisions to the durable power of attorney for health care decisions statute adopted by the 1989 General Assembly. The 1990 revision eliminated the burden placed upon physicians by the 1989 legislation to inquire into the validity of the durable power of attorney. The 1990 General Assembly carried over legislation that would have eliminated the remaining burden upon physicians, i.e., that a physician obtain a written certification by another licensed physician or clinical psychologist, not otherwise involved in the treatment of the person assessed, prior to relying upon the durable power of attorney for health care decisions for the initiation or cessation of treatment.

F. Medicaid and Charity Care Program Changes

The 1990 changes to the Department of Medical Assistance Services' ("DMAS") statutory authority included clarifications to the provider overpayment recovery statute. The 1990 amendment will...

108. Id.
112. VA. CODE ANN. § 37.1-134.4(B).
facilitate efforts by DMAS to recover Medicaid overpayments to
providers from successors in interest of a provider by giving
DMAS the authority to obtain payment recoveries from providers
who terminate operations, sell health care facilities, or reorganize
those facilities. The statute expanded the existing authority of
DMAS to obtain repayment of reimbursable depreciation to nurs-
ing home providers and to recover overpayments from providers
who do not terminate their provider agreement with DMAS. It
also provides DMAS with a remedy against providers who go bank-
rupt and whose owners offer services to Medicaid patients through
ownership of other existing or newly formed provider entities.

Other changes to the Medicaid program include the establish-
ment of a new drug review committee and statutes establishing a
Medicaid drug formulary which will allow DMAS to limit drugs
eligible for payment by the Medicaid program to those drugs in
the Virginia Medicaid drug formulary. The DMAS Director will
have the authority to negotiate and enter into agreements with
drug manufacturers on payment discounts for the use of a manu-
facturer's prescription drugs by Virginia Medicaid program benefi-
ciaries. The Director will also have the authority to negotiate
with health care providers to provide services to Medicaid recipi-
ents needing special assistance. Providers rendering services to
special needs patients such as persons with AIDS or those on ven-
tilators may receive special contract rates from DMAS as a result
of the statutory amendment. The 1990 General Assembly also
enacted other technical changes in the Medicaid eligibility statutes
to comply with federal law requirements governing Medicaid pa-
tient eligibility.

Finally, there were further changes to the Virginia Indigent
Health Care Trust Fund statutes enacted by the 1989 General As-
sembley. These amendments included minor revisions to the dead-

include any person having stockholders, directors, officers, or partners in common with a
health care provider for which an agreement has been terminated).
115. Id.
118. See id. §§ 32.1-331.1 to .5.
119. Id. §§ 32.1-331.6 to .11.
120. Id. § 32.1-331.11.
121. Id § 32.1-325.1(E).
122. Id.
123. See id. §§ 32.1-324.1(B), -325(A).
lines for hospitals to file charity care data,124 the method of calculating each hospital’s cost of charity care, the annual contribution rate,125 and the method of calculating the annual distributions to hospitals for charity care provided in excess of the charity care standard.126

IV. FEDERAL LAW ISSUES AFFECTING VIRGINIA PROVIDERS

A. The Omnibus Budget Reconciliation Act of 1989

1. Proscriptions on Patient Referrals

After much fanfare and debate, the United States Congress decided to proscribe physician referrals of Medicare patients to independent clinical laboratories owned in whole or in part by the referring physician.127 The anti-referral legislation was originally intended to address all physician referral relationships that could have an impact on the volume and cost of services provided to Medicare patients.128 The Ethics in Patient Referrals Act of 1989, along with its 1988 predecessor bill,129 would have barred virtually all referrals by physicians to entities, including hospitals and nursing homes in which the physician held a financial interest.130 The legislation would have also prohibited any entity, within the control of a physician or in which the physician held a financial interest, from billing any individual, third-party payor, or other entities for items or services provided by the entity pursuant to a patient referral by the physician.131

The penalties for physicians and clinical laboratory providers who fail to abide by the requirements of the anti-referral statute

126. Id. § 32.1-338.
130. Id. § 2(a).
132. See H.R., 939 § 2(a).
are significant. The clinical laboratory provider may not receive any payment for services provided and must refund any amounts that were billed in violation of the Act.\textsuperscript{133} The clinical laboratory provider is subject to a civil penalty of $15,000 for each service provided contrary to the statute or for which the provider has failed to refund any billings received.\textsuperscript{134} Other penalties for circumvention schemes include exclusion from the Medicare program and a civil penalty of up to $100,000.\textsuperscript{135}

There are two separate reporting requirements under the statute. First, clinical laboratory providers must advise the Secretary of Health and Human Services of the name and provider number for referring physicians regardless of whether an exception applies to the current referral proscription.\textsuperscript{136} Additionally, a clinical laboratory provider must indicate whether or not the referring physician is “an interested investor,” i.e., a physician in a position to make or to influence referrals or business to the clinical laboratory provider or the referrals or business of an immediate family member.\textsuperscript{137} The failure to report such information can result in exclusion from the Medicare program or assessment of a civil penalty in an amount not to exceed $2,000.\textsuperscript{138} In addition, all Medicare providers of covered items or services must provide the Secretary of Health and Human Services with information concerning the entity’s ownership arrangements, including the covered items and services provided by the entity and the names and Medicare provider numbers of the physicians who are interested investors, or who are immediate relatives of interested investors.\textsuperscript{139} This reporting requirement must be met in accordance with instructions from the Secretary by no later than December 19, 1990. Civil penalties of $10,000 apply to persons who do not comply with the reporting requirement.\textsuperscript{140}

\begin{itemize}
\item \textsuperscript{133} See 42 U.S.C.A. § 1395nn(g) (West Supp. 1990).
\item \textsuperscript{134} Id. § 1395nn(g)(3).
\item \textsuperscript{135} Id. § 1395nn(g)(4).
\item \textsuperscript{136} Id. § 1395nn(f).
\item \textsuperscript{137} Id.
\item \textsuperscript{138} Id. § 1395nn(g)(3).
\item \textsuperscript{139} Id. § 1395nn(f).
\item \textsuperscript{140} Id. § 1395nn(g)(5). The patient referral legislation also includes several study provisions which request the General Accounting Office to study the impact of physician ownership of health care facilities and entities on the utilization of Medicare covered items and services by Medicare beneficiaries, their Medicare expenditures, and service provider competition. See 103 Stat. at 2241. The Secretary is also required to report on the utilization of Medicare covered items and services by Medicare beneficiaries served by entities in which
2. Amendment to the Patient Dumping Legislation

The Omnibus Budget Reconciliation Act ("OBRA") of 1989 included significant changes to a five-year-old statutory requirement which obligates hospitals and physicians to screen patients presenting themselves at hospital emergency rooms across the country.\footnote{See 42 U.S.C.A. § 1395dd (West Supp. 1990).} The OBRA 1989 amendments to the Consolidated Omnibus Budget Reconciliation Act of 1985 provisions became effective July 1, 1990.\footnote{See Pinkney, Stricter Patient Transfer Rules Effective July 1, Am. Med. News, June 29, 1990, at 1.}

In the original patient dumping law, Congress required that all Medicare participating hospitals screen patients presenting themselves for treatment to determine if an emergency condition was present or if patients were in active labor. If a prescreening test revealed either condition, both the hospital and the emergency department physician had a statutory duty to stabilize the patient before discharge, unless the patient had requested a transfer or the responsible physician attested in writing that the benefits of patient transfer outweighed the risks and received permission from the receiving hospital prior to the transfer.\footnote{143. 42 U.S.C.A. § 1395dd(c)(2).} Additionally, the transferring hospital had the obligation to transfer medical records and to assure that patient transfer was appropriate by sending qualified personnel with the transferred patient.\footnote{Id.} Inappropriate prescreening examinations or inappropriate transfers in violation of the patient dumping law could result in the termination of the provider agreement, civil monetary penalties, and state law personal liability suits.\footnote{144. Id. § 1395dd(d).}

the referring physician has a direct or indirect financial interest and by Medicare beneficiaries served by other entities. \textit{Id.} The latter provision suggests that proscriptions for physician referrals to other physician controlled providers of Medicare covered items and services beyond clinical laboratories could take place in the near future.

\footnote{141. See 42 U.S.C.A. § 1395dd (West Supp. 1990).}
\footnote{142. See Pinkney, Stricter Patient Transfer Rules Effective July 1, Am. Med. News, June 29, 1990, at 1.}
\footnote{143. 42 U.S.C.A. § 1395dd(c)(2).}
\footnote{144. Id.}
\footnote{145. Id. § 1395dd(d). Notably, the duty to evaluate and treat patients at common law did not exist. It is only with the gradual changes in case law over time that hospitals have been required to treat patients who have entered the emergency room of a hospital in reliance on the custom that care is rendered in an emergency in the emergency room. This duty to treat has been expanded over time through other federal statutes. \textit{E.g.}, 42 U.S.C. § 291 (1988) (the Hill-Burton Act) (providing funds for construction and modernization of health care facilities in consideration for facilities agreeing to meet specific uncompensated care obligations over a 20 year period and to care for Medicare and Medicaid beneficiaries for the life of the facility). The patient dumping law goes beyond both prior case law and the Hill-Burton Act obligations to require that hospitals care for any patient who comes into the}
Since the enactment of the patient dumping law, reports of patient dumping activities have continued to make headlines. Questions regarding the implementation of the patient dumping law had been raised before legislative committees and by a division of the agency responsible for investigating patient dumping complaints. Although a number of complaints had been investigated and penalties issued, Congress apparently enacted the statutory amendments to respond to external and internal criticisms of patient dumping law enforcement.

The OBRA 1989 amendments eliminate the definition of "responsible physician" originally in the statute. The amendments specify that any physician who is responsible for examination, treatment or transfer of a patient in a participating hospital and who knowingly violates the appropriate transfer provisions is subject to a civil monetary penalty and/or exclusion from the Medicare program. The 1989 OBRA amendments also substitute the emergency room in an emergency condition or in labor, regardless of payment source. See 42 U.S.C.A. § 1395dd (West Supp. 1990); Note, Preventing Patient Dumping: Sharpening the COBRA's Fangs, 61 N.Y.U. L. Rev. 1186 (1986).


147. See generally H.R. Rep. No. 531, supra note 146.


149. Based on the OIG study of three regions of the country, 151 complaints were filed in a one and one-half year period. Id. at 18991. The 1988 Congressional study cited a total of 129 complaint cases from the initiation of the Act to January 31, 1988 based on conversations with Department of Health and Human Services staff. See H.R. Rep. No. 531 at 13. These data, while inconsistent, do not compare favorably to the reported volume of abuses in the Congressional study. Id. at 3-5. More recent data indicate that as of March 31, 1990, 437 cases had been referred to and investigated by the Health Care Financing Administration and, of these, eight cases were referred to the Inspector General's office for sanctions, resulting in $272,000 in fines. Pinkney, supra note 142, at 21.

word “individual” for the word “patient” throughout the patient dumping statute, in an apparent attempt to eliminate any questions regarding the necessity for a patient-physician relationship.\footnote{151} The 1989 amendments to the patient dumping law also require on-call physicians to be responsible for the screening and transfer of patients in an emergency medical condition. The physician who performs the initial screening examination of a patient may have no liability whatsoever if the examining physician is unable to get the on-call physician specialist to appear within a reasonable period of time to evaluate and treat a patient in need of the on-call physician’s services.\footnote{152} Under such circumstances, the attending physician is not subject to civil monetary penalties or exclusion from the Medicare program if any transfer is later found to be inappropriate. However, the on-call physician who fails or refuses to appear can be subject to such penalties.\footnote{153}

The patient dumping law amendments also require additional record keeping for hospitals\footnote{154} and include whistle blower provisions which protect receiving hospitals and other providers. The amended statute mandates that hospitals and physicians provide an appropriate screening examination, including all necessary diagnostic tests, prior to any inquiry into the patient’s method of payment or insurance status.\footnote{155}

One of the most noticeable changes in the patient dumping law is the elimination of the active labor requirement and the inclusion of “labor,” defined as a woman having contractions, into the definition of an “emergency medical condition”.\footnote{156} The definition of an emergency medical condition includes both acute bodily injury or dysfunction and the threat of inadequate transfer time or risk during transfer. Accordingly, for a patient in false labor who has no destabilizing complications, the receiving hospital and attending/on-call physician have a obligation to review the patient’s condi-

\footnotetext{151}{See 42 U.S.C.A. § 1395dd.}
\footnotetext{152}{Id.}
\footnotetext{153}{Id.}
\footnotetext{154}{See id § 1395dd(i). Hospitals must record patient vital signs and more detailed diagnostic work-up information than the previous statute required. The amendments also require the hospital transferring a patient because of the non-appearance of an on-call physician to identify that physician. The hospital and its medical staff are required now to take all reasonable steps to obtain a patient’s written, informed refusal to further treatment following a pre-screening examination and before patient discharge. Id.}
\footnotetext{155}{Id.}
\footnotetext{156}{Id.}
tion upon arrival and may only discharge the patient after the attending/on-call physician has ruled out active labor and other complications.\textsuperscript{157}

Over the last year, the patient dumping statute has been interpreted by a growing number of courts in a variety of contexts.\textsuperscript{158} The statute provides a basis for medical malpractice claimants to obtain either state or federal court jurisdiction.\textsuperscript{159} Once claimants obtain such jurisdiction, at least one federal court has found that the patient dumping statute provides a strict liability-based private right of action for the health care consuming public.\textsuperscript{160}

3. Other OBRA 1989 Changes

The OBRA 1989 legislation will affect Virginia health care providers in other ways.\textsuperscript{161} Some of the major provisions include physician payment reform\textsuperscript{162} and the establishment of a new federal agency within the Public Health Service to study and make recommendations on improvements in clinical practice and the organization, financing, and delivery of health care services.\textsuperscript{163} The new

\textsuperscript{157} See Letter from Kathleen A. Buto, Director, Bureau of Policy Development, Department of Health and Human Services, to the Honorable Ted Stevens (June 19, 1990).


\textsuperscript{159} See Reid, 709 F. Supp. at 854; Bryant, 689 F. Supp. at 493.

\textsuperscript{160} Reid, 709 F. Supp. at 855 (conceded by defendant hospital). The automatic application of strict liability to persons directly resulting from patient dumping statute violations has been rejected by other commentators. See Krugh, Is COBRA Poised to Strike? A Critical Analysis of Medical COBRA, 23(b) J. HEALTH & Hosp. L. 161, 164 (1990) (describing negligence standards applicable to proving a patient dumping statute violation). The Krugh article discusses in detail some of the difficulties that hospitals face in complying with the strict requirements of the patient dumping statute and thereby avoiding civil liability. The article also proposes statutory amendments that would reduce hospital exposure and limit the broad scope of the statute to instances of patient dumping.

\textsuperscript{161} The OBRA 1989 legislation follows Congress’ recent pattern of imposing major changes in Medicare and Medicaid policy through budget bill provisions. This legislative mechanism has been criticized in the past by former President Reagan, among others.

\textsuperscript{162} Other legislative changes include disproportionate share adjustment changes, changes to payments for sole community hospitals and regional referral centers that would affect rural hospitals, reductions in outpatient capital costs, and further delays in implementation of Omnibus Budget Reconciliation Act of 1987 requirements that nursing home aides complete training/competency evaluation programs. See Pub. L. 101-239, 103 Stat. 2169 (1989) (codified at 42 U.S.C.A. § 1395w-4 (West Supp. 1990)).

Agency for Health Care Policy and Research will consolidate and expand existing treatment research functions at the federal level.\textsuperscript{164} The OBRA 1989 legislation also expanded eligibility coverage of children in certain low income families and of pregnant women for Medicaid covered items and services. Additional provisions revised the 1988 exclusion of the income and resources of a spouse of a nursing home resident in computing the income and resources of the institutionalized spouse.\textsuperscript{165} This substantially changes the availability of Medicaid coverage for nursing home services.\textsuperscript{166}

B. Federal Court Decisions Affecting Virginia Providers and Consumers

1. Provider Suits Against State Medicaid Programs: \textit{Wilder v. Virginia Hospital Association}\textsuperscript{167}

On June 14, 1990, the United States Supreme Court determined that a health care provider such as a hospital, nursing home, or association of providers may bring suit under 42 U.S.C. § 1983 to enforce the federal Medicaid Act’s provider reimbursement standards.\textsuperscript{168} The Court decided that the applicable provider payment standards created a substantive federal “right” enforceable by providers under 42 U.S.C. § 1983 to ensure the adoption of reasonable and adequate reimbursement rates. The Court noted that providers are clearly the intended beneficiaries of the payment provisions in the Medicaid Act, thereby resolving a dispute which has divided the federal courts.\textsuperscript{169}

\textsuperscript{164} Id.
\textsuperscript{166} Id.
\textsuperscript{167} 110 S.Ct. 2510 (1990).
\textsuperscript{168} See 42 U.S.C.A. § 1396a(a)(13)(A) (West 1982 & Supp. 1990), providing that a state plan for medical assistance must provide for payment:

\begin{quote}
of the hospital skilled nursing facility, and intermediate care facility services [for the mentally retarded] provided under the plan through the use of rates . . . which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
\end{quote}

In reaching its decision, a five-member majority of the Court found that the statutory language, past administrative practice, and legislative history all supported the view that the Medicaid Act's payment provisions imposed a binding provider payment obligation on the states. The Court further found that the reasonable and adequate rate standard was not so vague as to prevent judicial enforcement, and that the limited remedies available to providers through the Secretary of Health and Human Services' review of state plans and the availability of state administrative appeals of certain issues did not foreclose a federal judicial remedy. The Court noted that the ability of states to limit administrative review of reimbursement rates to the mere recalculation of those rates and to exclude any consideration of the methodology in state administrative reviews provided hospitals and nursing home providers with no opportunity to challenge state Medicaid payment methodologies absent federal court review.

2. Advance Medical Directives: Cruzan v. Director, Missouri Department of Health

On June 25, 1990, the United States Supreme Court decided that the United States Constitution permits states to limit an incompetent patient's ability to forego all medical treatment, specifically artificial nutrition and hydration. The Court's decision in Cruzan upheld a Missouri State Supreme Court decision denying the parents of Nancy Cruzan the right, as her guardians, to order the withdrawal of feeding tubes based on the lack of clear and convincing evidence of their daughter's treatment wishes. The Cruzan decision reaffirmed a state's role in the life or death decisions of an

170. Wilder, 110 S. Ct. at 2522; cf. Pennhurst State School and Hosp. v. Halderman, 451 U.S. 74, 198 (1981) (holding that the statutory language in that case was cast in precaitory instead of mandatory terms and therefore did not mandate state agency compliance with federal law).

171. Wilder, 110 S. Ct. at 2522-23. The Court noted with approval that the Virginia Hospital Association brought suit to seek prospective relief through reformation of the Virginia State Plan for Medical Assistance. Id. at 2520. The case has yet to go to trial on VHA claims that the Virginia Department of Medical Assistance Services officials have been under-reimbursing Virginia hospitals by approximately $1 million a week in Medicaid allowable costs. See Henry & Johnson, Provider Challenges to Medicaid Plan Provisions in Federal Court: Baliles v. Virginia Hospital Association, VI(1) HEALTH L. NEWS 3 (Va. St. B., Mar. 1990).


incompetent and represented the first United States Supreme Court ruling in a right to die case.\textsuperscript{174}

In reaching its decision, the Court considered the rights of incompetent patients, through their guardians, to withhold medical treatment generally and life supporting medical treatment in particular. Four of the dissenting justices and one of the concurring justices specifically found that there is a federal constitutional right under the fourteenth amendment due process clause allowing incompetents to refuse medical treatment.\textsuperscript{175} The majority opinion also found that an incompetent has a liberty interest in refusing medical treatment, but the majority assumed without deciding that this interest rose to the level of a federal constitutional right.\textsuperscript{176}

However, the Court went on to find that Missouri was entitled to establish strict evidentiary standards for the exercise of an incompetent patient’s rights by a guardian.\textsuperscript{177} The Court acknowledged that Missouri’s clear and convincing evidentiary standard was one of several approaches that states could adopt and noted that the lack of a true adversarial process in reaching termination of treatment decisions was one basis for the clear and convincing evidentiary standard.\textsuperscript{178} The Court also acknowledged that the Missouri rules may, on occasion, frustrate the desires of persons who do not take the time to express their treatment wishes while competent.\textsuperscript{179} However, the Court noted that an erroneous decision to withdraw life-sustaining treatment is not susceptible of correction.\textsuperscript{180}

In his dissent, Justice Brennan questioned the ability of a state to make such a decision on behalf of the incompetent patient. He would leave the decision-making role to those persons most knowledgeable of the incompetent patient’s true desires, i.e., the patient’s family and friends.\textsuperscript{181} Justice Stevens in his dissent also questioned whether the state had any legitimate interest in personal decisions that do not affect anyone other than the incompe-

\textsuperscript{174} Id. at 2852.
\textsuperscript{175} See id. at 2859 (O’Connor, J., concurring); see also id. at 2864 (Brennan, J., dissenting).
\textsuperscript{176} Id. at 2851. The Court relied instead upon the common law rights of competent patients to informed consent prior to treatment as the foundation for its decision. Id. at 2852.
\textsuperscript{177} See id. at 2853-53.
\textsuperscript{178} Id. 2853.
\textsuperscript{179} See id. at 2854.
\textsuperscript{180} Id.
\textsuperscript{181} Id. at 2876 (Brennan, J., dissenting).
tent patient. Both dissenting opinions questioned the Missouri Supreme Court's determination that Nancy Cruzan's expressions to family and friends of her desire not to be maintained in a comatose condition failed to satisfy the standard for treatment withdrawal. The Missouri trial court had relied on both these expressions and the court appointed guardian ad litem's supporting findings to rule in favor of treatment termination. The dissenting justices questioned whether any prior expressions of comatose patients short of a properly executed living will or durable power of attorney for health care decisions would be sufficiently probative under the Court's view of the Missouri standard.

3. Antitrust Litigation Against Health Care Providers

In *Wilk v. American Medical Association*, the Court of Appeals for the Seventh Circuit ruled that the American Medical Association ("AMA") has unreasonably restrained referrals of patients to chiropractors in violation of Section 1 of the Sherman Act. The district court's ruling followed a lengthy trial and was based upon AMA documents, such as Principle 3 of the AMA's Principles of Medical Ethics, which the district court found were used as a basis for boycott of referrals to chiropractors. The evidence demonstrated that the AMA had previously labeled the practice of chiropractic an unscientific cult.

The Court of Appeals for the Seventh Circuit rejected the AMA's claim that its conduct represented protected activity under the Noerr-Pennington Doctrine, relying on district court findings that the AMA's conduct was not aimed at legislative bodies and

---

182. See id. at 2881-82 (Stevens, J., dissenting).
183. Id. at 2874 (Brennan, J., dissenting); see also id. at 2881-83 (Stevens, J., dissenting).
186. Former Principle 3 provided: "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate with anyone who violates this principle." *Wilk*, 895 F.2d at 355, n.1.
187. Id. at 355-57. The district court had rejected the AMA's claim that it acted because of a genuine and reasonable concern for scientific method in patient care and that it could not adequately satisfy its concern in a way that was less restrictive of competition. *Id.* The district court went on to find that, although the legal conspiracy had ended in 1980, the boycott's "lingering effects" still threatened plaintiffs with current injury and ordered injunctive relief, i.e., affirmation by the AMA to its members that there are no current impediments to professional association and cooperation between chiropractors and physicians, except as provided by law. *Id.*
administrative agencies but was instead targeted at members of its own association. The appeals court also affirmed district court findings that there was not convincing evidence of either the Joint Commission on Accreditation of Hospitals or the American College of Physicians’ alleged membership or participation in the AMA's unlawful boycott.188

In United States v. Carilion Health System,189 the Court of Appeals for the Fourth Circuit affirmed a lower court ruling which found that the proposed merger of Roanoke Memorial Hospitals and Community Hospital of Roanoke Valley did not violate section 1 of the Sherman Act.190 The court ruled that prior findings of the United States District Court for the Western District of Virginia regarding the relevant product and geographic markets were not clearly erroneous.191 The Fourth Circuit noted that the district court was evaluating the reasonableness of the merger as a whole. Accordingly, the appeals court held that the district court’s determination that a significant number of problems could be treated on an inpatient or outpatient basis and that the hospitals compete within the areas defined by the district court was not clearly erroneous.192

With regard to the geographic market for hospital services, the Fourth Circuit noted that it should include all of the places to

188. Id. at 357-58.
189. 892 F.2d 1042 (4th Cir. 1989) (unpublished opinion).
191. In United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), the district court determined that the relevant product market included both inpatient and outpatient services due to the differences of medical opinion as to whether a problem must be treated in a hospital or whether outpatient treatment is appropriate. Id. at 844-45. Moreover, the district court found that the geographic market for hospital services differed with respect to primary/secondary hospital services and tertiary hospital services. The district court defined the geographic market for primary/secondary services as all areas from which Roanoke Memorial Hospitals draws at least 100 patients per year. The district court then determined that the tertiary service market included such areas as Richmond and Charlottesville, Virginia and Winston-Salem and Durham, North Carolina. Id. at 847-48. For further discussion of the district court decision, see generally Urbanski, Antitrust Law Annual Survey of Virginia Law, 23 U. Rich. L. Rev. 455, 480-82 (1989).
192. In support of the district court’s findings regarding the relevant product market, the Fourth Circuit noted that the Supreme Court had grouped banking services together and considered all of the separate markets for loans, checking accounts, certificate of deposit, etc. as one unit in evaluating the anti-competitive effects of bank mergers. United States v. Philadelphia Nat’l Bank, 374 U.S. 321 (1963). An Illinois district court adopted a more service-specific approach in ruling against the proposed merger of two Rockford, Illinois hospitals. See United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill.), aff’d, 898 F.2d 1278 (7th Cir. 1990), petition for cert. filed July 2, 1990 No. 90-162.
which patients would go if the hospitals were to raise the price of their services. In affirming the district court decision on the reasonableness of the Roanoke Memorial Hospitals--Community Hospital of Roanoke Valley merger, the Fourth Circuit did not have occasion to consider the district court’s dismissal of the Clayton Act claim raised by the government.

In Advanced Health-Care Services, Inc. v. Radford Community Hospital, and in Oksanen v. Page Memorial Hospital, the Court of Appeals for the Fourth Circuit remanded four separate antitrust cases filed against health care providers for further discovery. The court also decided whether sibling corporations and whether a hospital and its medical staff may “conspire” for purposes of antitrust immunity.

In each of its complaints, Advanced Health-Care Services alleged that an acute care hospital located in Southwest Virginia was exclusively marketing a competitor’s durable medical equipment (“DME”) products to its patients in return for a financial stake in those DME sales. The plaintiff requested relief under the Sherman Act, the Clayton Act, and Virginia common law. The Fourth Circuit found upon review that there was insufficient basis on the record to dismiss the cases and instead found that factual development through discovery should proceed. Both the court’s opinion and the concurring opinion concluded that summary judg-

193. See Carilion, 707 F. Supp. 840 (W.D. Va. 1989) (citing Satellite Television v. Continental Cablevision, 714 F.2d 351, 357 (4th Cir. 1983)). Again, the court found that while the government’s argument had some force, the record contained sufficient evidence that the hospitals compete within the areas defined by the district court. The Justice Department decided not to appeal the Carilion decision, and the merger of the hospitals went forward as of July 18, 1990. See McGinn, Merger of Non-Profit Hospitals to Stand, Am. Med. News May 18, 1990, at 3.

194. The district court had dismissed the government’s actions under § 7 of the Clayton Act, 15 U.S.C. § 18 (1982), on the ground that it had no application because the merging corporations neither had stock nor were they subject to the jurisdiction of the Federal Trade Commission. The government cited the Clayton Act claim dismissal as an error in the district court decision but only asked that it be considered if the Fourth Circuit remanded the case to the district court for further proceedings. See Carilion, 707 F. Supp. 840.

195. 910 F.2d 139 (4th Cir. 1990).


197. Advanced Health-Care Servs., 910 F.2d at 142-43. As the court noted, DME consists of wheelchairs, hospital beds, walkers, crutches, and other equipment often used by persons convalescing at home after hospitalization. Advanced Health-Care Servs., Nos. 89-2312, 89-2376, 89-2377, slip op. at note 2 and accompanying text.


199. Advanced Health-Care Servs., 910 F.2d at 145, 149-51, 153.
ment may be appropriate at a later stage of the case.200

In Oksanen, Dr. Oksanen brought antitrust claims under sections 1 and 2 of the Sherman Act as well as pendent state claims under the Virginia Antitrust Act201 and also for civil conspiracy, tortious interference with contract, and defamation.202 Dr. Oksanen alleged that Page Memorial Hospital and several members of its medical staff collectively forced him from practice and conspired to restrain competition in, and monopolize, the practice of medicine in Page County through the use of the hospital peer review process and through other steps taken to impair Dr. Oksanen's ability to practice medicine, such as refusing to provide emergency room coverage for Dr. Oksanen's patients and coverage during his absences.203 The United States District Court for the Western District of Virginia granted defendants' Motion for Summary Judgment without allowing Dr. Oksanen an opportunity to receive defendants' responses to his initial discovery request.204 As in Advanced Health-Care Services, the Fourth Circuit reversed and remanded the case to allow plaintiff an opportunity to conduct further discovery on his antitrust and pendent state law claims.205

The Fourth Circuit in both Advanced Health-Care Services and Oksanen had the opportunity to consider the application of the intra-corporate immunity doctrine to allegedly concerted, anticompetitive conduct by hospitals and other persons.206 In Advanced Health-Care Services, the court applied the intra-corporate immunity doctrine to two wholly-owned sibling corporations, while in Oksanen, the court applied the doctrine to a hospital and its medical staff.

In Advanced Health-Care Services, the court found that two wholly-owned subsidiaries of Southwest Virginia Health Services Corporation, Radford Community Hospital and its sibling DME supplier corporation, were legally incapable of conspiring with one another for purposes of section 1 of the Sherman Act.207 The court

200. Id. at 145 n.8.
202. Oksanen, 912 F.2d at 75.
203. Id.
204. Id. at 75-76.
205. Id. at 79-80.
206. But see Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 769 (1984)(holding that officers or employees of the same firm do not provide the plurality of actors imperative for a Sherman Act § 1 conspiracy).
207. Advanced Health-Care Servs., 910 F.2d at 147.
adopted the reasoning of the Fifth and Sixth Circuits and several district courts in finding that two corporations with identical owners are legally incapable of conspiring with one another and can be viewed as a single entity. The Fourth Circuit also affirmed the dismissal of the conspiracy to monopolize claim under section 2 of the Sherman Act and the Clayton Act claim against Southwest Health Services Corporation, Radford Community Hospital and its sibling DME supplier corporation based on the inability of these corporations to conspire with one another in accordance with the court's interpretation of the intra-corporate immunity doctrine.

In Oksanen, the Fourth Circuit relied on prior rulings of the Ninth and Eleventh Circuits to find that physicians on a hospital medical staff may conspire with the hospital and with each other in the peer review process. In so holding, the court noted that hospital staff doctors may have interests that diverge from each other and that may be out of sync with the interests of the hospital.

C. Implementation of the Health Care Quality Improvement Act

On October 17, 1989 the Department of Health and Human Services published final regulations designed to implement the Health Care Quality Improvement Act ("HCQIA") requirements that

210. Advanced Health-Care Servs., 910 F.2d at 150, 152.
212. Oksanen, 912 F.2d at 77 (citing Blumstein & Sloan, Antitrust and Hospital Peer Review, LAW & CONTEMP. PROBS. 7, 51 (1988)). Notably, the court concluded that the hospital medical staff members acted as independent sole practitioners and pursued in many instances personal economic interests. Oksanen, 912 F.2d at 77. This conclusion seems a bit premature based upon the pre-discovery status of the case and may explain the court's decision to rehear the case en banc. However, the intent of this ruling could be limited by the court's acceptance of plaintiff's allegations as true for purposes of summary judgment and not that the court has found that medical staff physicians at Page Memorial Hospital acted independently of the hospital in relation to Dr. Oksanen's continued medical staff membership. See Fed. R. Civ. P. 56.
each person or entity, including an insurance company, which makes a payment for the benefit of a physician or other health practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such physician or health care practitioner for medical malpractice, report such payments to a National Practitioner Data Bank ("the Data Bank").214 Additionally, the Data Bank will receive and collect information based on state licensing authority reports of adverse licensure actions taken by state licensing boards215 and adverse actions on a practitioner’s membership status or clinical privileges taken by hospitals or other health care entities.216 As the regulations indicate, a health care entity can include a hospital, a health maintenance organization, and a professional society.217

In early 1990, the Public Health Service, in conjunction with Data Bank contractor UNISYS, offered informational conferences around the country to explain the requirements of the HCQIA and specifically the Data Bank to practitioners, hospital administrators

---

215. Id. § 11132.
216. Id. § 11133. The incentive offered to hospitals and other health care entities for compliance with HCQIA reporting and inquiry requirements, is the availability of immunity from federal antitrust liability. See 42 U.S.C.A. §§ 11111(a)(1), 11112 (West Supp. 1990). While the HCQIA offers no immunity from suits filed by physicians subject to disciplinary action, e.g., reductions or revocations of hospital staff privileges, the HCQIA immunity provisions do provide reviewing courts with a basis to enter summary judgment for health care entities who comply with the Act’s due process and reporting requirements. See Note, Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act, 29 WM. & MARY L. REV. 609, 628 (1988); Mellette, Patrick v. Burget Decision sets Antitrust Limits on Hospital Peer Review, 16(12) MED. UTIL. REV. June 23, 1988, at 5. A recent California federal district court case granted summary judgment to a hospital and its medical staff reviewers, adopting this approach. Austin v. McNamara, 731 F. Supp. 934, (C.D. Cal. 1990).
217. See 45 C.F.R. § 60.3 (1989). Both the statute and the regulations require health care entities to request data bank reports every two years and to report adverse actions against health care practitioners in order to obtain the protections from suit offered by the statute. The failure to report can lead to loss of immunity from antitrust actions, 42 U.S.C. §§ 11111(b), 11133(c). The failure to obtain reports creates a presumption that the health care entity knew of the information contained in the reports in the event of a medical malpractice suit. See id. § 11135(b). In the event that a payment to a claimant is made as a result of a judgment in or settlement of a medical malpractice complaint, an insurer or other person making the payment is subject to substantial civil monetary penalties. Penalties of up to $10,000 per payment can be assessed. Id. § 11131.
and staff, and malpractice insurers. The conferences highlighted key interpretive issues regarding Data Bank regulations and answered many of the outstanding questions regarding Data Bank operations. The Data Bank opened on September 1, 1990.

V. CONCLUSION

The practice of health care continues to experience revolutionary changes in the 1990's. Recent legal case decisions and legislative enactments have created new challenges and opportunities for health care providers, insurers, and the public at large.


219. Id.