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HEALTH CARE LAW

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I. INTRODUCTION

This article discusses the state of health care law in Virginia. It is not intended to be a primer on regulatory or corporate health care law, and therefore, is in no way comprehensive in nature. Rather, it is a survey of the more newsworthy areas of the law that impact medical professionals, patients, and the attorneys who represent both groups. With increasing media and government attention, the laws that govern the medical profession and health care litigation in general are evolving. On the verge of another medical malpractice insurance crisis, this article examines the status of, and recent changes to, the body of law that controls Virginia's professionals and the delivery of health care services to the Commonwealth at large.

II. THE MEDICAL MALPRACTICE ACT

Virginia, like other states, found itself in the midst of a medical malpractice crisis in the mid-1970s when medical professional liability insurance carriers drastically increased premiums for coverage. The crisis prompted the General Assembly of Virginia to find a way to contain costs and protect physicians from increasing premiums. The General Assembly ordered a study of the issue,[1]

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1. *See* INTERIM REPORT OF THE JOINT SUBCOMM. STUDYING VA. MED. MALPRACTICE LAWS, H. Doc. No. 21 (1985).

which resulted in the passage of the Medical Malpractice Act ("Malpractice Act").[2] The Malpractice Act created a pretrial screening tool,[3] and a cap on damage recoveries.[4] It further provided for the Chief Justice of the Supreme Court of Virginia to promulgate rules of practice under the statute.[5] These rules are not part of the Malpractice Act, but are found at the back of the Rules of the Supreme Court of Virginia.[6] The Malpractice Act changed the way civil litigators approached medical negligence cases, as the statutes of the Malpractice Act and the related Rules of Practice control the manner in which this special category of tort actions is prepared for trial and ultimately tried to a jury in the Commonwealth of Virginia.

A. *Medical Malpractice Review Panels*

The Medical Malpractice Rules of Practice ("Rules") permit any party to a malpractice case to request a Medical Malpractice Review Panel ("Panel") after civil litigation against a health care provider has been instituted.[7] The party must request the Panel within thirty days of the date the defendant(s) filed responsive pleadings.[8] Historically, defendants requested Panels more frequently than plaintiffs, as physicians wanted the benefit of case review by a jury of their "peers."

In accordance with Medical Malpractice Rule 2(b), a Panel request must include the names, addresses, and telephone numbers of the parties and their respective counsel.[9] The request must include a certification—similar to that included with a legal pleading—that the request has been mailed to all other parties and their attorneys, if their identities are known.[10] With the request, counsel for the requesting party is required to send copies of the Motion for Judgment and all responsive pleadings to the clerk of

2. VA. CODE ANN. § 8.01-581.1 to -581.20 (Repl. Vol. 2000 & Cum. Supp. 2003).
3. *See id.* § 8.01-581.2 (Cum. Supp. 2003) (allowing for either party to request a panel within thirty days from the filing of the responsive pleading).
4. *Id.* § 8.01-581.15 (Cum. Supp. 2003).
5. *Id.* § 8.01-581.11 (Repl. Vol. 2000).
6. VA. MED. MAL. R. 1–7.
7. VA. CODE ANN. § 8.01-581.2(A) (Cum. Supp. 2003).
8. *Id.*; VA. MED. MAL. R. 2(a).
9. VA. MED. MAL. R. 2(b).
10. VA. MED. MAL. R. 2(b)(6).

the supreme court.[11] A copy of the request is also sent to the clerk of the circuit court where the matter is pending.[12]

Once the request is received, the Supreme Court of Virginia selects four members from a list of attorneys and physicians compiled by the Virginia State Bar and the Virginia Board of Medicine to serve on the Panel.[13] The judge from the circuit court where the underlying action is pending presides over the Panel.[14] In appointing members of the Panel, the supreme court endeavors to appoint health care professionals who practice in the same specialty of medicine as the defendant.[15]

Once a Panel is designated, either party may request an *ore tenus* hearing before the Panel.[16] The request must be made in writing within ten days of the designation of the Panel members.[17] Also within that time limitation, the circuit court judge presiding over the Panel will advise the parties of the discovery cut-off date.[18] This date should not exceed 120 days from the date the Panel was originally requested.[19] Standard pretrial discovery is accepted and may be used later at the trial in circuit court.[20]

The judge presiding over the Panel holds the same authority as he or she would in Virginia's circuit courts. The judge may administer the oath,[21] rule on the admissibility of evidence,[22] advise the Panel on legal issues,[23] issue subpoenas,[24] and prepare the

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11. VA. CODE ANN. §§ 8.01-581.2(A) (Cum. Supp. 2003).

12. *Id.*

13. *Id.* §§ 8.01-581.2(A), -581.3 (Repl. Vol. 2000 & Cum. Supp. 2003). Specifically, the court appoints two "impartial" attorneys and two "impartial" health care providers who are actively practicing their professions in the Commonwealth. *Id.* § 8.01-581.3(i) (Repl. Vol. 2000). The supreme court appoints the panel members from a pool of 240 attorneys and 915 health care professionals, which have been provided by the Virginia Board of Medicine and the Virginia State Bar, respectively. VA. MED. MAL. R. 3(c)–(d).

14. VA. CODE ANN. § 8.01-581.3(ii) (Repl. Vol. 2000). The judge has no vote and does not take part in the Panel's deliberations. *Id.*

15. *Id.* § 8.01-581.3 (Repl. Vol. 2000).

16. *Id.* § 8.01-581.5 (Repl. Vol. 2000); VA. MED. MAL. R. 5.

17. VA. MED. MAL. R. 5.

18. VA. CODE ANN. § 8.01-581.3:1 (Repl. Vol. 2000); VA. Med. Mal. R. 4(d).

19. VA. CODE ANN. § 8.01-581.3:1 (Repl. Vol. 2000).

20. *See id.* § 8.01-581.4 (Repl. Vol. 2000).

21. *See id.* § 8.01-581.3:1 (Repl. Vol. 2000).

22. *Id.* § 8.01-581.4 (Repl. Vol. 2000).

23. *Id.*

24. *See id.* § 8.01-581.6(3) (Repl. Vol. 2000).

Panel's opinion.[25] Evidence is submitted to the Panel members and the judge prior to or in lieu of an *ore tenus* hearing.[26] The submission includes a statement of facts and all documentary evidence the party plans to introduce to the Panel.[27] The plaintiff's submission is due no later than ten days after the discovery cut-off.[28] Similarly, the defendant's submission is due no later than ten days after receiving the plaintiff's submission.[29] In reaching its decision, the Panel may consider the parties' written submissions,[30] and, in the case of an *ore tenus* hearing, live testimony of fact and expert witnesses.[31]

In the cases where an *ore tenus* hearing has been requested and scheduled, the hearing is conducted like a "mini-trial." The parties offer the testimony of witnesses under oath,[32] present relevant evidence, and conduct cross-examination.[33] A party is not, however, compelled to appear in order for the Panel to reach a decision.[34] In the absence of a hearing, the Panel will convene in executive session to review the submissions, deliberate, and reach a decision.[35] The parties are given notice of the date, time, and place for the executive session.[36]

The Panel must render an opinion within thirty days of receiving all the parties' submissions.[37] The Panel may make one of the following decisions: (1) the defendant did not breach the standard of care; (2) the defendant breached the standard of care and the breach was the proximate cause of the plaintiff's alleged damages; (3) the defendant breached the standard of care but did not cause the alleged damages; or (4) there is a material fact, not re-

25. *Id.* § 8.01-581.4 (Repl. Vol. 2000).

26. VA. MED. MAL. R. 4(e).

27. *Id.*

28. *Id.*

29. VA. MED. MAL. R. 4(f).

30. Evidence may include medical records, radiology studies, lab studies, excerpts from medical literature, and depositions of witnesses. *See* VA. CODE ANN. § 8.01-581.4 (Repl. Vol. 2000).

31. *See id.* § 8.01-581.6(2) (Repl. Vol. 2000).

32. *Id.* § 8.01-581.6(1) (Repl. Vol. 2000); VA. MED. MAL. R. 6(j)(4).

33. VA. CODE ANN. § 8.01-581.6(2) (Repl. Vol. 2000).

34. *Id.*

35. VA. MED. MAL. R. 5.

36. *Id.*

37. VA. CODE ANN. § 8.01-581.7(A) (Repl. Vol. 2000); VA. MED. MAL. R. 6(j)(13).

quiring expert testimony but related to liability, which should be considered by a judge or jury.[38]

The decision must be reached by a majority of the Panel. The opinion must be in writing and any member of the Panel may note his dissent.[39] It must then be mailed to the parties within five days of the decision and may be announced in the presence of the parties at the *ore tenus* hearing.[40]

The Panel opinion is admissible at trial, but is not conclusive or binding on the trier of fact.[41] Furthermore, any party may call a Panel member (excluding the judge) as a trial witness.[42] The Panel enjoys immunity from civil liability for opinions or conclusions reached in the course of and within the scope of its duties.[43] All documentary evidence, a transcript of the *ore tenus* hearing, if applicable, and a copy of the Panel's decision are filed with the clerk of the circuit court.[44] The materials remain part of the court file until completion of the legal action and are included with the case record.[45]

Medical Malpractice Review Panels are being requested less frequently than they have been in the past. Most parties now recognize that the Panel process adds delay and expense to the underlying action. Health care defendants are beginning to appreciate that a favorable outcome from the Panel is no guarantee that the case will be dismissed by the plaintiff, disposed of after discovery, or won by the defense at trial. In fact, when the defendant requests the Panel, most plaintiffs opt out of the process and observe from a distance. This decision provides the plaintiff access to "free" discovery and some insight into the defense strategy prior to trial. This strategy, in the end, places the defendant at a disadvantage not contemplated by the General Assembly when the Malpractice Act was first instituted.

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38. VA. CODE ANN. § 8.01-581.7(A)(1)–(4) (Repl. Vol. 2000).

39. *Id.* § 8.01-581.7(C) (Repl. Vol. 2000).

40. *Id.*

41. *Id.* § 8.01-581.8 (Repl. Vol. 2000). *See also* Raines v. Lutz, 231 Va. 110, 115–16, 341 S.E.2d 194, 197 (1986) (holding that the opinion of the review panel was not binding upon the trier of fact, but may be considered with other evidence).

42. VA. CODE ANN. § 8.01-581.8 (Repl. Vol. 2000).

43. *Id.*

44. *Id.* § 8.01-581.4:1 (Repl. Vol. 2000); VA. MED. MAL. R. 6(d).

45. VA. CODE ANN. § 8.01-581.4:1 (Repl. Vol. 2000).

B. *Medical Malpractice Damages Limited by Statute*

From its inception, the Malpractice Act has limited recovery for damages associated with medical malpractice litigation.[46] The cap only applies to an alleged act of medical negligence against a "health care provider," as defined in Virginia Code section 8.01-581.1.[47] The total amount recoverable includes both prejudgment interest[48] and punitive damages.[49] A plaintiff may seek to recover any amount, but the judge must reduce a jury's verdict to comply with the statutory limit.[50]

In 1999 the General Assembly raised the cap to $1,500,000.[51] It will increase annually every July 1 by $50,000,[52] and in 2007 and 2008 it will increase by $75,000 each year to reach $2,000,000.[53] The final increase will occur on July 1, 2008.[54] The constitutionality of this limit has been an issue since the enactment of the Malpractice Act. Most recently, the Supreme Court of Virginia upheld the constitutionality of the cap in *Pulliam v. Coastal Emergency Services*.[55] Specifically, the supreme court ruled that the statutory cap does not violate the right to trial by jury,[56] prohibitions against special legislation,[57] the Fifth Amendment's takings clause,[58] or the Due Process and Equal Protection Clauses.[59] It is anticipated that the Virginia Trial Lawyers Association will resume its lobby to increase the limitation on recovery or abolish the malpractice cap altogether in the 2009 legislative session.[60]

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46. *See id.* § 8.01-581.15 (Cum. Supp. 2003).

47. *Id.*; *see id.* § 8.01-581.1 (Cum. Supp. 2003) (defining health care provider).

48. VIRGINIA CLE, MEDICAL MALPRACTICE LAW IN VIRGINIA § 2.403, at 47 (Malcolm P. McConnell III ed., 2002).

49. *Id.* § 2.402, at 46–47.

50. *Id.* § 2.401, at 46.

51. Act of Mar. 28, 1999, ch. 711, 1999 Va. Acts 1190 (codified as amended at VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 2003)).

52. VA. CODE ANN. § 8.01-581.15 (Cum. Supp. 2003).

53. *Id.*

54. *Id.*

55. 257 Va. 1, 509 S.E.2d 307 (1999).

56. *Id.* at 15, 509 S.E.2d at 315.

57. *Id.* at 19, 509 S.E.2d at 315.

58. *Id.* at 20, 509 S.E.2d at 318.

59. *Id.* at 21, 509 S.E.2d at 318.

60. For further discussion on statutory limitations on medical malpractice awards, see Michael L. Goodman et al., *Damages for Medical Malpractice in Virginia*, 33 U. RICH. L. REV. 919 (1999) and VIRGINIA CLE, *supra* note 48, at 46–47.

C. *Standard of Care*

In 2003 the General Assembly amended the statute that controls how claimants prove the applicable standard of care and any breach of that standard in any proceeding before a medical malpractice review panel or an action for civil damages.[61] House Bill 1906 amended the statute to limit the number of experts permitted to testify in any action.[62] Specifically, the statute limits each party to no more than two medical experts from any medical specialty on any issue presented.[63] It does not limit the number of treating health care providers who may be called to testify as experts in accordance with Virginia Code section 8.01-399.[64]

III. VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT

In response to the burgeoning cost of malpractice insurance coverage, the General Assembly enacted the Virginia Birth-Related Neurological Injury Compensation Act ("Act") in 1987.[65] The Act established the Virginia Birth-Related Neurological Injury Compensation Program ("Program"),[66] which has been fraught with criticism in recent years. As a result, it garnered the attention of the General Assembly in 2003.

During this legislative session, House Bill 2048 was introduced to address some of the provisions of the Act that have come under fire.[67] The legislation amends the definition of "birth-related neu-

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61. The standard of care is defined as "that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth and the testimony of an expert witness." VA. CODE ANN. § 8.01-581.20(A) (Cum. Supp. 2003).

62. H.B. 1906, Va. Gen. Assembly (Reg. Sess. 2003) (enacted as Act of Mar. 16, 2003, ch. 251, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 8.01-581.20(C) (Cum. Supp. 2003))).

63. *Id.*

64. *Id.*

65. Act of Mar. 27, 1987, ch. 540, 1987 Va. Acts 830 (codified as amended at VA. CODE ANN. §§ 38.2-5000 to -5021 (Repl. Vol. 2002 & Supp. 2003)).

66. *Id.*

67. H.B. 2048, Va. Gen. Assembly (Reg. Sess. 2003) (enacted as Act of Mar. 22, 2003, ch. 897, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. §§ 2.2-3701, -3705 (Cum. Supp. 2003); *id.* §§ 38.2-5001, -5002, -5004, -5004.1, -5005, -5007, -5008, -5009, -5015, and -5016 (Supp. 2003); codified at *id.* §§ 38.2-5002.1, -5002.2, -5009.1, and -5016.1 (Supp. 2003))).

rological injury" to include an injury "occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery . . . ."[68] The Act, as amended, further authorizes the Worker's Compensation Commission to award up to $100,000 to the parents or legal guardian of an infant who meets the criteria of the program and dies within 180 days of birth.[69] The Office of the Attorney General is required to provide legal services for the Program.[70] Other changes to the Act include: (1) a requirement that the Board of Health Professions or Department of Health investigate health care providers and participating hospitals if the conduct rises to the level of disciplinary action;[71] (2) a requirement that hospitals release fetal heart monitoring strips to the Program or the claimant;[72] and (3) a requirement that the report of the reviewing panel of physicians be mailed to all parties and the Program within sixty days after filing of the petition with the Worker's Compensation Commission.[73]

With regard to the obligations of participating physicians and hospitals, the amended Act now requires physicians and midwives to inform their patients, in writing, as to whether they participate in the Program.[74] The Act also requires hospitals to provide a brochure on the Program to all parents of infants admitted to the neonatal intensive care unit.[75] The exclusive remedy provisions remain, although the General Assembly clarified the scope of the statute. The mother of the injured infant is not subject to the Program's exclusivity provision regarding her own physical injuries sustained during the birthing process; however, the provision applies to claims by an infant's parents or representative if the claim is derivative of the medical malpractice claim for the infant's injuries.[76]

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68. *Id.* (codified as amended at VA. CODE ANN. § 38.2-5001 (Supp. 2003)).

69. VA. CODE ANN. § 38.2-5009.1 (Supp. 2003).

70. *Id.* § 38.2-5002.1(A) (Supp. 2003).

71. *Id.* § 38.2-5004(B)–(C) (Supp. 2003).

72. *Id.* § 38.2-5004(E)–(F) (Supp. 2003). Failure to provide the fetal heart monitor strips creates a rebuttal presumption of fetal distress. *Id.* § 38.2-5008(A)(1)(b) (Supp. 2003).

73. *Id.* § 38.2-5008(C) (Supp. 2003).

74. *Id.* § 38.2-5004.1(A) (Supp. 2003).

75. *Id.* § 38.2-5004.1(B) (Supp. 2003).

76. *Id.* § 38.2-5002(B) (Supp. 2003).

With patient privacy also in the spotlight, the General Assembly enacted a statute to maintain as confidential certain records of the Program. Those records include: (1) records subject to the attorney-client privilege; (2) medical and mental records of claimants; (3) records relative to deliberations of the board of directors of the Program; (4) reports of expert witnesses; and (5) all records required to be maintained as confidential by federal law.[77]

Finally, the Supreme Court of Virginia laid to rest the controversy as to whether the April 1, 2000 amendments to the Act were intended to be retroactive. In *Berner v. Mills*,[78] the court held that the emergency legislation amending the statutory definition of "participating physician" was effective as of the date it was passed—the amendment was not retroactive.[79]

The Program came under fire by the General Assembly, the local media, and some of Virginia's health care law experts.[80] It is anticipated that the 2004 legislative session will include discussions about reorganizing or abolishing the Program in its entirety.

IV. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

The federal Emergency Medical Treatment and Active Labor Act ("EMTALA")[81] applies to any hospital that has an emergency room.[82] The statute provides that the hospital is liable for failure to treat any patient who arrives at the facility in an emergent condition.[83] EMTALA causes of action arising in Virginia are governed by the federal procedures provided in EMTALA rather than the Virginia Medical Malpractice Act.[84]

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77. Act of Mar. 22, 2003, ch. 897, 2003 Va. Acts ___ (codified at VA. CODE ANN. § 38.2-5002.2 (Supp. 2003)).

78. 265 Va. 408, 579 S.E.2d 159 (2003).

79. *Id.* at 414–15, 579 S.E.2d at 162.

80. *See generally* K. Marshall Cook, *The Virginia Birth Injury Program: Challenges of Adolescence*, VA. HEALTH LAW., (Va. State Bar, Richmond, Va.) June 2003, at 10, *available at* http://www.vsb.org/sections/hl/index.htm (last visited Sept. 22, 2003).

81. 42 U.S.C. § 1395dd (2000).

82. *Id.* § 1395dd(a) (2000).

83. *Id.* § 1395dd(b)(1) (2000).

84. VIRGINIA CLE, *supra* note 48, § 2.1.

While EMTALA is a remedial statute designed to prevent discrimination against those patients who are unable to pay for treatment or who are covered under Medicare or Medicaid, the statute reaches more broadly than its intended purpose. EMTALA imposes affirmative obligations on health care providers that go beyond non-discrimination. Section 1395dd(d)(1)(C), by its very terms, applies to physicians as well as hospitals.[85] This section of the Act imposes a penalty on the physician who fails to respond to a patient's emergency medical condition when he or she is the physician on-call.[86] An "emergency medical condition" is defined as:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
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> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> (ii) serious impairment to bodily functions, or
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant women [sic] who is having contractions—
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[87]

Not providing treatment to someone who presents any of these symptoms subjects an individual physician "to a civil money penalty of not more than $50,000."[88] Likewise, hospitals may be "subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds)."[89] In essence, the provisions of EMTALA impose equal liability on both the health care employees of the hospital and the institution itself. Accordingly, some courts have allowed hospitals to make a claim for contribution or indemnity against the individual health care provider who makes a decision against which

85. 42 U.S.C. § 1395dd(d)(1)(C) (2000).
86. *Id.*
87. *Id.* § 1395dd(e)(1) (2000).
88. *Id.* § 1395dd(d)(1)(B) (2000).
89. *Id.* § 1395dd(d)(1)(A) (2000).

an EMTALA claim is made.[90] There have been no such decisions in the courts of Virginia to date. Of course, the individual providers most likely to encounter such difficult EMTALA decisions are those employed in hospital emergency rooms.

EMTALA allows plaintiffs to seek recovery for personal harm to the patient[91] or for financial losses to the receiving medical facility.[92] The statute of limitations for recovery under EMTALA is two years from the date of the violation.[93]

The Supreme Court of the United States interpreted the provisions of EMTALA in *Roberts v. Galen of Virginia, Inc.*[94] The Supreme Court rejected the position of the United States Court of Appeals for the Sixth Circuit,[95] which held that in order to prevail on an EMTALA claim, the claimant must show that the hospital acted with an improper motive.[96] That is, that the violation resulted from discrimination based on the patient's race, sex, ethnic group, disease, occupation, or political or cultural affiliation.[97] The Supreme Court's opinion, while not detailed, states that patients who allege that they have been improperly treated in violation of EMTALA need not show that the hospital acted with an improper motive.[98] In sum, the opinion suggests that liability under EMTALA need not be based on an improper transfer due to financial considerations, but rather that the patient was not properly stabilized in accordance with the provisions of the Act, irrespective of any improper motive.[99] The effect of this ruling, it seems, is that an EMTALA claim sounds in simple negligence rather than for violations born out of discrimination.

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90. *See, e.g.*, McDougal v. LaFourche Hosp. Serv. Dist. No. 3, No. 92-2006, 1993 U.S. Dist. LEXIS 7381, at *3–4 (E.D. La. May 25, 1993) (unpublished decision) (holding that a hospital may assert its state law claim against a doctor at fault).

91. 42 U.S.C. § 1395dd(d)(2)(A) (2000).

92. *Id.* § 1395dd(d)(2)(B) (2000).

93. *Id.* § 1392dd(d)(2)(C) (2000).

94. 525 U.S. 249 (1999) (per curiam).

95. *Id.* at 252.

96. Roberts v. Galen of Virginia, Inc., 111 F.3d 405, 409 (6th Cir. 1997).

97. *Roberts*, 525 U.S. at 252 (noting that the Sixth Circuit's position was contrary to the law of other circuits who have addressed the motive issue); *see also* Cleland v. Bronson Health Care Group, 917 F.2d 266, 272 (6th Cir. 1990) (holding that EMTALA section 1395dd(a) contains an improper motive requirement).

98. *See Roberts*, 525 U.S. at 253.

99. *Id.*

It will be interesting to see whether the *Roberts* opinion neutralizes the effect of EMTALA and results in no more than a state court action for medical malpractice. As with most issues in health care, the laws that affect and govern the profession are constantly evolving. Time will be the best determinant as to the true impact of EMTALA on the individual practitioner.

V. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The media and legislative spotlights have been on the Health Insurance Portability and Accountability Act ("HIPAA") since the Clinton Administration. At one time known as the Kassebaum-Kennedy Law, Congress passed HIPAA in 1996.[100] The primary purpose of HIPAA was to improve the continuity and portability of health care while preserving the privacy of certain health information.[101] Additionally, the Act seeks "to combat waste, fraud, and abuse in health insurance and health care delivery . . . [and] to simplify the administration of health insurance . . . ."[102] In an effort to carry out these purposes in the information age, HIPAA targets three areas of the health care industry: (1) insurance portability;[103] (2) fraud enforcement;[104] and (3) administrative simplification.[105] Patient privacy is the focus of HIPAA's administrative simplification section.[106]

These privacy regulations ("Privacy Rule") are designed to maintain the privacy of certain protected health information ("PHI") of patients. The final Privacy Rule was published in December 2000, to be effective in April 2001.[107] The Privacy Rule applies to certain covered entities, including the following: (1)

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100. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of the United States Code).

101. *Id.*

102. *Id.*

103. *Id.* §§ 101–02, 110 Stat. at 1939–55.

104. *Id.* §§ 200–50, 110 Stat. at 1991–2021.

105. *Id.* §§ 261–64, 110 Stat. at 2021–34. For a more comprehensive discussion of the administrative simplification process, *see* Elizabeth Guilbert Perrow & Thomas W. Farrell, *The Health Insurance Portability and Accountability Act: An Overview of Administrative Simplification*, XIV J. CIV. L. 231 (2002).

106. 42 U.S.C. §§ 1320d to -1320d-8 (2000).

107. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164).

health plans; (2) health care clearinghouses; and (3) health care providers who transmit health information in electronic form related to a transaction covered by the federal regulations.[108] Final modifications to the Privacy Rule were published in August 2002,[109] and covered entities were required to comply with the Privacy Rule by April 14, 2003.[110]

HIPAA's Privacy Rule protects "individually identifiable health information," whether oral or written, that is maintained or transmitted by a covered entity.[111] "Individually identifiable health information" includes "demographic information collected from an individual [patient]."[112] It further includes any information "created or received by a health care provider, health plan, employer, or health care clearinghouse . . . [that] [r]elates to the past, present, or future physical or mental health or condition of an individual."[113] It also relates to information regarding "the past, present, or future payment for the provision of health care to an individual," if the information identifies the individual patient.[114]

The Privacy Rule does not prohibit disclosure of PHI; rather, it requires that the information be disclosed only in accordance with HIPAA.[115] The Privacy Rule requires that when a covered entity discloses PHI or when it is requesting protected information from another covered entity, it must make reasonable efforts to limit PHI to the minimum disclosure necessary to meet the requirements of the request.[116] That being said, this requirement does not apply to the release of PHI in the following situations: (1) requests from or disclosure to a health care provider for the purpose of medical treatment; (2) release of PHI to the patient himself; (3) disclosure of PHI to the Department of Health and Human Services; (4) disclosures or requests required by law; or

108. 45 C.F.R. § 164.104 (2001).

109. Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,182 (Aug. 14, 2002) (to be codified at 45 C.F.R. pts. 160, 164).

110. 45 C.F.R. § 164.534 (2002). Small health plans must comply by April 14, 2004. *Id.*

111. *Id.* § 164.501 (2002).

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.* § 164.502(a) (2002).

116. *Id.* § 164.502(b)(1) (2002).

(5) release of, or request for, information in accordance with the Privacy Rule.[117]

Individuals are granted certain rights to their PHI under HIPAA's Privacy Rule. These rights include the following: (1) to request that certain restrictions be placed on the disclosure of their PHI;[118] (2) to review and copy their PHI;[119] (3) to amend their PHI;[120] (4) to receive a copy of the notice from the covered entity;[121] and (5) to receive an accounting of disclosures of PHI.[122] Despite the patient's rights under HIPAA, PHI—as contained in the medical records—remains the property of the health care provider.[123]

The Privacy Rule requires that a covered entity not disclose or use PHI without authorization, unless the disclosure is contemplated by the regulations.[124] For an authorization to be valid under HIPAA, it must include the following information: (1) a description of the information to be disclosed; (2) "identification of the person(s), or class of persons, authorized" to use or disclose the PHI; (3) identification of the person(s), or class of persons, to whom disclosure may be made; (4) a description of the purpose of the use of disclosure; (5) an expiration date or event; (6) the individual's signature and date; and (7) a description of the authority of the signator to act on behalf of the individual, if signed by a personal representative.[125] The authorization must also notify the patient of his or her rights by including: (1) a statement that the individual may revoke authorization and instructions regarding how to do so, and (2) a statement that medical treatment, payment, enrollment in a plan, or eligibility for benefits may not be predicated on obtaining the authorization from the individual if such a condition is prohibited by the Privacy Rule.[126] To the degree it is not prohibited, the authorization must also include: (1) a statement about the consequences of not authorizing use and/or

117. *Id.* § 164.502(b)(2) (2002).
118. *Id.* § 164.522(a)(1) (2002).
119. *Id.* § 164.524(a)(1) (2002).
120. *Id.* § 164.526(a)(1) (2002).
121. *Id.* § 164.520(a)(1) (2002).
122. *Id.* § 164.528(a)(1) (2002).
123. *See* VA. CODE ANN. § 54.1-2403.3 (Repl. Vol. 2002).
124. 45 C.F.R. § 164.508(a) (2002).
125. *Id.* § 164.508(c)(1) (2002).
126. *Id.* § 164.508(c)(2)(i)–(ii)(A) (2002).

disclosure,[127] and (2) a statement about the likelihood that the PHI will be disclosed by the recipient.[128]

Authorization is *not* required for disclosure in accordance with the following: (1) public health activities;[129] (2) reporting victims of abuse, neglect, or domestic violence;[130] (3) health oversight activities;[131] (4) judicial and administrative proceedings;[132] or (5) law enforcement purposes (i.e., pursuant to court order or subpoena).[133]

It is important to note that any provision of the HIPAA Privacy Rule that is contrary to Virginia law preempts that provision of state law.[134] That being said, federal law will not preempt state law if the state law is promulgated as necessary to: (1) "prevent fraud and abuse related to the provision of or payment for [medical services]"; (2) ensure state regulation of the insurance industry and health care plans; (3) report on the delivery of health care and related costs; or (4) "serv[e] a compelling need related to public health, safety, or welfare."[135] The general rule also does not apply if the state law's principal purpose is to regulate controlled substances.[136] Furthermore, HIPAA will *not* preempt a state law if the state law is more stringent than the federal statute.[137]

VI. MEDICAL RECORDS AND PATIENT PRIVACY IN VIRGINIA

A. *The Virginia Patient Privacy Act*

The Virginia Patient Privacy Act ("Patient Privacy Act") controls the release of private health information in Virginia.[138] Dur-

127. *Id.* § 164.508(c)(2)(ii)(B) (2002).
128. *Id.* § 164.508(c)(2)(iii) (2002).
129. *Id.* § 164.512(b) (2002).
130. *Id.* § 164.512(c) (2002).
131. *Id.* § 164.512(d) (2002).
132. *Id.* § 164.512(e) (2002).
133. *Id.* § 164.512(f) (2002).
134. 42 U.S.C. § 1320d-7(a)(1) (2000). "Contrary to state law" is defined as impossible to comport with both state and federal law or that the state law is a major obstacle to the implementation of the Privacy Rule. 45 C.F.R. § 160.202 (2002).
135. 45 C.F.R. § 160.203(a)(1)(i)–(iv) (2002).
136. *Id.* § 160.203(a)(2) (2002).
137. *Id.* § 160.203(b) (2002).
138. *See* VA. CODE ANN. § 32.1-127.1:03 (Cum. Supp. 2003).

ing the 2002 legislative session, the General Assembly made anticipatory amendments to several state statues in order to be HIPAA compliant.[139] Like the Privacy Rule, the Patient Privacy Act has many exceptions to the general rule against disclosure.[140] In instances where the Virginia rule is more strict than HIPAA, the state statute will control the use and disclosure of PHI in Virginia.[141]

In 2003, the legislature revised the subpoena provisions of the Patient Privacy Act to comport with federal regulations promulgated pursuant to the Privacy Rule of HIPPA.[142] Specifically, the amendment addresses the return date of a subpoena duces tecum for medical records and the notice requirements.[143] No subpoena return date shall be less than fifteen days unless by court order or at the direction of an administrative agency for good cause.[144] A motion to quash must be filed within fifteen days of the notice to the patient or the medical provider.[145] The notice to the provider must include language that the patient or his counsel had received a copy of the subpoena, that the patient or his counsel has a right to file a motion to quash, and that the provider must not comply with the subpoena until he receives notice that no motion to quash has been filed.[146]

Upon receiving notice that the patient or his counsel has filed a motion to quash, the provider must send the records to the court or administrative agency under seal with a cover letter stating that confidential medical records are enclosed and are to be held pending a hearing and ruling by the court.[147] The revised statute further requires that if *no* motion to quash is filed within fifteen

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139. Act of Apr. 17, 2002, ch. 835, 2002 Va. Acts 2044 (codified as amended at VA. CODE ANN. §§ 32.1-127.1:03, -127-1:04 (Cum. Supp. 2003) (relating to sharing of protected health information between state agencies)); Act of Apr. 6, 2002, ch. 568, 2002 Va. Acts 757 (codified as amended at VA. CODE ANN. §§ 32.1-116.1, -127.1:03 (Cum. Supp. 2003) (allowing the release of patient care reports for victims of crimes)).

140. VA. CODE ANN. § 32.1-127.1:03(D)(1)–(27) (Cum. Supp. 2003).

141. 45 C.F.R. § 160.203(b) (2002).

142. Act of Mar. 31, 2003, ch. 907, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 32.1-127.1:03(H)(1) (Cum. Supp. 2003)). For additional discussion of this change, see James R. Kibler, Jr., *Annual Survey of Virginia Law: Administrative Law*, 38 U. RICH. L. REV. 39, 47 (2003).

143. *Id.*

144. VA. CODE ANN. § 32.1-127.1:03(H)(1) (Cum. Supp. 2003).

145. *Id.*

146. *Id.*

147. *Id.* § 32.1-127.1:03(H)(4) (Cum. Supp. 2003).

days of the date of the request for records, the party issuing the subpoena has the duty to certify[148] to the subpoenaed provider that no motion has been filed and it is appropriate to comply with the request.[149] The medical records requested shall be produced by the original return date or fifteen days after receipt of the certification, whichever is later.[150]

The Patient Privacy Act was further amended to address juvenile medical records and release of such information in the face of federal privacy protection.[151] House Bill 2155 amends the Patient Privacy Act to include section 16.1-248.3.[152] The statute provides for disclosure of otherwise protected medical information to a secure facility (i.e., a juvenile detention facility) directly from a health care provider if consent from the parent or guardian is refused or not readily available.[153] The records may be obtained only if they are necessary: (1) for the provision of medical care and treatment to the juvenile; (2) to protect the health and safety of the juvenile; or (3) to maintain the security and safety of the facility.[154]

B. *Treating Health Care Providers*

Virginia also has a unique statute that limits interaction with an individual's treating physician without the express permission of the patient. Virginia Code section 8.01-399 controls communications between physicians and patients.[155] Specifically, the statute mandates that no licensed practitioner of any branch of the healing arts may be compelled to testify in any civil action re-

148. "Certification" is defined as "a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted. Act of Mar. 31, 2003, ch. 907, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 32.1-127.1:03(B) (Cum. Supp. 2003)).

149. *Id.* (codified as amended at VA. CODE ANN. § 32.1-127.1:03(H)(5) (Cum. Supp. 2003)).

150. VA. CODE ANN. § 32.1-127.1:03(H)(5) (Cum. Supp. 2003).

151. H.B. 2155, Va. Gen. Assembly (Reg. Sess. 2003) (enacted as Act of Apr. 2, 2003, ch. 983, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 32.1-127.1:03 (Cum. Supp. 2003); codified at *id.* § 16.1-248.3 (Cum. Supp. 2003))).

152. *Id.*

153. VA. CODE ANN. § 16.1-248.3 (Cum. Supp. 2003); *id.* § 32.1-127.1:03(C)(3) (Cum. Supp. 2003).

154. *Id.* § 16.1-248.3 (Cum. Supp. 2003).

155. *Id.* § 8.01-399 (Cum. Supp. 2003).

garding information learned in the course of the physician-patient relationship without the consent of the patient or as provided by the section.[156] If the physical or mental condition of the patient is at issue in a civil action, the diagnosis or treatment plan of the practitioner *as documented* in the patient's medical records shall be disclosed, but only in the course of discovery.[157] "Only diagnos[es] offered to a reasonable degree of medical probability [will] be admissible at trial."[158]

The statute further prohibits a lawyer, or someone acting on his behalf, from obtaining information "in connection with pending or threatened litigation . . . from a practitioner . . . without the consent of the patient," unless it is done through the discovery process.[159] This section does not apply, however, to communications between an attorney who "represent[s] a practitioner of the healing arts . . . and that practitioner's employers, partners, agents, servants, employees, co-employees or others for whom, at law, the practitioner is or may be liable or who, at law, are or may be liable for the practitioner's acts or omissions."[160]

VII. VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

The Virginia Department of Health Professions ("Department") was established as an administrative department that is comprised of various health regulatory boards.[161] The Department includes the

> Board of Health Professions . . . Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Funeral Directors and Embalmers, Board of Medicine, Board of Nursing, Board of Nursing Home Administrators, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, Board of Social Work and Board of Veterinary Medicine.[162]

156. *Id.* § 8.01-399(A) (Cum. Supp. 2003).
157. *Id.* § 8.01-399(B) (Cum. Supp. 2003).
158. *Id.*
159. *Id.* § 8.01-399(D) (Cum. Supp. 2003).
160. *Id.* § 8.01-399(D)(1) (Cum. Supp. 2003).
161. *Id.* §§ 54.1-2501, -2503 (Repl. Vol. 2002).
162. *Id.* § 54.1-2503 (Repl. Vol. 2002).

The Board of Health Professions consists of one member from each health regulatory board and five members from the Commonwealth at large.[163] All members are appointed by the Governor, confirmed by the General Assembly, and serve a four-year term.[164] The Board has multiple duties, which include the following: (1) coordination of the health regulatory boards; (2) evaluation of health care professions and occupations in Virginia; (3) review and comment on the budget of the Department of Health Professions; (4) providing the means of citizen access to the member boards; (5) public education of Department activities; (6) review and regulation of all disciplinary processes within the Department; and (7) advising the Governor, the General Assembly, and the Director of the Department on matters relating to the regulation of its professionals.[165]

The individual health regulatory boards have similar and complimentary powers, which include the following: (1) establishing the qualifications for registration, certification, or licensure of their professional members;[166] (2) registering, certifying, or licensing applicants as practitioners of their particular profession;[167] and (3) establishing schedules for renewal of such registration, certification, or licensure.[168] The boards also promulgate regulations in accordance with the Administrative Process Act,[169] which is necessary and reasonable to administer the regulatory system.[170] The boards have the authority to revoke, suspend, restrict, or refuse to issue or reissue a member's certification, registration, or license,[171] and may take appropriate disciplinary action.[172] In general, reports, information, or records received and compiled in the course of a board investigation are confidential[173] and may not

163. *Id.* § 54.1-2507 (Repl. Vol. 2002).
164. *Id.* § 54.1-2400 (Supp. 2003).
165. *Id.* § 54.1-2510 (Repl. Vol. 2002).
166. *Id.* § 54.1-2400(1) (Supp. 2003).
167. *Id.* § 54.1-2400(3) (Supp. 2003).
168. *Id.* § 54.1-2400(4) (Supp. 2003).
169. *Id.* §§ 2.2-4000 to -4032 (Repl. Vol. 2001 & Cum. Supp. 2003).
170. *Id.* § 54.1-2400(6) (Supp. 2003).
171. *Id.* § 54.1-2400(7) (Supp. 2003).
172. *Id.* § 54.1-2400(9) (Supp. 2003).
173. *Id.* § 54.1-2400.2(A) (Supp. 2003).

be obtained by subpoena, through the discovery process, or introduced into evidence in any medical malpractice action.[174]

Lawsuits involving allegations of malpractice are often followed by an inquiry by one of the regulatory boards. These inquiries usually are instituted in one of two ways. First, an individual may file a complaint with the appropriate board (i.e., Board of Medicine, Board of Nursing, Board of Psychology, etc.), which will then be investigated[175] and sometimes followed up by either an informal conference[176] or a full formal conference.[177] Second, investigations by the Department may also be triggered by a report to the National Practitioner Data Bank[178] relative to a settlement or verdict in a medical malpractice case.[179]

In the wake of increased publicity regarding the licensing and regulation of health professionals nationwide, a bill was introduced during the 2003 legislative session to change the disciplinary procedures and burden of proof applicable to board proceedings in Virginia.[180] The General Assembly changed the disciplinary standard for persons licensed by the Board of Medicine from gross negligence to simple negligence.[181] As amended, the statute authorizes disciplinary action for "[i]ntentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients."[182]

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174. *Id.* § 54.1-2400.2(B) (Supp. 2003).

175. *Id.* § 54.1-2506.01 (Supp. 2003).

176. *Id.* § 2.2-4019 (Repl. Vol. 2001 & Cum. Supp. 2003).

177. *Id.* § 2.2-4020 (Repl. Vol. 2001 & Cum. Supp. 2003).

178. 45 C.F.R. §§ 60.1–60.14 (2000). The National Practitioner Data Bank was established in 1986 in an effort to provide information regarding the professional competence of health care providers. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, § 414, 100 Stat. 3784, 3787 (codified at 42 U.S.C. § 11101 (2000)). Medical malpractice insurers must report all payments resulting from insurance claims or judgments against other health care providers. *Id.* § 421(a), 100 Stat. at 3788.

179. Inquiries are also instituted in accordance with a report generated in response to the requirements of Virginia Code sections 54.1-2709.3, -2709.4, and -2906 to -2909, which require individual boards and other health institutions to report disciplinary action to the Department of Health Professions. *See* VA. CODE ANN. § 54.1-2506.01 (Supp. 2003).

180. H.B. 1441, Va. Gen. Assembly (Reg. Sess. 2003) (enacted as Act of Mar. 20, 2003, ch. 762, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 54.1-2915(A)(4) (Supp. 2003))). House Bill 1441 is identical to Senate Bill 1334.

181. *Id.* For a summary of the new rules, see Patrick C. Devine, Jr. & Karen W. Perrine, *Virginia's New Rules for Health Care Practitioner Disciplinary Proceedings*, VA. HEALTH LAW. (Va. State Bar, Richmond, Va.) June 2003, at 2, *available at* http://www.vsb.vipnet.org/sections/hl/ (last visited Sept. 22, 2003).

182. VA. CODE ANN. § 54.1-2915(A)(4) (Supp. 2003).

The effect of the amendment is to blur the line between the administrative process and the legal process.

By definition, medical malpractice involves negligent conduct that causes injury to a patient.[183] Accordingly, any act or omission actionable under the Medical Malpractice Act[184] could potentially result in disciplinary action by the Board of Medicine.[185] The amendment could have devastating results on the profession in Virginia, particularly in the face of another impending liability insurance crisis.

In addition to changing the standard of review, the legislature created a confidential consent agreement to be entered into in lieu of disciplinary action in cases involving minor misconduct where there is little to no injury to a patient or the public and where likelihood of repetition of the misconduct by the practitioner is slight.[186] The consent order is not intended for cases of demonstrated gross negligence, intentional misconduct, or in cases where a practitioner has conducted his practice in a manner that creates a danger to the health and welfare of his patients or the public.[187] The General Assembly further clarified existing reporting requirements by hospitals, health care institutions, and health care professionals regarding disciplinary actions, medical malpractice settlements and judgments, and certain disorders.[188] Civil penalties for failure to report are increased to a maximum of $25,000 for acute care facilities and health care institutions and $5,000 for others.[189]

VIII. MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

The Medical Malpractice Joint Underwriting Association[190] ("JUA") was created due to concern that certain medical special-

183. *See generally id.* § 8.01-581.1 (Cum. Supp. 2003) (defining terms relevant to Medical Malpractice Review Panels).

184. *Id.* §§ 8.01-581.1 to -581.20 (Repl. Vol. 2000 & Cum. Supp. 2003).

185. *Id.* § 54.1-2915(A)(4) (Supp. 2003) (permitting the Board to refuse to issue a license, suspend a license, revoke a license, or censure or reprimand any person for negligent conduct likely to injure a patient).

186. Act of Mar. 20, 2003, ch. 753, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 54.1-2400(14) (Supp. 2003)).

187. *Id.*

188. *Id.* (codified as amended at VA. CODE ANN. § 54.1-2400.3 (Supp. 2003)).

189. *Id.* (codified as amended at VA. CODE ANN. § 32.1-27 (Cum. Supp. 2003)).

190. VA. CODE ANN. §§ 38.2-2800 to -2814 (Repl. Vol. 2002 & Supp. 2003).

ists would not be able to obtain professional liability coverage in Virginia's voluntary market.[191] In certain circumstances the JUA, through activation by the State Corporation Commission ("SCC"), provides medical malpractice insurance for new obstetricians in Virginia who have trouble securing coverage.[192] The SCC has not activated the JUA in this decade; however, some fear that the need will arise in the near future in response to substantially increasing professional liability insurance premiums.[193]

In response to this fear, the legislature passed Senate Bill 1316, which amends Virginia Code section 38.2-2801 to require the SCC to immediately begin an investigation of the voluntary market for medical malpractice insurance in Virginia.[194] If after investigation, the SCC determines that malpractice coverage cannot be made "reasonably available" for a significant number of health care providers, the SCC shall activate the JUA.[195] The SCC's report of findings is due to the Governor and the chairmen of the Commerce and Labor committees of the General Assembly no later than December 31, 2003.[196]

Prior to the 2003 General Assembly Session, limits for medical malpractice policies written by the JUA were not to exceed one million dollars for each claimant under any one policy and three million dollars in any one year.[197] The General Assembly increased limits to two million dollars and six million dollars, respectively, in keeping with the increase in the medical malpractice cap.[198] Now that the JUA limits comport with the statutory cap on damages, the JUA may be an effective remedy to the potential insurance crisis facing Virginia health care professionals. The next legislative session should shed some light on whether the JUA will be implemented in the immediate future.

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191. *Id.* § 38.2-2801(A) (Supp. 2003).

192. *Id.*

193. *See* Act of Mar. 16, 2003, ch. 488, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 38.2-2801(E) (Supp. 2003) (increasing limits on medical malpractice insurance policies issued by the JUA as "emergency legislation")).

194. S.B. 1316, Va. Gen. Assembly (Reg. Sess. 2003) (enacted as Act of Apr. 3, 2003, ch. 1026, 2003 Acts ___ (codified as amended at VA. CODE ANN. § 38.2-2801 (Supp. 2003))).

195. VA. CODE ANN. § 38.2-2801(A) (Supp. 2003).

196. Act of Apr. 3, 2003, ch. 1026, 2003 Acts ___ (codified as amended at VA. CODE ANN. § 38.2-2801 (Supp. 2003)).

197. VA. CODE ANN. § 38.2-2801(E) (Supp. 2003).

198. Act of Mar. 16, 2003, ch. 488, 2003 Va. Acts ___ (codified as amended at VA. CODE ANN. § 38.2-2801(E) (Supp. 2003)).

IX. CONCLUSION

Health care is a progressive, controversial, and ever-changing area of the law. These are turbulent times for Virginia's health care industry and the professionals who practice here. There will be more change in the future, with the fate of the Birth-Related Neurological Injury Compensation Program and the Joint Underwriting Association at the forefront of the agenda. Time will tell us the effect of amendments to the Board of Medicine's standard for review, as well as the true nature of the liability insurance crisis that looms inevitably over the horizon.

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