

VIRGINIA'S NEW RULES FOR HEALTH CARE PRACTITIONER DISCIPLINARY PROCEEDINGS

*By Patrick C. Devine, Jr., Esquire**
Hofheimer Nusbaum, P.C.
and
*Karen W. Perrine, Esquire**
Deputy Executive Director, Virginia Board of Medicine

Introduction

Amid growing public discussion over the manner in which the Virginia Board of Medicine disciplines its licensees, the Virginia General Assembly adopted House Bill 1441 during the 2003 Session substantially to revamp the procedures and standards that apply in connection with disciplinary proceedings of the Board of Medicine (“Board”) and the other health regulatory boards, and the reporting obligations imposed on certain practitioners and institutional providers.¹ The legislation, spearheaded by freshman Delegate Winsome E. Sears of Norfolk, was sparked in large measure by a series of articles published in The Virginian-Pilot newspaper criticizing the efficacy of the Board of Medicine in disciplining doctors. Some of those criticisms were reflected in a 1999 study conducted for the General Assembly by the Joint Legislative Audit and Review Commission (“JLARC”), which found that “the Board of Medicine does not adequately protect the public from substandard care by physicians.”²

The need for, and manner of, any reform has been the subject of considerable debate over the last year. The final legislation resulted from lengthy negotiations among Delegate Sears as the bill’s patron, the Medical Society of Virginia (“MSV”), the Virginia Hospital & Healthcare Association (“VHHA”), the Department of Health Professions (“DHP”), JLARC staff and other affected parties. The final legislation reflects the attempt to balance the sometimes competing interests of practitioners, institutional providers, the thirteen health regulatory boards of DHP, and the general public. That consensus is reflected in the final version of HB 1441, which was unanimously passed by both the House and the Senate.

* Mr. Devine is a principal with the law firm of Hofheimer Nusbaum, P.C. in Norfolk, and he regularly represents practitioners before the health regulatory boards. Mr. Devine is the current Chair of the Health Law Section of the Virginia Bar Association and is past-Chair of the Health Law Section of the Virginia State Bar. He received his law degree from the University of Richmond Law School and a Masters of Law and Taxation from William and Mary Law School. Mr. Devine is included in The Best Lawyers in America in the categories of Health Care Law and of Corporate, M&A and Securities Law. Mr. Devine may be reached at (757) 629-0614 or at pdevine@hnlaw.com.

* Ms. Perrine is the Deputy Executive Director, Discipline, for the Virginia Board of Medicine and is responsible for management of the Board’s disciplinary caseload and adjudication process, as well as regulatory and legislative matters. Ms. Perrine received her law degree from the College of William and Mary in 1983. She is an Ex Officio member of the Board of Governors of the Virginia State Bar’s Health Law Section. She was certified by the Federation of State Medical Boards as a “Certified Executive Medical Board Executive” in April 2001. Ms. Perrine may be reached at (804) 662-7693 or at karen.perrine@dhp.state.va.us.

The new legislation is designed to (i) enable the Board to take a more active role in disciplining physicians and other licensees for substandard care, (ii) expedite the disciplinary process by improving the quantity, quality and timeliness of information reported to the health regulatory boards, (iii) permit confidential settlement of less egregious infractions by all thirteen health regulatory boards and (iv) improve the system for monitoring the overall performance of DHP and the health regulatory boards. Following is a summary of the more important aspects of this legislation.

Standard of Care

One of the more significant aspects of the legislative discussions involved the establishment of a new standard of conduct that may subject a licensee of the Board, and the Board of Physical Therapy, to disciplinary action.³ Under prior law, a practitioner's patient care activities were only subject to sanction by the boards if they resulted from conducting the practice "in such a manner as to be a danger to patients" or "gross ignorance or carelessness in . . . practice, or gross malpractice."⁴ This gross negligence standard has now been replaced by a lower "simple negligence" standard that permits the boards to sanction a practitioner based on a single instance of "intentional 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."⁵ The Board supported this change in the statutory scheme. This new standard will apply to conduct occurring on or after the July 1, 2003, the effective date of the legislation.

A concern was raised that this lower standard could result in a disproportionate allocation of the limited resources of the Board to address minimal patient care mistakes by otherwise apparently competent practitioners that are not likely to recur and that many believe are better left to the malpractice system for resolution. The fiscal impact statement that accompanied the legislation anticipated that the change in the standard, combined with increased reporting as discussed below, could result in approximately 1,000 additional complaints annually, which, in turn, could necessitate the hiring of an additional 27 employees by DHP at an annual cost of almost \$1.7 million.

Although the new legislation affords no direction on the issue, the Board presumably will be permitted to exercise an appropriate degree of prosecutorial discretion in determining which standard of care cases to pursue.

Confidential Consent Agreements

The new law affords practitioners, their counsel, and all of the health regulatory boards a valuable new tool for addressing comparatively less serious misconduct in a manner that both protects the general public and treats the practitioner fairly under the circumstances. DHP and the Board viewed this provision as an important complement to the change in the statutory standard for disciplinary action.

By way of background, two existing federal regulations and two separate state systems address the reporting of adverse disciplinary actions against a practitioner by any of the health regulatory boards. Depending on the nature of the disciplinary action, reports under the two federal regulations are filed either with the National Practitioner Data Bank (“NPDB”) ⁶ or the Healthcare Integrity and Protection Data Bank (“HIPDB”).⁷ In addition, two separate state reporting systems exist. First, DHP posts on its internet site (www.dhp.state.va.us) a Recent Case Decisions list regarding licensees of all thirteen health regulatory boards. Also, the Board posts on its internet profiling system for doctors of medicine, osteopathy and podiatry (www.vahealthprovider.com) all notices and orders issued by the Board, including when allegations are dismissed, as Virginia law specifically provides that all notices and orders are public documents.⁸

These reporting obligations may have unintended adverse consequences, as many managed care plans will automatically exclude a practitioner from the plan’s networks for most adverse Board actions, including a censure or reprimand, except those involving a matter viewed as purely “administrative” in nature, and hospital medical staffs and health regulatory boards in other jurisdictions may take reciprocal adverse actions as well.

For example, when a physician fails to follow appropriate prescriptive protocols, the Board may conclude that the best way to protect the public and to improve the physician’s practice patterns is to require that the physician attend a CME course on appropriate documentation and prescriptive practices. If such a decision is publicly reportable, it may, in effect, operate as a suspension or revocation because managed care plans may use it as a basis to terminate the practitioner’s essential managed care plan participation agreements. In other self-regulated professions such as accounting, engineering and law, private reprimands are a valuable regulatory tool with few, if any, unintended economic consequences. Even public disclosure of corrective action by the regulatory board in those professions will not automatically cause the loss of contracts that are essential to the professional’s business.

Over the years, the Board has been cognizant of the unintended adverse economic consequences that may result from a minor sanction or a corrective action where public safety was not compromised. The only legislative response to date has been an amendment to the law regulating the state employees’ health plan to provide that networks in the plan that utilize “preferred providers shall not exclude any physician solely on the basis of a reprimand or censure” from the Board.⁹ The Managed Care Health Insurance Plan (“MCHIP”) regulations also afford practitioners a modicum of due process if a managed care plan proposes to exclude them for quality of care considerations.¹⁰

As a result of discussion at its June 2002 meeting, the Board convened a workshop in September 2002 to discuss the disciplinary process in general and, specifically, the need for mechanisms other than administrative proceedings to handle cases that were of some concern but did not appear to warrant disciplinary action. The Board envisioned a remedy that would afford an alternative to disciplinary action and would enhance public safety by improving the skills of the practitioner. Further, the Board desired an efficient mechanism to handle certain issues--such

as failure to complete continuing education requirements--outside of the current administrative process to conserve limited adjudicatory resources.

The terms and consequences of the confidential consent agreements were heavily debated during the legislative process, and the resulting compromise appears to strike a practical balance between the interests of the public and the practitioner. Under appropriate circumstances, a health regulatory board is now permitted “to request and accept from a . . . practitioner, in lieu of disciplinary action, a confidential consent agreement . . . which shall be subject to [statutory] . . . confidentiality provisions”¹¹ Further, the bill expressly provides that a confidential consent agreement is “in lieu of disciplinary action” and “shall not be considered either a notice or order of any health regulatory board”¹² Thus, the confidential consent agreement is designed to foster practitioner cooperation and improvement to enhance public safety while reducing the possibility of unintended economic consequences for the practitioner.

The confidential consent agreement will not, however, result in the underlying misconduct being swept under the rug, as it “may be considered by a board in future disciplinary proceedings.”¹³ Further, since it “shall include findings of fact and may include an admission or finding of a violation,”¹⁴ the regulatory board will not need to relocate witnesses and evidence long after the violation has occurred in the event it needs to revisit the practitioner’s admittedly inappropriate actions at a later date.

To strike a balance with the public interest, the new law provides that a “confidential consent agreement shall be entered into only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner.”¹⁵ Further, a confidential consent agreement is not permitted

if there is probable cause to believe that the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public.¹⁶

While some of the standards contained in that condition are not clearly defined, the language is intended to afford appropriate protection to the public against truly incompetent practitioners.

Finally, the new law does not permit the entry into more than two confidential consent agreements involving a standard of care violation by any one practitioner during any 10-year period “unless the board finds that there are sufficient facts and circumstances to rebut the presumption that the disciplinary action be made public.”¹⁷

Reporting

The new legislation changes the reporting obligations of health care institutions (including hospitals and nursing homes), malpractice carriers and practitioners that become aware of a potential infraction under Va. Code §§54.1-2906 and 2909. The reporting obligations under these two statutes are sometimes confused because they apply to different (though partially overlapping) classes of players in the health care field and because the types of licensees, matters to be reported, and potential sanctions also differ.

Virginia Code §54.1-2906 requires “hospitals and other health care institutions” to report certain conduct by any person licensed by any of the 13 health regulatory boards. On the other hand, Va. Code §54.1-2909 places a reporting obligation on licensed health care institutions, practitioners, malpractice carriers and others, but this reporting obligation applies only to conduct by persons licensed by the Board of Medicine.

Subject to the confidentiality provisions under federal substance abuse regulations, hospitals and other health care institutions are required, under Va. Code §54.1-2906, to report within 30 days: (a) “information . . . indicating [the] professional is in need of treatment or has been committed or admitted . . . for treatment of substance abuse or a psychiatric illness which may render [him] . . . a danger to himself, the public or his patients;” (b) of a determination, “after reasonable investigation and consultation as needed with the appropriate internal [disciplinary] boards or committees . . . , [that there is] a reasonable probability [of] unethical, fraudulent or unprofessional conduct;” (c) “any disciplinary action, including denial or termination of employment [or of] . . . privileges or restriction of privileges while under investigation or during disciplinary proceedings, taken . . . as a result of . . . intentional or negligent conduct that . . . is likely to cause injury . . . , professional ethics, professional incompetence, moral turpitude or substance abuse, . . . with the report to be filed within 30 days of written communication to the professional notifying him of the disciplinary action;” and (d) “voluntary resignation . . . [,] restriction or expiration of privileges while . . . under investigation or [while he] is the subject of disciplinary proceedings . . . related to” any such matter.¹⁸ Reports may need to be filed within five days in the case of certain commitments or admissions.¹⁹

The timing of the required reports under the new legislation was very important to the Board. The Board’s position was that reports needed to be made once an initial determination or recommendation was made by the medical staff, or a committee thereof, to take or impose any adverse action, and that the report should not wait until the due process provisions of the hospital bylaws, and all appeals, were exhausted. The new law adopted the Board’s position on that issue.

Virginia Code §54.1-2909 requires that reports be filed in the case of (a) disciplinary actions in other states; (b) malpractice settlements and judgments; and (c) “evidence that indicates a reasonable probability that a [practitioner] . . .” (i) “may be incompetent,” (ii) “has engaged in intentional or negligent conduct that causes or is likely to cause injury . . . [or] unprofessional conduct,” or (iii) “may be mentally or physically unable . . . safely [to] . . . practice. . . .” The report must be filed within “30 days from the date of . . . occurrence.”²⁰

For the first time, potential civil penalties for failure by licensees, hospitals and other mandated reporters to make a timely report of a reportable event were authorized, with the penalty being \$25,000 or \$5,000, depending on the context.²¹ If the civil penalties are ordered and not timely paid, an institution may lose its license.

One area of contention among the stakeholders involved the substance of the report that must be made by a hospital and other health care institutions as a result of its medical staff peer review activities. One justification for an enhanced reporting obligation was to facilitate DHP's investigative process and to improve the health regulatory board's ability to act quickly. Early versions of the bill potentially would have required hospitals and health care institutions to share with DHP and the health regulatory boards virtually all of the institutions' investigative information and incident reports. The concern of the provider community was that the potential quality enhancing aspects of the peer review process under existing law might be undermined if all confidentiality and privilege protections were lost.

In a December 3, 2002, letter to Delegate Sears, representatives of the MSV and the VHHA explained their position regarding the benefits of existing hospital peer review protocols in improving quality of care and the role that confidentiality plays in that process. The DHP and the Board understood those concerns, but believed that access to certain information and documentation, such as contemporaneous incident reports by nursing staff, were necessary to conduct an appropriate and successful investigation.

The resulting compromise tempers the scope of the peer review information that must be reported, while still affording DHP a significant head start in the investigative process.²² Specifically, the hospital or other health care institution's required written report shall:

- give the name and address of the person who is the subject of the report,
- fully describe the circumstances surrounding the facts required to be reported,
- include the names and contact information of individuals with knowledge about the facts required to be reported and the names and contact information of individuals from whom the hospital or health care institution sought information to substantiate the facts required to be reported,
- include all relevant medical records if patient care or the health professional's health status is at issue, and
- provide notice to the Board that the institution has submitted any required report to the National Practitioner Data Bank.²³

Further, it is specifically stated that

[t]his section shall not be construed to require the hospital or health care institution to submit any proceedings, minutes, records or reports that are privileged under §8.01-581.17, except that the provisions of §8.01-581.17 shall not bar (i) any report required by this section or (ii) any requested medical records which are necessary to investigate unprofessional conduct . . . [, and u]nder no circumstances shall compliance with this section be construed to waive or limit the privilege provided in Section §8.01-581.17.²⁴

The new legislation confirms that there is no reporting obligation for any matter “if the person or entity has actual notice that the same matter has already been reported to the Board.”²⁵ Appropriate NPDB reporting is also required, and for certain reports, sending the Board a copy of the NPDB report may satisfy the reporting obligation.²⁶

A new provision requires the hospital or health care institution to “give the health care professional who is the subject of the report an opportunity to review the report [, and] the health professional may submit a separate report if he disagrees with the substance of the [institution’s] report.”²⁷ Importantly, the broad immunity from liability to those persons who properly make reports is now also afforded to any person providing information “pursuant to an investigation.”²⁸

Finally, the new law contains a provision that requires the reporting of any malpractice settlement, where, formerly, the law required reporting only when there were two settlements within a three-year period.²⁹ The new law also adds language confirming the Board’s historic position that any disciplinary action arising from a malpractice settlement report must be based on the underlying conduct, not the fact of the malpractice settlement itself.³⁰

Monetary Penalty

The new law increases the monetary penalty that a health regulatory board may impose on a practitioner who violates any statute or regulation pertaining to that board, and is not criminally prosecuted. A practitioner may be fined up to \$5,000 per violation, instead of \$1,000 under prior law.³¹ This penalty is separate from those that may be imposed on practitioners or institutions that fail timely to report information as discussed above.³²

Confidentiality of Certain Information

All information received and maintained by a health regulatory board in connection with a possible disciplinary proceeding shall be strictly confidential, and may only be disclosed in certain enumerated circumstances.³³ The new law changes the current provisions as follows:

- the prohibition on the use of any confidential material in any malpractice proceeding or related discovery has been expanded to any “civil proceeding,”

- the ability to share information with law enforcement relating to violations of state drug laws has been expanded to all “criminal matters,” and
- the standard of “for good cause arising from extraordinary circumstances” has been added to the provision permitting the release of information “pursuant to an order of a court of competent jurisdiction.”³⁴

Revocation and Reinstatement

The new law precludes any practitioner regulated by any of the health regulatory boards whose license has been revoked from applying for reinstatement for a period of three years.³⁵ Under prior law, a licensee of the Board of Medicine could not reapply for reinstatement until one year after revocation; however, there was no statutory limitation imposed on licensees of the other health regulatory boards.³⁶

Unlicensed Activity

Under prior law, the only remedy available to DHP and the health regulatory boards for addressing unlawful practice by a person not licensed by any health regulatory board was to seek criminal sanctions or an injunction and civil penalties from a circuit or general district court. In response to comments in the JLARC report, the new law authorizes the Director of DHP to issue a summons to a person who violates the laws and regulations governing the unlicensed practice of the professions regulated by DHP.³⁷ Failure to obey the summons or discontinue the unlawful acts may result in criminal action.³⁸

Accountability

In order to monitor the performance of DHP and the health regulatory boards under this new law and to determine whether further legislative action may be necessary, the new law modifies the requirements of the biennial report that the Director of the Department of Health Professions must present to the General Assembly.³⁹

First, the Director’s report must be made “for each of the health regulatory boards.”⁴⁰ Second, “the report shall contain for each profession regulated by a health regulatory board the number of cases in which a sanction was imposed.”⁴¹ Third, the “sanctions shall be reported by category of violation for each profession, and [one] reported category shall be cases involving standard of care violations.”⁴² Finally, the report must include

- (i) case processing time standards for resolving disciplinary cases,
- (ii) an analysis of the percentage of cases resolved during the last 2 fiscal years that did not meet such standards, (iii) a 6-year trend analysis of the time required to process, investigate and adjudicate cases, and (iv) a detailed reporting of staffing levels for the 6-year

period for each job classification that supports the disciplinary process.⁴³

The Director's initial biennial report shall require a four-year, rather than six-year, trend analysis and staffing level report.

Composition of the Board of Medicine

Legislation sought by the Board and enacted by the 2001 General Assembly increased the number of citizen members on the Board from two to four.⁴⁴ The new law increases the size of the Executive Committee from seven to eight and requires that at least two of the members be citizen members.⁴⁵ The Board supported this change.

Burden of Proof

The burden of proof necessary to find a violation of the Code that currently is followed by the health regulatory boards is the "clear and convincing" standard.⁴⁶ Many who were critical of the actions of the health regulatory boards had advocated for a lower "preponderance of the evidence" standard. Indeed, the Board sought legislation this session to lower the standard in cases that did not result in revocation or suspension; however, the new legislation does not lower the burden of proof, and the clear and convincing standard continues to apply.

Conclusion

What began as a high-profile, sometimes acrimonious and divisive public relations and legislative battle evolved through education and cooperation into what appears to be a balanced approach to improved practitioner self-regulation. All stakeholders participated equally in a process marked by patience and a willingness to listen and compromise. Whether, in practice, the new law will work to the satisfaction of the various parties remains to be seen. However, it is important that practitioners and health care institutions, and their counsel, understand these new rules when developing strategies to address and comply with the new practitioner disciplinary process and requirements.

This article was prepared as of May 1, 2003, and is for informational purposes only. It is not intended as legal advice and is not intended to reflect the formal position of the DHP or any of its health regulatory boards.

END NOTES

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- ¹ Identical legislation introduced in the Senate, SB 1334, passed unanimously as well and was the product of two merged bills introduced by Senators William Bolling and Creigh Deeds. HB 1441 can be accessed at <http://legis.state.va.us>.
- ² The JLARC website link to the report is: <http://jlarc.state.va.us/Summary/Rpt233/health.htm>
- ³ The Board of Medicine licensed physical therapists until July 1, 2000 when the Board of Physical Therapy was established (see Section 54.1-3473 et seq.) The laws regarding physical therapy, including grounds for disciplinary action, were adapted from the Board of Medicine's laws.
- ⁴ See Va. Code §54.1-2914(A)(8) and 2915(A)(4) under prior law. Unless otherwise stated, the statutes referred to in these footnotes are intended to reflect the statutory changes adopted by the General Assembly during the 2003 Session which become effective on July 1, 2003.
- ⁵ Va. Code §2915(A)(4).
- ⁶ 42 U.S.C. §11132(a)(1)(A) and 45 C.F.R. §60.3 and 60.8(a)(1) and (2). The NPDB regulations require reports of "any action ...[w]hich revokes or suspends (or otherwise restricts) a physician's or dentist's license (emphasis added)." Since the opening of NPDB in 1990, DHP has reported any order containing an additional term or condition imposed on a practitioner, however minor, in connection with the retention of his or her license which is not likewise imposed on all other licensed practitioners, as a "restriction" of the license for the purposes of NPDB, although some attorneys may disagree with this interpretation.
- ⁷ 42 U.S.C. §1320(a)-7e(b)(1) and (g)(1)(A)(iii)(I) and (III) and 45 C.F.R. §61.3 and .7. The HIPDB reporting provisions would not appear to be implicated by a confidential consent agreement. These regulations only require reporting of "final and adverse actions (not including settlements in which no findings of liability have been made)..." "Final adverse actions" are defined as "actions by [a health regulatory board]...including (I) formal or official actions, such as revocation or suspension..., reprimand, censure or probation...[or] (III) any other negative action or finding...that is publicly available" even if no sanction is imposed. A confidential consent agreement should not be considered a "formal or official action" under subsection (I), as the confidential consent agreement cannot impose any of the five separate sanctions specifically listed therein. Finally, the "other negative action or finding" concept in subsection (III) is limited to those determinations which are "publicly available," and the Virginia statute expressly states that confidential consent agreements are not to be made publicly available.
- ⁸ See §54.1-2400.2(F) and 2910.1(A)(12). See also 18 VAC 85-20-290(B).
- ⁹ Va. Code §2.2-2818(F).
- ¹⁰ 12 VAC 5-408-170.
- ¹¹ Va. Code §54.1-2400(14).
- ¹² Id. This provision obviates the need to report an agreement on the state web sites. Further, although the Virginia Attorney General's Office, which coordinates the reporting obligations of the health regulatory boards under the NPDB and the HIPDB regulations, has not, as of the date of this publication, taken a final position on the possible need to report certain confidential consent agreements, it appears the bill's drafters intended the "consent agreements" to be "confidential," except in the limited circumstances expressly contemplated in the bill. An analysis of the language of these reporting regulations in the context of the language of the bill could support the absence of a reporting obligation to the federal data banks.

¹³ Va. Code §54.1-2400(14).

¹⁴ Id.

¹⁵ Id.

¹⁶ Id.

¹⁷ Id.

¹⁸ Va. Code §54.1-2906(A). See Va. Code §54.1-2906(E) and 42 U.S.C. §290dd-2.

¹⁹ Va. Code §54.1-2906(B).

²⁰ Va. Code §54.1-2909.

²¹ Va. Code §§2505(21), 2906(F), 2908(G) and 2909(G). Compare Va. Code §54.1-2401 concerning penalties for violation of a statute or regulation discussed in the text accompanying footnote 32, infra. See also Va. Code §54.1-111(B).

²² See Va. Code §§54.1-2400.2(B) and (C), 2906(A) and 2909(D).

²³ Va. Code §54.1-2906.

²⁴ Va. Code §54.1-2906(A).

²⁵ Va. Code §§54.1-2906(A) and 2909(C).

²⁶ Va. Code §§54.1-2906(A) and 2909(A). See also Va. Code §54.1-2908(C).

²⁷ Va. Code §54.1-2906(A).

²⁸ Va. Code §§54.1-2906(D), 2908(E) and 2909(E).

²⁹ Va. Code §54.1-2909(A)(3).

³⁰ Va. Code §54.1-2909(H).

³¹ Va. Code §54.1-2401.

³² See discussion of Va. Code §§54.1-111(B), 2906(F) and 2908(G) in the text accompanying footnote 21, supra.

³³ Va. Code §54.1-2400.2.

³⁴ Id.

³⁵ Va. Code §54.1-2408.2.

³⁶ See former Va. Code §54.1-2921. During the 2002 General Assembly session, the Board unsuccessfully sought the ability to impose a period of revocation of between one and five years.

³⁷ Va. Code §54.1-2506(C). See also Va. Code §54.1-111(B).

³⁸ Id. A fine is also a permissible sanction.

³⁹ Va. Code §54.1-2400.3. See Va. Code §54.1-114.

⁴⁰ Va. Code §54.1-2400.3.

⁴¹ Id.

⁴² Id.

⁴³ Id.

⁴⁴ Va. Code §54.1-2911.

⁴⁵ Id.

⁴⁶ See 1979-80 Opinion of Office of Attorney General at 168.