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Disciplinary Proceedings for Virginia's Health-Care Practitioners

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Amid growing public discussion over the manner in which the Virginia Board of Medicine disciplines its licensees, the Virginia General Assembly adopted legislation during the 2003 session to substantially revamp the procedures and standards that apply in connection with disciplinary proceedings of the Board of Medicine and the other health regulatory boards within the Department of Health Professions (DHP). In its 2004 session, the General Assembly passed legislation sought by DHP to improve timeliness and effectiveness of case resolution. This article outlines the disciplinary process (as modified by the 2003 and 2004 legislation) used by the Department of Health Professions and the health regulatory boards to fulfill their statutory obligation to take appropriate action against Virginia physicians and other health care practitioners to ensure the protection of the public.¹

Receiving Complaints and Reports

For each of the thirteen health regulatory boards, the disciplinary process begins with the receipt of complaints or reports that allege practitioner misconduct. Some are Voluntary complaints. Some are mandatory: Hospitals and other health-care institutions are required to report certain conduct by licensed practitioners,²

and treating practitioners are required to other report their patients or clients under certain circumstances.³ *Va. Code* § 54.1-2909 places an additional obligation on licensed health-care institutions, practitioners, malpractice carriers and others, to report conduct by persons licensed by the Board of Medicine.⁴

All misconduct allegations received by the department are reviewed by the complaint intake unit of DHP to determine if a violation of law or regulation may have occurred. The 2004 legislation added a general immunity provision for a person who makes a report regarding the conduct or competency of a health-care practitioner as required by law or regulation.⁵ This provision also provides immunity for a person who provides information pursuant to an investigation. The immunity is not available in either case, however, if the person acted in bad faith or with malicious intent.

The Investigation

DHP's enforcement division investigates reports of potential misconduct. Typically, an investigator interviews the source of the initial report and all witnesses or persons with pertinent information. After collecting and reviewing relevant documents, the investigator interviews the person being investigated or responding to a complaint.

The results of the investigation are documented in a written report.

If a case involves potential violations of criminal law, the local commonwealth's attorney may conduct a criminal investigation concurrent with DHP's investigation of regulatory violations, and the findings of the criminal investigation may be made part of DHP's investigative report. In certain instances, DHP's report may be provided to a commonwealth's attorney or state or federal law enforcement officials.

It is usually most helpful for the practitioner to involve counsel promptly upon learning of an investigation. Counsel may attend the practitioner's interview with the investigator and help the practitioner in locate or develop information helpful to the investigator's analysis. Counsel can also provide additional information to the regulatory board for consideration and work to resolve the matter early through a confidential consent agreement, if the circumstances warrant.

Once the investigation is concluded, the investigator submits a report to the applicable board for a probable-cause analysis as discussed below. While additional statutory confidentiality requirements apply once the report is submitted, counsel may still assist by submitting additional information or proposing a confidential consent agreement at this stage.

Confidentiality and Disclosure

Records of active investigations being conducted by DHP are exempted from the provisions of the Virginia Freedom of Information Act,⁶ are “strictly confidential,” and may be disclosed by a health regulatory board only under limited circumstances.⁷ Confidential information received, maintained or developed by the board is not subject to discovery or subpoena and may not be introduced into evidence in a civil action.⁸ Once the board has issued a notice or order relating to a disciplinary proceeding, however, those documents are required to be disclosed.⁹ The respondent is provided a copy of the investigation report and any other materials, facts or information that the board may rely on in making a decision.

Determining Probable Cause

The thirteen boards at DHP utilize similar, yet different, processes for review of investigation reports and determinations on how to proceed with a case. Some boards appoint a disciplinary committee for this process, while others have delegated this decision to staff. The Board of Medicine has developed a policy wherein two physicians decide: the medical review coordinator, in conjunction with the executive director makes a preliminary determination of probable cause.¹⁰ If it appears that probable cause exists to believe a violation occurred, the case is reviewed with the board president. If he or she also finds probable cause, the board’s options are to issue a notice of informal conference or enter into a pre-hearing consent order or a confidential consent agreement with the respondent. If probable cause is not found after review by the medical review coordinator and confirmation by a board member, the source and the respondent are so notified.

Regardless of the procedure used for determining probable cause, a regulatory board’s options are as follows:

- If there is no jurisdiction and/or no probable cause, the complaint may be dismissed and the case closed.

- If the facts are complete and probable cause is found, a pre-hearing consent order may be offered to the respondent in lieu of an informal conference, but the respondent is advised that an informal conference may be requested.
- If the misconduct is not serious, the board and the practitioner may enter into a confidential consent agreement—an option created by the 2003 legislation.
- An informal conference before a committee may be convened.

Summary and Mandatory Suspensions

When the conduct of a respondent represents a “substantial danger to the public health or safety,” the board may meet, in person or by telephone conference call, and summarily suspend a license, certificate or registration without a hearing. If the board votes to suspend a license, it must then institute proceedings for a formal hearing,¹¹ and an informal conference is not held. In addition, the law provides for suspension of a license by the director of DHP when a respondent has been convicted of a felony been adjudged to be incapacitated, or had his license revoked or suspended in another jurisdiction and not reinstated.¹² The director has no dis-

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cretion in this matter, and must suspend even if the felony or loss of license in another state is based on matters already adjudicated by the board. The practitioner must request a hearing to petition for reinstatement before one will be scheduled by the board.

Consent Orders

A consent order is an agreement between the board and a respondent to resolve a

case without having to conduct an informal conference or a formal hearing. While consent orders are generally offered before an informal conference or formal hearing is scheduled, they may be used anytime prior to a final order being entered. Requests for or negotiations leading to a consent order are sometimes initiated by a respondent or his counsel.

A consent order typically includes findings of fact, conclusions of law and the action or sanction agreed to by the board and respondent. A consent order may result from a case in which the facts are admitted and the sanction is negotiated, or where the respondent neither admits nor denies the allegations as contained in the findings of fact but agrees to a sanction or specific terms of practice. If the respondent agrees to the settlement offered, the consent order may be entered and the case closed. This tool provides rapid settlement and avoids costly proceedings.

Confidential Consent Agreements

The 2003 legislation gave practitioners, their counsel and all of the health regulatory boards a valuable new tool for addressing comparatively less serious misconduct in a confidential 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 actions alleging potential injury to patients from gross malpractice to negligent conduct, which also resulted from the 2003 legislation.¹³

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)¹⁴ or the Healthcare Integrity and Protection Data Bank (HIPDB).¹⁵ In addition, two separate state reporting systems exist. First, DHP posts on its Web site (www.dhp.virginia.gov) a recent case-decisions list regarding licensees of all thirteen health regulatory boards. Also, the Board of Medicine 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. (Virginia law provides that all notices and orders are public documents.)¹⁶

These reporting obligations may have adverse economic consequences for a practitioner, as many managed care plans regularly query these reports and may automatically exclude a practitioner from the plan's networks if they found adverse board actions, including a censure or reprimand, but not including matters viewed as purely "administrative" in nature. Hospital medical staffs and health regulatory boards in other jurisdictions may take reciprocal adverse actions as well.

Over the years, the board has been aware of unintended adverse economic consequences that may result from a minor sanction or a corrective action where public safety was not compromised. The option of entering into confidential consent agreements was developed 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 . . ." ¹⁷ 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 . . ." ¹⁸ 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 mis-

conduct being swept under the rug, as it "may be considered by a board in future disciplinary proceedings."¹⁹ Further, since it "shall include findings of fact and may include an admission or finding of a violation,"²⁰ the regulatory board will not need to relocate witnesses and evidence long after the violation has occurred should it need to revisit the practitioner's admittedly inappropriate actions at a later date.

To strike a balance with the public interest, the 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."²¹ Further, a confidential consent agreement is not permitted

if there is probable cause to believe that the practitioner has demonstrated gross negligence or intentional misconduct in the care of patients or conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public.²²

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 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 ten-year period "unless the board finds that there are sufficient facts and circumstances to rebut the presumption that the disciplinary action be made public."²³ Although not stated specifically in the statute, DHP's position is that once a notice of informal conference has been issued a confidential consent agreement is no longer available to resolve the case, because the notice is a matter of public record and resolution by a confidential document leaves the public without a means to determine how the public allegations were resolved. Respondents and their counsel who believe a matter may be appropriate for resolution by a confidential consent agreement should present all information in support of their position during the investigation process or while the board's probable cause analysis is ongoing. The DHP and its boards advise

the respondent of the potential availability of a confidential agreement as a remedy when they notify the respondent of the investigation and when the investigator's report is submitted to a board.

Informal Conferences

The Virginia Administrative Process Act provides for two types of proceedings, informal fact-finding conferences and formal hearings.²⁴ An informal conference is required unless it is either waived by both parties or is not permitted by law (e.g., following summary suspensions and mandatory suspensions). Most allegations of misconduct are resolved by the boards after the informal conference.

Section 54.1-2400(10) contains the basic law defining the powers and duties of informal or special conference committees for all boards. In addition, until July 1, 2004, the Board of Medicine and the Board of Nursing have specific statutes in their respective enabling laws to more specifically address the powers and duties of these informal committees. Other boards have some, but not all, of the provisions in the enabling laws for the Board of Medicine and Nursing. The 2004 legislation repeals the boards' individual statutes and amends the general powers and duties to include these provisions in *Va. Code* § 54.1-2400 for more uniformity among boards. For example, as of July 1, 2004, all boards may direct a practitioner to submit to a mental or physical examination after preliminary investigation by an informal fact-finding proceeding when a board has probable cause to believe the practitioner is unable to practice with reasonable skill and safety, and failure to submit to such an exam constitutes grounds for disciplinary action.²⁵

Currently, at an informal conference, a special committee consisting of at least two board members meets with the respondent accused of a violation. Under the 2004 legislation, all boards have the authority to delegate some informal fact-finding proceedings to an appropriately qualified agency subordinate. Each board is required to promulgate regulations that define who is eligible to be an agency subordinate for that board and what types of cases may be considered by an agency subordinate. The agency subordinate will

conduct the proceeding and make a final case decision. The anticipated effect is to reduce the number of proceedings considered by board members and, therefore, decrease case resolution time. More importantly, it will enable the board members to focus their time and attention on cases involving standard-of-care and other more complex issues.

Prior to the convening of an informal conference, the respondent receives a notice that contains the specific allegations and violations asserted by the board. In addition, the respondent receives all information the committee may rely upon in making a decision. Informal conferences are open to the public, but may be closed pursuant to the Virginia Freedom of Information Act to discuss medical or mental records and information.²⁶

The respondent and his counsel should take the opportunity to submit, in advance of the informal conference, letters of support, a memorandum or other information that may help exonerate the respondent or explain the conduct. Testimony from witnesses may also be presented at the informal conference.

After reviewing the investigative report and having an opportunity to meet and discuss the alleged violations with the respondent, the committee convenes in closed session to deliberate and reach a decision.²⁷ The matter is dismissed if insufficient evidence exists to substantiate a violation of law or regulation. If the committee concludes there is evidence of a violation, the committee may enter an order that contains findings of fact, conclusions of law and an appropriate action. The options available to the committee generally are:

- place the respondent on probation with terms;
- reprimand;
- modify a previous order; and/or
- impose a monetary penalty.

Additionally, the committee may agree that suspension or revocation of the respondent's license is justified. In such a case, the matter may be referred to the full board for a formal hearing, or the com-

mittee may recommend a consent order for suspension or revocation to the full board.

The committee's decision typically is announced in the form of motion, read aloud in the open session following deliberations and subsequently written as an order.

Once an order is entered and mailed, the respondent has thirty days to decide to accept or reject the order.²⁸ During this period, the order is a public document and available upon request. Rejection of the order of the informal conference will cause the order to be vacated. When a decision is vacated, the matter is referred to a formal hearing.

Formal Hearings

A formal hearing must be conducted when it is required by the basic law applicable to the board (e.g., when summary or mandatory suspensions are imposed) or when the informal procedures under *Va. Code* § 2.2-4019 were not utilized (e.g., the respondent waived that procedure) or otherwise failed to dispose of a case.

The purpose of formal hearings, as described in *Va. Code* §§ 2.2-4020 and 54.1-110, is to take evidence upon relevant factual issues through an adversarial, trial-like *de novo* process.

Should a case proceed to a formal hearing, the process begins again with notice to the respondent. A formal hearing may be conducted by a hearing officer, a panel of the board or the full board or quorum thereof. Committee members who participated in the informal conference proceeding are excluded from the subsequent formal hearing.

A formal hearing is similar in many ways to a trial. It is open to the public, and the parties may call witnesses and introduce evidence. The board decides whether the practitioner has violated a law or regulation and, if so, what action is warranted.

Under *Va. Code* § 2.2-4020 parties to a formal hearing are provided with rights to:

- Receive reasonable notice of the date, time, place, and nature of the hearing.

("reasonable notice" usually is thirty days prior to the date of the hearing).

- Have notice of the basic law or laws under which the board contemplates its possible exercise of authority.
- Have notice of the matters of fact and law asserted or questioned by the board as contained in the statement of particulars.
- Be accompanied and represented by counsel.
- Subpoena witnesses and documents; to submit oral and documentary evidence and rebuttal proofs to conduct cross-examination; and have the proceedings completed and a decision made with dispatch.

When a formal hearing is conducted before a quorum or a panel of the board,²⁹ the presiding officer at a formal hearing is a board member designated for that purpose. The presiding board member is empowered to administer oaths, receive evidence, subpoena testimony or produce documents, and regulate and expedite the course of the formal hearing. The presiding officer may seek advice from an assistant attorney general who serves as counsel for the board. Prior to the hearing, the presiding officer may convene a pre-hearing conference to resolve issues relating to evidence and witnesses or to hear oral argument on motions.³⁰

At a formal hearing, preliminary motions may be made, opening statements summarizing the facts may be given, testimony may be taken by both direct and cross-examination of witnesses called on behalf of the commonwealth and the respondent, documentation may be offered for the record, and parties may make a closing statement to the board. A court reporter transcribes the proceeding.

After all evidence is presented, each party is given the opportunity to submit closing argument or proposed findings of fact and conclusions of law for consideration by the hearing board. The board then convenes in closed session to deliberate and reach its final decision, which is typically announced in open session the same day. The board reads, in the form of a motion, the findings of fact, conclusions of law,

and ordered sanction (if any). The decision is transcribed by a court reporter. After the proceeding, the motion is captured in a written order that is provided to the respondent and available to the public.

As with the informal conference, sanctions for each violation may be levied separately or in combination, and may include a reprimand, a monetary penalty, probation, suspension or revocation of a license. If the respondent wishes to contest the action, he or she may appeal to the circuit court. For the Board of Medicine, any practitioner whose license is suspended or revoked may not practice pending the appeal.³¹

Formal hearings may also be conducted before hearing officers in the absence of

the board. In that case, the hearing officer becomes the presiding officer and is empowered with the same authority as the board, except that the hearing officer may only recommend findings of fact and conclusions of law. This recommendation may be adopted by the board subsequent to the formal hearing. In all cases, the board retains the sole authority to impose disciplinary action.

In all disciplinary matters and proceedings, whether informal or formal, the burden of proof rests with the board to establish by clear and convincing evidence a violation of law or regulation governing the practice of that respondent. In reinstatement cases, the burden of proof rests with the applicant to establish evidence that he or she is safe and competent to resume practice.

Conclusion

Complaints against health-care practitioners in Virginia are adjudicated pursuant to the regulations and practices governing the applicable health regulatory boards. Practitioners are afforded important procedural due process rights, and the determination is made by regulatory bodies which include peers of the practitioner. By understanding the rules and processes applicable to these proceedings, practitioners and their counsel may better ensure that an appropriate disposition results. ☺

This article is for informational purposes only and is not intended to reflect the formal position of the DHP or any of its health regulatory boards.



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Endnotes:

- 1 The Virginia Board of Medicine is one of thirteen regulatory boards under the Department of Health Professions charged with licensing and oversight of over 250,000 Virginia health-care practitioners and facilities. Those boards include boards of nursing, dentistry, pharmacy, medicine, optometry, physical therapy, psychology, counseling, social work, audiology and speech-language pathology, nursing home administrators, veterinary medicine and funeral directors and embalmers. The policies and procedures described in this article with respect to the Board of Medicine are substantially similar but not identical to policies and procedures used by the other health regulatory boards. General guidelines for the disciplinary process to be followed by all of the health regulatory boards are set forth in *Department of Health Professions Adjudication Manual*, (the "adjudication manual") available online at www.dhp.state.va.us/dhp_guidelines.htm. A substantial portion of this article is a summary and restatement of the adjudication manual.
- 2 *Va. Code* § 54.1-2906. This section will become § 54.1-2406.1 as of July 1, 2004. Also, the 2004 legislation rewrote former section A3 into A3 and A4 to clarify when hospital disciplinary proceedings or actions must be reported.
- 3 *Va. Code* § 54.1-2907. This section will become § 54.1-2400.7 as of July 1, 2004.
- 4 The Board of Medicine licenses and regulates doctors of medicine, osteopathy, podiatry, and chiropractic; interns/residents; physician assistants; practitioners in physical therapy, occupational therapy, respiratory therapy, radiological technology and acupuncture. See *Va. Code* § 54.1-2900 and -2908.
- 5 *Va. Code* § 54.1-2408.8.
- 6 *Va. Code* § 2.2-3705.A.13.
- 7 *Va. Code* § 54.1-2400.2.A.
- 8 *Va. Code* § 54.1-2400.2.B.
- 9 *Va. Code* § 54.1-2400.2.F.

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to allow the plaintiff to cross-examine the defendant on his alleged prior bad "acts of misconduct and negligence relating to his former patients" or "his pattern and history of substandard care"¹ The Court found these issues to be collateral, and therefore, outside the proper scope of cross-examination. The Court also ruled that the trial court was correct in choosing to bifurcate the trial. The Court did not address the statutory privilege.

On the issues of negligent credentialing or supervision, the Court found these causes of action to be moot in light of the jury's finding at trial that Dr. Ghramm was not negligent. The Court, therefore, did not address the apparent trial court split on the issue of negligent credentialing. There are, however, some important lessons to be drawn from the Court's opinion.

While the Court did not decide whether negligent credentialing is a viable cause of action in Virginia, the Court did make clear for future litigants that negligent credentialing is not an issue absent a finding of negligence against the involved physician. Thus, hospitals faced with negligent credentialing claims in the future can at least rely on *Stottlemeyer* as authority to compel the bifurcation of any negligent credentialing claim against the hospital from the related medical malpractice claim against the physician; and the dismissal of any negligent credentialing claim if the involved physician prevails on the medical malpractice claim.

Although the Supreme Court decision left open the ultimate issue of whether negligent credentialing is a cause of action in Virginia, what is certain is that the debate over negligent credentialing and the proper scope of Virginia's peer review privilege will continue to be deliberated in the commonwealth.

—James M. Daniel Jr., June 17, 2004

Endnote:

1 *Stottlemeyer v. Ghramm*, No. 031613 (Va. June 10, 2004).

- 10 The policies of the other boards are available from their staffs and are reflected either in board minutes or as guideline documents.
- 11 *Va. Code* § 54.1-2408.1.
- 12 *Va. Code* § 54.1-2409.
- 13 *Va. Code* §§ 54.1-2915(A)(4) (for the Board of Medicine) and -3480(A)(4) (for the Board of Physical Therapy)
- 14 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.
- 15 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.
- 16 *See* §§ 54.1-2400.2(F) and 2910.1(A)(12). *See* also 18 VAC 85-20-290(B). The DHP is in the process of developing a system which will afford public access to the notices and orders of the other boards through their Web sites.
- 17 *Va. Code* § 54.1-2400(14).
- 18 *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.
- 19 *Va. Code* § 54.1-2400(14).
- 20 *Id.*
- 21 *Id.*
- 22 *Id.*
- 23 *Id.*
- 24 *Va. Code* §§ 2.2-4019 and -4020.
- 25 *Va. Code* § 54.1-2400(15)
- 26 *Va. Code* § 2.2-3711(A)(15).
- 27 *Va. Code* § 2.2-3711(A)(28).
- 28 *Va. Code* § 54.1-2400(10). Three additional days are permitted if service is accomplished by mail.
- 29 *Va. Code* § 54.1-2400(11).
- 30 As with an informal conference, formal hearings may be convened even though a respondent's license has expired or has been "surrendered," i.e., even though the respondent has determined not to use the license any longer. A practitioner cannot, however, unilaterally surrender a license. Accordingly, ceasing use of the license or mailing it to the board does not deprive a board of the authority to conduct an administrative proceeding and render appropriate sanctions against a respondent.
- 31 *Va. Code* § 54.1-2920.

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