



# The Virginia Health Lawyer

Bringing Healthcare and Law Together

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## Message from the Chair

*Thomas C. Brown, Jr., McGuireWoods LLP*

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Your Health Law Section continues to have a busy and productive year.

**Annual Legislative Update and CLE.** Our Section has worked cooperatively and successfully with our counterpart Section in the Virginia Bar Association to present a combined four-hour Annual Legislative Update and CLE program in Richmond on the afternoon of April 30th. The program will commence at 1:00 p.m. in Senate Room A of the Virginia General Assembly Building.

The noted and humorous legal ethics lecturer, Tom Spahn, will lead off with an hour on the ethical aspects of lawyer marketing.

The next two hours will be devoted to the Annual Legislative Update. A blue-ribbon panel of healthcare association executives and government officials will speak on recent developments in the Virginia General Assembly.

The last hour will feature a CLE program organized by the Section's Vice Chair, Walt Sowers, on the topic of "Anatomy of Peer Review Proceeding". Walt has assembled an experienced panel of healthcare lawyers and a physician to present what promises to be both an entertaining and informative program.

At \$65, the cost of this annual event is very modest. You may register by sending that amount to The Virginia Bar Association, 701 East Franklin Street, Suite 1120, Richmond, Virginia 23219.

**Annual Business Meeting.** A brief annual business meeting of the Section will be held at the conclusion of the Annual Legislative Update and CLE program.

**Compendium of Virginia Health Care Trade Associations and Regulatory Agencies.** This Compendium, prepared by the Section in 1999, has been posted to the Section's website. Thanks to the good work of Steve McCoy, Marie Graham, Pat Devine and Molly Evans, we expect to have an update of the Compendium ready by this summer.

**Principles of Cooperation for Physicians and Attorneys.** In 1993, the Section worked with the Medical Society of Virginia to promulgate Principles of Cooperation for Physicians and Attorneys in Virginia. Pat Devine and other members of the Section have commenced an effort to update and republish these Principles of Cooperation.

**North Carolina Society of Healthcare Attorneys.** The North Carolina Society of Healthcare Attorneys has a website found at <http://www.ncshca.org> that contains articles that may be of interest to our members. For example, the website currently contains an article and sample Business Associate Agreement for lawyers.

**Virginia Business Magazine.** Finally, next year's edition of Virginia Business magazine's "Legal Elite" will for the first time contain a section on health law. Additionally, the April issue of the magazine will feature an article on the evolution of health law as a specialty and its impact on businesses in the Commonwealth.

# Health Care Worker Shortages Hit Code Red! *The Immigration Answer?*

By Eliot Norman, Esquire

The Department of Homeland Security is not the only government department talking about Code Orange or worse. The HHS laments that the national nursing shortage will reach 128,000 in 2003; Virginia is hurting now and will face a 21% vacancy rate for RNs in 2010, 36% in 2020. Already, some hospitals talk of closing beds and reducing admissions due to the scarcity. And it doesn't stop with nurses. From therapists to pharmacists to med techs to rehab, recruiters are using stopgap measures and still not meeting their needs. Nor is the crisis just with your hospital clients: nursing homes, even clinical practices are feeling the pressure.

No wonder! For \$40,000 a year (or less) would you put up with 12 hour days, juggling pills and life-or-death issues, and taking orders from some M.D.s who think they "walk on water"? Fewer nursing schools, nursing teachers and better job choices for women mean fewer newcomers and higher turnover for the nursing profession. Over the long run it will take increased training, education, better pay and working conditions and showing a little respect for the RN to reduce conditions from Code Red to Code Green. But in the short-run, you may find your client's HR Manager off in Toronto at a Job Fair or in the Philippines looking for qualified nurses to "bridge-the-gap." Will many hospitals, including those in smaller communities, soon resemble a mini-United Nations?

It appears so. Once again, just as the dot.com and telecommunications companies relied upon thousands of Indian IT workers on H-1B visas to fuel the tech bubble from 1997 to 2000, it looks like another visa game is being played out in the health care sector. In India, more than 3,000 foreign nurses took the qualifying CGFNS exams last year, all hoping to land jobs in the USA. Both large chains

and small hospitals are recruiting internationally to find scarce radiation techs, RNs or physical therapists. As one HR manager put it: "We have to get aggressive and work smarter. Maybe one way is to recruit globally. But how? And is all that visa red tape worth it?"

## The Visa Maze

So far, the benefits seem to outweigh the cost of roundtrip airfare to Manila. But keeping up with monthly immigration rule changes in this post 9/11 era--where the

official INS motto is: "Zero Tolerance for mistakes"--is not easy. You will need to put on your eyeshades to read the fine print in the Federal Register. For those of you not eager--after HIPAA--to master yet another set of regulations, I can offer this general roadmap to navigate through the visa maze. (Download updates at [www.world-visas.com](http://www.world-visas.com) for more details.)

Let's start with the basics. Foreign health care workers can apply for a variety of visas. The "right choice" varies. It depends on the applicant's nationality, the occupation, whether a Visa Screen or Certification is required, State licensing rules, where the applicant went to school, and whether she is applying for a temporary (nonimmigrant) or permanent (immigrant or Green Card) visa. And a

completely different set of rules applies to foreign physicians.<sup>1</sup>

## Canada

Lets start with Canada, our ally and friendly neighbor to the North. The NAFTA Treaty did create a "great sucking sound" as Ross Perot predicted. United States of America manufacturing jobs did migrate to low-paying Mexico. But Canada also ended up a loser under NAFTA. The Canadians have experienced an enormous brain drain to the USA for

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all sorts of professions. In the health care sector, the NAFTA or TN Visa is available for Canadian RNs, recreational, physical and occupational therapists, nutritionists, dietitians, pharmacists and medical lab technologists, among other allied health professionals. It takes one day or less at the border to be admitted on a TN visa. The TN will be valid for one year and can be renewed indefinitely in one year increments. A similar TN, which takes longer to process, is available for these same occupations for Mexicans. In 2001, the Virginia Board of Nursing changed the rules for Canadian RNs to permit licensure "by endorsement," eliminating any need to sit for the NXCLEX-RN examination or obtain CGFNS certification (See [RNs and the Green Card](#) below).

## H1-Bs for Other Nationalities

For countries other than Canada, the most practical temporary visa is the H-1B, provided that the occupation is one which requires at least a four-year college degree. A candidate should have either a U.S. degree or a foreign degree equivalent to an U.S. baccalaureate degree. The H-1B is a temporary or non-immigrant visa. It is valid for an initial period of three years, with only one three-year extension allowed, except under unusual circumstances. Typical H-1B occupations include pharmacists, some nursing supervisory positions, dietitians, nutritionists and physical therapists. RNs and techs do not qualify because these two high-shortage occupations do not require a B.A. or B.S. degree.

Successful processing of an H-1B may require pre-certification of the candidate by a national board. For example, pharmacists educated overseas must first pass the Foreign Pharmacy Graduate Equivalency Examination (FPGEE), administered by the National Association of Boards of Pharmacy (NABP), before beginning work under the H-1B program. All H-1B candidates must also comply with any state licensing requirements. Actual processing times for H-1B petitions and visas can take from 15-75 days, depending upon the location of the work site, the foreign country involved and whether the employer is willing to pay an extra fee for premium processing. Transfers of H-1Bs

from one hospital or health care provider to another can now be handled in a few days without waiting for approval of the visa petition under new INS portability rules. This development may mean that foreign workers with H-1B visas may be more willing to change employers than in the past.

## New Developments Affecting TNs and H-1Bs.

Proposed INS regulations would "add the requirement that all nonimmigrants coming to the United States for the primary purpose of labor as health care workers, including those seeking a change of status, be required to submit a health care worker certification." This new development, if adopted, would delay by 3-4 months the rapid process described above for TN and H-1B workers, because they would be required to obtain a Visa Screen Certificate from a third party credentialing organization, such as the CGFNS (Council for Graduates of Foreign Nursing Schools). The CGFNS would be required to review foreign educational credentials, English proficiency, and pertinent examination and licensing results.

The INS is proposing to apply this requirement to foreign workers, whether or not they received their education and training in the United States. Anyone now working in the U.S. would be required to obtain certification before they can: apply for a temporary visa abroad; change their status or extend their stay in the U.S.; or exit the U.S. and attempt to reenter the country. Imagine the nightmare if your hospital's Canadian nurses go home to Montreal for the weekend and find out they have to wait 90 days to obtain a Visa Screen Certificate before being allowed back in. Hopefully, the interim regulations will be modified to at least exempt existing workers already in the U.S., based upon comments to be received during the rulemaking process now underway.

For information on the INS proposal, which would adversely affect foreign nurses, physical therapists, occupational therapists, speech-language pathologists, medical technologists (also known as clinical laboratory scientists), medical technicians (also known as clinical laboratory technicians), and physician assistants, working in the U.S. on temporary visas, email me at [enorman@reedsmith.com](mailto:enorman@reedsmith.com).

*"Reliance upon international personnel is one alternative strategy to a problem--staffing shortages for RNs and allied health professionals--that defies a magic or quick fix. If your hospital or nursing home client is not now involved in the visa game, it soon will be."*

## RNs and the Green Card

A Green Card grants the holder and her spouse and children the right to permanently reside and work in the United States and to apply eventually for U.S. citizenship. This immigrant visa is widely used for jobs that are pre-certified by the Department of Labor as Schedule A "shortage occupations."

Currently, only RNs and physical therapists can so benefit and thus apply for "Fast-Track" Green Cards. Other professionals can apply for green cards under regular processing by first obtaining certification from the Department of Labor that there are not enough U.S. workers to fill the available vacancies at the hospital meeting the minimum qualifications of the positions. The entire Green Card process can take anywhere from 8 to 12 months for RNs and physical therapists and currently 18 to 24 months for other occupations. However, proposed Department of Labor regulations (PERM), to be implemented as early as August, 2003, will drastically shorten processing times for Permanent Labor Certifications from 12 months or more to 60 days or less. Thus, the good news is that by January, 2004, we should be experiencing overall processing times for Green Cards for all foreign health care occupations from all countries of about 8 to 12 months.

The path to ultimate admission is, however, arduous and requires some expertise in mastering the licensing and Visa Screen requirements. To start with, any foreign RN seeking to practice in Virginia must:

- (1) Pass the CGFNS exam given in any of 40 foreign countries, which predicts the likelihood of success on the NCLEX-RN examination, required for licensure in the U.S.
- (2) Have the employer (hospital or recruiting agency) file an I-140 Petition with the Vermont Service Center of the INS, attaching the results of the CGFNS examination.
- (3) Obtain a Visa Screen (CGFNS) certificate from the International Commission on Healthcare Professionals (ICHP), a Division of the CGFNS. Its Visa Screen Program analyzes education, tests English proficiency, and validates past and present licenses.
- (4) File for an immigrant visa overseas at the U.S. consulate once the I-140 is approved by the Vermont INS.
- (5) Obtain the immigrant visa (equivalent to Green Card issued in the U.S.).
- (6) Enter the U.S., apply to the Virginia Board of Nursing for a license and obtain permission to take the NCLEX-RN (Social Security number is not required; use DMV Control Number).
- (7) Use the CGFNS Certificate to obtain a Temporary Exemption to Licensure to begin practicing as an RN for 90 days while waiting to take the NCLEX-RN exam.

- (8) Take and pass the NCLEX-RN, at which time a Virginia Nursing License is issued.<sup>2</sup>

## Conclusion

It would appear that global recruiting of health care workers by U.S. health care facilities will increase, not decrease, for at least the next 3-5 years. Reliance upon international personnel is one alternative strategy to a problem--staffing shortages for RNs and allied health professionals--that defies a magic or quick fix. If your hospital or nursing home client is not now involved in the visa game, it soon will be. They may soon be turning to you for advice for long range planning to establish a pipeline of qualified workers from overseas. Your hospital client may also wish to recruit foreign personnel directly--rather than relying solely upon staffing agencies--as a way to reduce overall compensation costs. You may also consider using Canada and the NAFTA TN to solve your client's short-run staffing crises. For now, there is some light at the end of the tunnel, even in the post 9/11 climate. Stay tuned for further developments.

<sup>1</sup>Foreign medical residents, for example, are subject to returning to their home country for two years unless they receive a waiver under the Conrad 30 program to practice in an HHS-designated shortage area for 3 years after graduation.

<sup>2</sup>For some other states (currently, NY, CA., GA., MD., SC, AK and HA) the nurse can enter on a B-2 tourist visa to take the NCLEX-RN. The nurse then returns to her home country, and uses success on the NCLEX-RN to obtain approval of the I-140 Petition, obtain CGFNS Certification and an immigrant visa to re-enter the USA. (The NCLEX-RN may in the future be given overseas but at present can only be taken in the U.S.). Foreign nursing graduates from the UK, Australia, U.S., South Africa Canada (except Quebec), Ireland and New Zealand are exempt from obtaining CGFNS Certification to obtain Green Cards. They only need present proof of success on the NCLEX-RN exam and a valid license from the state where they intend to practice. A cautionary note: this process is unavailable to foreign nurses seeking to practice in Virginia. Due to Virginia's stricter licensing requirements, such nurses would have to obtain licensure in another state and then transfer to Virginia under licensure by endorsement. Contact: [www.dhp.state.va.us/nursing/forms](http://www.dhp.state.va.us/nursing/forms) for more information.

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# Virginia's New Durable Do Not Resuscitate Program

By Karen N. Swisher, MS, JD  
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With a growing emphasis on respect for patient autonomy and patient control over end-of-life decision-making, Virginia, like most states has continued to revise and fine tune its "living will" and "durable medical power of attorney" statutes. However, even though these documents have been publicized and promoted throughout the country, their limitations also have become increasingly apparent.

Living wills and durable medical powers of attorney have proved particularly unhelpful in situations where a dying patient residing outside a hospital environment suffers a medical crisis and a family member or a caretaker dials 911 for help. Upon arrival, emergency medical services (EMS) personnel do what they are trained to do--provide aggressive life support, including cardio-pulmonary resuscitation. Despite family protests and the evidence of a living will, this response "reflects exactly the standard of care required of EMS personnel--to resuscitate aggressively unless a doctor on the scene directs otherwise" Do Not Resuscitate Orders (DNR) issued in hospitals and other acute care facilities frequently were considered ineffective outside these medical facilities, and often had to be reinstated every time a patient was admitted to a health care facility.

Support for expanded DNR options grew out of the increased desire for chronically ill and terminally ill patients to remain at home as much as possible, and was further supported by the hospice movement, which provides for aggressive comfort care, emotional, social, and spiritual care for patients wishing to die in their homes surrounded by supporting friends and family. In addition, the medical literature clearly documented that resuscitation that was routinely used on patients in hospitals and nursing homes had a dismal success rate, demonstrating that patients seldom survived this procedure, and often times, for those who did survive, there was evidence of extreme negative consequences, including crushed ribs, permanent intubation, brain damage, and coma.

The Virginia Durable Do Not Resuscitate Order (DDNR) has been revised to further assist patients' requests for

avoiding resuscitation. This new form follows a patient throughout the entire health care setting and can be honored in pre-hospital settings, hospitals, nursing homes, and other licensed institutions. The new law allows patients, including minors, to request a DDNR order from their physician. New changes, effective March 27, 2002, now provide patients the option of purchasing state-approved bracelets and necklaces in addition to the DDNR Order form which EMS personnel will look for in order to determine if they should initiate comfort care rather than cardiopulmonary resuscitation (CPR). The Virginia Department of Health no longer issues the old EMS DNR Form. All EMS DNR Orders that were in effect on July 1, 1999, or issued after that date, are considered DDNR Orders and shall remain valid until or if revoked.

It is important to note that only physicians can issue a DDNR Order to the patient. Physicians and health care facilities must request the DDNR Order form on office or facility letterhead and mail or fax this request to the Office of Emergency Medical Services, Virginia Department of Health. The forms are now available without cost, and are not available to the public. However, once the patient has a DDNR Order, he/she may directly purchase an approved bracelet or necklace as an alternative form of the DDNR identification. The patient should keep the original DDNR form. It is printed on distinctive paper. While patients are encouraged to provide copies to their physicians and family members, EMS personnel will *not* honor copies and must see the *original* form or alternative identification (the necklace or bracelet) in order to validly withhold CPR.

EMS personnel responding to requests for help require the original Virginia DDNR form or the EMS DNR Order, or look for either form at the patient's bedside, on the back of the patient's bedroom door, on the refrigerator, in the patient's wallet, or look for an approved DDNR necklace or bracelet on the patient's body. If the patient has one of these and is in cardiac arrest, resuscitation will be withheld

or withdrawn. These resuscitation procedures include:

- Cardiopulmonary resuscitation (CPR)
- Endotracheal intubation or other advanced airway management
- Artificial ventilation
- Defibrillation
- Cardiac resuscitation medications
- Continuation of related procedures, as prescribed by the patient's physician or medical protocols.

If the patient with a DDNR is not in cardiac or respiratory arrest, the patient will receive emergency medical care. All patients with DDNR orders will receive comfort care, which includes the following:

- Airway management, (excluding intubation or advanced airway management)
- Suction
- Supplemental oxygen delivery devices
- Pain medications or intravenous fluids
- Bleeding control
- Patient positioning
- Other therapies deemed necessary to provide comfort care or to alleviate pain

It is very important for patients who have DDNR orders to discuss the meaning of this order with family and friends who may be with the patient when EMS personnel are called in for crisis intervention. EMS providers have been instructed to continue to provide comfort care to the patient if there is an emotional confrontation with the patient's family. If CPR is indicated, and if the family insists on resuscitation, the patient will be transported to the ambulance and the EMS provider will contact on-line Medical Direction for further instructions.

It is easy for patients to revoke a DDNR order. Patients may revoke the order by destroying the form, or by verbally withdrawing consent to the order. A physician who is physically present at the patient's side may revoke an order. Finally, a person authorized to consent on the patient's behalf may revoke an order.

Patients should always travel with their original DDNR order or the DDNR bracelet or necklace to be assured that their

wishes are respected in Virginia. However, the Virginia DDNR order may or may not be honored in other states, and Virginia EMS providers are not permitted to recognize a DNR order from another state. It is recommended that if patients travel out of state, they should contact that state's health department or department of emergency medical services for guidance.

While Virginia's Health Care Decisions Act and the new regulations surrounding durable DNR orders have made significant strides in promoting patient autonomy and choice in medical decision-making, Sabatino and others note there still remain certain logistical and practical concerns in honoring patients' wishes. These include:

*"Patients still experience confusion over the use and need for living wills, medical powers of attorney, and DNR orders. A living will document is not a durable DNR order; and patients need another form to fill out and discuss with their physician. Counseling and education of patients wishing to do advance planning for their impending dying and death process should include a living will (which in Virginia also includes a form to designate a surrogate), durable medical power of attorney, DDNR order, regular will, and financial power of attorney."*

- Patients still experience confusion over the use and need for living wills, medical powers of attorney, and DNR orders. A living will document is not a durable DNR order; and patients need another form to fill out and discuss with their physician. Counseling and education of patients wishing to do advance planning for their impending dying and death process should include a living will (which in Virginia also includes a form to designate a surrogate), durable medical power of attorney, DDNR order, regular will, and financial power of attorney.

- Physicians need continued education and support on how to discuss the meaning of a DDNR order with patients. It is ironic that resuscitation is the only medical procedure done that does not require a patients' informed consent. Rather, patients must consent to a DNR order instead. It is unfortunate that some patients are not told of the risks, and the consequences of resuscitation, along with the alternatives to treatment which commonly include aggressive comfort care. Patients and health care workers sometimes misunderstand that a DNR order does not mean non-treatment or abandonment of the patient. Pain management typically does not include resuscitation but does include other aggressive procedures.

- Simplicity is a key to helping patients decide if a DDNR order is what they want. In Virginia, patients still do not

have access to the DDNR order form. Only physicians and hospitals may request such forms. In addition a few other states do allow for interstate reciprocity while Virginia does not. A few states allow for wallet card identification while Virginia does not.

- DDNR orders must be supplemented with extensive patient and family counseling regarding the dying process to minimize conflicts. Virginia statute supports patients' rights to DDNR despite family protests by stating that, "[n]o person shall authorize providing, continuing, withholding or withdrawing treatment . . . that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of a patient incapable of making an informed decision or the wishes of such patient fairly expressed when the patient was capable of making an informed decision . . . ." Hospices provide excellent counseling services for patients and family regarding the dying process at home and the limitations of resuscitation in providing comfort and pain management to such patients.

In the final analysis, DDNR protocols should be designed and measured against three goals articulated in the 1991 survey report of Sachs, Miles, and Levin:

First, patients should be able to exempt themselves from standing orders for cardiopulmonary resuscitation and possibly other unwanted heroic interventions. Second, ambulance service must be provided to all persons regardless of status, so that terminally ill patients have access to emergency palliative care and patients who decline cardiopulmonary resuscitation have access to other life-sustaining treatments. Third, some EMS operators wish to limit the dispatch of more costly (and in some cities, limited) advanced life-support ambulances to DNR patients, sending basic life-support units instead.

Virginia's new regulations make greater strides in meeting these goals.

#### Important websites, phone numbers, and articles:

- For approved DDNR bracelets and necklaces: vendor names can be requested from the Office of EMS by calling (804) 371-3500 or visit its Web page: [www.vdh.state.va.us/oems](http://www.vdh.state.va.us/oems).

- For a copy of Virginia DDNR Order Question and Answers (suitable for patients) which may be duplicated, contact Office of Emergency Medical Services, Virginia Department of Health Web page: <http://www.vdh.state.va.us/oems/DDNR/ddnr.htm> or call 1-800-523-6019. Be sure to open the PowerPoint presentation on DDNR. It's well done!

- Sabatino, "Survey of State EMS-DNR Laws and Protocols" 27 *J. Law, Medicine & Ethics* 297 (Winter, 1999). This article is an excellent reference for what other states are doing.

- Bosch, "Ohio's Do Not Resuscitate Law: A Guideline to Memorialize and Enforce and Individual's FINAL Decision" 28 *Ohio N.U.L.Rev.* 463 (2002)

- Hospice personnel are well trained to counsel patients on DDNR orders as well as other advance directives. They are excellent resources for help: <http://www.virginiahospices.org/Care.html>. The Hospice of Central Virginia has a good website: <http://www.americanhospice.com/hocv/hocvfrm1.htm>.

<sup>1</sup>For an excellent article on dying and death in America during the past 25 years, see Norman Cantor, "Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying", 29 *J. Law, Medicine & Ethics* 182 (Summer 2001).

<sup>2</sup>Sabatino, CP, "Survey of State EMS-DNR Laws and Protocols", 27 *J. Law, Medicine & Ethics*, 297 (Winter 1999).

<sup>3</sup>See for example, RJ Hammill, "Resuscitation: When is Enough, Enough?," 40 *Respiratory Care* 515 (1995), Lombardi, Gallagher, and Gennis, "Outcome of Out-of-Hospital Cardiac Arrest in New York City," 271 *JAMA* 678, (1994).

<sup>4</sup>Va. Code Ann. Sec 54.1-2987.1 {Cum. Supp. 2002} and 12 Va. Admin. Code 5-65-10 to 110 {Cum. Supp. 2002}

<sup>5</sup>For a copy of Virginia DDNR Order Question and Answers (suitable for patients) which may be duplicated, contact Office of Emergency Medical Services, Virginia Department of Health Web page: <http://www.vdh.state.va.us/oems/DDNR/ddnr.htm> or call 1-800-523-6019.

<sup>6</sup>There has been much research on pain management during the last few years. For excellent reviews of this literature see; B Rich, "A Prescription for the Pain: The Emerging Standards of Care for Pain Management," 26 *William Mitchell Law Review* 1-91, (2000) and, Symposium, "Appropriate Management of Pain: Addressing the Clinical, Legal, and Regulatory Barriers," 24 *J. Law, Medicine & Ethics* 285, (1996).

<sup>7</sup>Va. Code Ann. Sec 54.1-2987.1.D. {Cum. Supp. 2002}.

<sup>8</sup>Conflicts still arise when family members demand that, "everything be done" despite patient's wishes to the contrary. See for example, NL Cantor, "Can Healthcare Providers Obtain Judicial Intervention Against Surrogates Who Demand 'Medically Inappropriate' Life Support for Incompetent Patients?," 24 *Critical Care Medicine* 883, (1996).

<sup>9</sup>GA Sachs, SH Miles, and RA Levin, "Limiting Resuscitation: Emerging Policy in the Emergency Medical System," 114 *Annals of Internal Medicine*, 151 at 153 (1991).

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# A Family Physician's Journey into the Study of Law

By Duane A. Lawrence, M.D.

It was near the end of the winter monsoon season in Da Nang, South Viet-Nam, in 1967. A young Marine lance corporal in the Tank Battalion of the First Marine Division faced serious charges for swiping a Jeep from the motor pool and racing it down Highway 1 for 60 miles in the dead of night before the MPs could apprehend him. The tank battalion commander needed three of his more senior officers to sit as members of a Special Court-martial according to the Uniform Code of Military Justice. "Lieutenant Lawrence, even if it is not medicine or surgery, this is one of your obligations as an Officer in my battalion; you are hereby assigned to this Court-martial," he ordered. That was my first experience in a "courtroom" role. Unlike the other panel members, as the Brig physician I would later be in charge of that same Marine's medical care during his three months in confinement.

Many experiences and numerous people slowly and subtly led me to law. A four-year immersion in Latin studies enhanced my understanding of English and the assimilation of the terminologies of both medicine and law. The broad liberal arts curriculum at Hamilton College in New York included studies in modern history, psychology, philosophy and religion, oratory and English literature as well as in the prerequisite premedical sciences. My interest in these subjects continued while my children prepared for their own college experiences at Harvard. Parents often are accused of guiding or pushing their progeny into or away from specific career paths. In my case, my son and I have inspired and influenced each other. As I have watched him study Government and Latin, serve as legal officer on a Navy warship, and now meet the challenges of medical school, I have witnessed the evolution of his and my own appreciation for the nexus of life, law and medicine.

After beginning my medical practice in Virginia Beach, I was elected and appointed to leadership roles in community health organizations, in local and state medical societies, and on hospital medical staff executive committees. In these positions, I observed first hand the activities of a number of attorneys working in health care law. I was especially impressed with the attorney who was Chairman of the Board of the local free health clinic during the two years

when I was a Board member. During that term, he helped our board methodically and logically solve the numerous problems brought about by three changes of key executive personnel.

As a delegate to the Medical Society of Virginia for many years, I have been closely involved with annual discussions of proposed legislation related to health care issues coming before each General Assembly. I will never forget how skillfully the attorney consultant to the Medical Society guided my reference committee after a day's deliberations upon twenty separate resolutions concerning unfair business practices of health insurance

companies. She showed us how to craft one all-encompassing and precisely worded substitute resolution that was adopted by the Society's House of Delegates and that subsequently formed the basis for Virginia's Fair Business Practice Act.

Leadership roles in local and state medical societies led to my appointment in the 1990's to the claims committee of one malpractice insurance company and to the physician advisory committee of another. In those quarterly meetings, I observed that many defense attorneys work primarily for the insurance company's bottom line; fewer work primarily to protect the defendant physician's interests. Many physicians are not yet aware of the jeopardy to their medical licenses created by settlement of medical malpractice suits.

*"Many physicians are not yet aware of the jeopardy to their medical licenses created by settlement of medical malpractice suits. More than ever before physicians need advocates thoroughly familiar with the demands of quality practice and with the laws and regulations affecting their practices in order to help them manage the legal risks involved."*

More than ever before, physicians need advocates thoroughly familiar with the demands of quality practice and with the laws and regulations affecting their practices in order to help them manage the legal risks involved. In the future, if proposed tort reforms are adopted, such attorneys also will be needed to participate in mediation panels on behalf of physicians, so that patients might be compensated appropriately for bad outcomes and the physicians educated appropriately as to future practices without destroying their focus on the care of their current patients.

*"At least some physicians must 'step up to the plate,' learn about the law, and share that knowledge with their colleagues in ways that will enable them to encompass goals wider than 'just practicing good medicine.'"*

Legal aspects of medical care have become increasingly important to physicians and hospitals with the passage of laws such as the Hill-Burton Act, EMTALA, COBRA, OBRA, OSHA, BIPA and HIPAA, which all regulate the daily practice of medicine and frequently in incongruous and confusing ways. During the six years that I served on the executive committee of the medical staff at the community hospital near my practice, I had the opportunity to take a two-year seminar course for physician leaders under the tutelage of three professors from the College of William & Mary Business School. I found the sessions that interested me the most were devoted to the legal aspects of hospital and physician office management. These seminars whetted my appetite to explore the field of health care law in greater depth. For the last three years, as the Medical Director of Quality Care, I continuously grappled with the interactions of law and medicine because my committee reviewed all issues affecting the quality of care delivered at the hospital. After we physicians had worked diligently to make reasonable and equitable decisions about thorny issues, invariably the administration would say, "All this sounds great, but we need to check with Legal first." I realized that as a physician also credentialed as an attorney, I will help my colleagues and the hospital contribute to better patient care within the constraints of the health care laws.

Physicians are sometimes uninformed and often underrepresented - uninformed about the legal risks in medical practice and underrepresented when the "practice guidelines" and laws affecting medicine are enacted. Perhaps by nature, they are much more interested in working to provide good health care than in concerning themselves with legal matters. Many would rather just let the lawyers do the lawyering. In the 21st century, it is a "clear and present danger" for physicians to ignore the legal aspects of medical practice like the proverbial ostrich with its head in the sand. At least some physicians must "step up to the plate," learn about the law, and share that knowledge with their colleagues in ways that will enable them to encompass goals wider than "just practicing good medicine." My aspiration is to combine medical and administrative expertise with legal knowledge and skills in order to help define and resolve medico-legal issues for the good of all.

Dr. Lawrence, a first year law student at the Marshall-Wythe School of Law of the College of William & Mary, is a board-certified family practitioner who has maintained a solo practice in Virginia Beach since 1974. He has served as Chief of Staff at Sentara Bayside Hospital, President of the Virginia Beach Medical Society and in various other leadership positions with the Medical Society of Virginia and the Virginia Academy of Family Physicians.

# Sarbanes-Oxley: *Potential Application to the HealthCare Industry*

By Victoria Willis, Esquire  
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## Introduction

The passage of the Sarbanes-Oxley Act of 2001<sup>1</sup> (the "Act") was an attempt by Congress to address identified issues dealing with financial reporting by publicly traded companies. This article reviews the background to this Act, its salient details, and its potential application to the healthcare industry and sets forth a suggested compliance strategy for consideration by both public and private healthcare entities.

## Background

Prior to the fall of Enron, insider-trading scandals of the 1980s rocked the securities world. A series of regulatory reforms were instituted in an effort to address specific abuses.<sup>2</sup> A decade later with the passage of the Securities Enforcement Remedies and Penny Stock Reform Act of 1990,<sup>3</sup> Congress sought to expand prospectus delivery requirements along with additional disclosures relative to broker trading.

Against this backdrop, the American investor weathered the storms created by the rise and fall of the "dot-com" companies, but after the terrorist attacks of September 11, 2001, the market hit rock bottom. Enron, WorldCom, Adelphia Communications, Tyco and a series of other entities began disclosing accounting improprieties that lead to the reduction of investors' net worth by an estimated \$8.5 trillion.<sup>4</sup>

Congress passed the Sarbanes-Oxley Act in an attempt to address problems identified as contributing to the fall of Enron. Under the Act, a public accounting oversight board is created and charged with regulatory oversight of auditing firms and publicly traded companies.

## Overview of the Act

President Bush called the Act, "the most far-reaching reform of American business practices since the time of Franklin Delano Roosevelt."<sup>5</sup> Given that lead-in, it is evident that the Act encompasses more than can be addressed in this brief overview. Selected for consideration are the sections that may have potential application to healthcare entities.

*"While compliance with the Act is not mandatory for any healthcare entity that is not publicly traded, it would be wise for entities to consider a gradual movement to comply. The benefits would include greater access to potential financial funding and possibly improved rating in the bond industry."*

The cornerstone of the Act is the creation of the Public Company Accounting Oversight Board (the "Board").<sup>6</sup> It is a not-for-profit corporation set up under the laws of the District of Columbia and is not a federal agency. The Board's duties include the registration, inspection, and investigation of public accounting companies. It also has regulatory authority over private audit firms and is charged with developing standards for quality controls as well as ethical standards. There are five members of the Board, no more than two of whom can be certified public accountants. The members are limited to two five-year terms.

Of significance to the healthcare industry are the auditing, quality control and independence standards and rules issued in the Act, including the following:

- (1) the preparation and maintenance for not less than seven years of all audit work papers,
- (2) the provision of either a concurring or second partner review of the audit report,
- (3) a description in the audit report of the testing of internal controls,
- (4) a presentation of the findings relative to an evaluation of internal control structures and procedures, and
- (5) a description of any identified weaknesses in the internal controls.<sup>7</sup>

Additionally, there is a mandatory rotation imposed on the audit partner. Neither the audit partner nor the audit partner reviewer may perform audit services if they have performed them for the company for the previous five fiscal years.<sup>8</sup>

The Act envisions a much broader role for a public company's audit committee.<sup>9</sup> This committee must work independently of the company's board of directors, with the ability to hire and fire the company's audit firm and also to hire independent counsel as well as other financial advisors. Additionally, the Act requires membership of this committee be comprised of individuals that are "independent." In order to qualify as independent, a member may not "accept any consulting, advisory, or other compensatory fee from the issuer; or be an affiliated person of the issuer or any subsidiary thereof."<sup>10</sup>

Significantly, the Act prohibits the concurrent provision of audit and non-audit functions by the same company.<sup>11</sup> The following services cannot be dually provided: bookkeeping, financial information system design and implementation, appraisal services, actuarial services, internal audit outsourcing functions, management of human resources services, broker/dealer services, legal or other expert services,<sup>12</sup> and any other service that the Board deems impermissible.<sup>13</sup>

This would appear to exclude any cross provision of services. This is of particular importance when considered in conjunction with the pre-approval process for services not on the list.<sup>14</sup> The pre-approval must occur by the audit committee unless it meets the de minimis exception.<sup>15</sup>

Officer certification of the financial report is detailed in 15 U.S.C. 7241. This certification requires that the signing officer confirm that s/he has reviewed the report, that the report does not contain any untrue statement of a material fact or omission of a material fact, and that the report fairly states the financial condition of the company. The Act requires the signing officer to further certify that s/he is responsible for maintaining internal controls designed to ensure material information is disclosed and that the controls have been tested within 90 days of the date of the report along with a statement on the effectiveness of the controls.<sup>16</sup> Finally, the signing officer must also certify that any and all significant deficiencies in the internal controls, any fraud whether or not material that involves personnel with a significant role in the internal controls, and any significant changes in the internal controls have been disclosed to the audit committee.<sup>17</sup>

The mandatory development of a code of ethics for senior financial officers is the last area that may have potential application to healthcare entities.<sup>18</sup> The code of ethics is defined as standards designed "to promote honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships."<sup>19</sup>

## Potential Application

While the Act is currently limited to publicly traded companies, the potential for expansion exists in a myriad of forms. First, the Internal Revenue Service, with its focus on the not-for-profit delineation of healthcare systems, will more than likely seek to adopt, in part, if not in whole, the requirements relative to auditing controls and conflict issues. Secondly, state attorneys general will more than likely look to these requirements as they continue to seek avenues to increase state regulation over tax-exempt entities. In the wake of the collapse of the Allegheny System and the problems currently facing Tenet Healthcare Corporation, increased state and federal regulation of the healthcare industry can be expected, since they provide a unique and necessary public service. Third, the financial industry will seek to have stricter internal controls and possibly certification requirements in order to protect bank depositors and investors in bonds. Finally, the parallel to corporate compliance initiatives is evident. While such programs are designed to address specific issues of federal non-compliance, the application of the accounting controls and financial disclosures fits nicely within the same parameter.

## Compliance

The first step toward voluntary compliance is education of the company's board and the audit committee. While there is a plethora of books on the subject of corporate compliance, the use of current review articles is recommended, which are more concise, timely and easier to digest. If possible, secure the services of a local attorney or professor of business or law to lecture on the topic of Sarbanes-Oxley.

Once the education phase has been completed, the entity should examine its relationship with its accounting firm. Determine what services the accounting entity is providing and request a detailed listing of all payments made to the accounting firm over the past five years. At the same time, examine the relationships between the board members and the accounting firm. Does the accounting firm provide

auditing services to any member of the board and/or audit committee or to a company upon which those members also serve as directors? Knowledge of potential conflicts is the key to making the process both fair and responsible.

Consider requesting the accounting firm to adopt the standards as outlined above relative to the maintenance of records and the provision of a second reviewer. The entity may also want to establish a mandatory bid period so that every five years a new accounting firm will be brought in to conduct the audit. The testing of internal controls and the reporting of any weakness are critical to a healthcare entity and can further enhance the functions of its corporate compliance program.

During the examination phase, the entity should also review its own internal policies and procedures for financial transactions. This review must include the process for documentation as well as approval of transactions and services to be provided. Many entities may discover that numerous individuals are signing contracts, agreements, and guarantees that commit substantial resources of the company and that these commitments have not been calculated into the financial reporting of the entity. One approach to uncover such instances is to call for copies of all contracts and or agreements of each officer, manager or director and then determine the level of financial commitment. After this, the entity should develop a contracting policy dealing with financial signatory authority.

The healthcare entity should also carefully consider the officer certification requirement. The preparation of financial reporting that is utilized for governmental purposes already requires faithful adherence to generally accepted accounting standards, but there is no requirement relative to the development and testing of internal controls. Healthcare entities may want to consider a form of certification from the chief financial officer that complies with this requirement.

The development of a code of ethics has substantial application for healthcare entities. The code should be applicable to all those involved in the financial transactions of the company and not just the senior financial officers. In many ways, this may be akin to a corporate code of ethics or a corporate compliance code.

The entity may want to review its bylaws and determine if changes are necessary to permit the audit committee to function independently. At a minimum, entities should

establish a procedure for the management of complaints relative to financial matters, as well as a process for reporting those matters to the audit committee. For many entities, this function is similar to that of the compliance committee and if possible, they may want to combine these functions into one committee.

## Conclusion

The healthcare industry is not without its own scandals. The collapse of the Allegheny Healthcare System in many ways mirrors the fall of Enron. It may be a question of time before the Act is expanded to non-publicly traded companies, but nevertheless, the access to financial fundings alone, should provide incentive to healthcare entities to consider a form of voluntary compliance. Employing the provisions discussed above, a healthcare entity can assure the public as well as other regulatory federal and state agencies that they may continue to have confidence in the financial stability of its provider for healthcare services. Additionally, familiarization with the requirements of the Act will be beneficial to the investment committees as they consider investment of institutional funds.

While compliance with the Act is not mandatory for any healthcare entity that is not publicly traded, it would be wise for entities to consider a gradual movement to comply. The benefits would include greater access to potential financial fundings and possibly improved rating in the bond industry. Most financial institutions will begin to examine carefully the financial reporting of any entity and with a minimal amount of disruption, voluntary compliance will only add to the strength of any application for funding.

<sup>1</sup>15 U.S.C. 7201

<sup>2</sup>Insider Trading and Securities Fraud Enforcement Act of 1988, 15 U.S.C. Section 78u.

<sup>3</sup>15 U.S.C. Section 78(a)

<sup>4</sup>Wall Street Journal, October 1, 2002

<sup>5</sup>Elizabeth Bumiller, "Bush Signs Bill Aimed at Fraud in Corporations," N.Y. Times, July 31, 2002.

<sup>6</sup>15 U.S.C. 7211

<sup>7</sup>15 U.S.C. 7213

<sup>8</sup>15 U.S.C. 78j-1(j)

<sup>9</sup>15 U.S.C. 78j-1(m)

<sup>10</sup>Id.

<sup>11</sup>15 U.S.C. 78j-1(g)

<sup>12</sup>Id. at subsections 1 through 8.

<sup>13</sup>Id at subsection 9.

<sup>14</sup>15 U.S.C. 78j-1(i)

<sup>15</sup>15 U.S.C. 7231

<sup>16</sup>15 U.S.C. 7241(a)

<sup>17</sup>15 U.S.C. 7241(a)(5) and (a)(6)

<sup>18</sup>15 U.S.C. 7264

<sup>19</sup>15 U.S.C.7264(c)

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# You Too Can Own and Operate a Defibrillator: *The Shocking Truth*

By John C. Bilzor  
Hofheimer Nusbaum, P.C.

Every Thursday night on NBC, Dr. Carter or one of his ER cohorts is certain to yell "Clear!" as they attempt to resuscitate yet another patient in cardiac arrest at County General. As well-coached actors, they make it look easy, but we all know that what is easy on TV is maybe not so easy in real life. Like the car commercials say: "Closed course and professional drivers-do not attempt this at home." But wait. With the development of automated external defibrillators (AED) and appropriate training, you could do this at work or even at home.

AEDs are increasingly being deployed on commercial airlines and other public places, and lives are being saved by people who are able to resuscitate heart attack victims using an AED before the arrival of emergency medical personnel. Increased use of AEDs is being promoted by federal, state, and local governmental agencies. As a healthcare attorney, you may be called upon to assist a client that is interested in purchasing an AED to serve its employees or customers and wants to know the legal requirements and risks of liability.

What is an AED? According to the American Heart Association, an AED is "a device used to administer an electric shock through the chest wall to the heart. Built-in computers assess the patient's heart rhythm, judge whether defibrillation is needed, and then administer the shock. Audible and/or visual prompts guide the user through the process. . . . An AED is safe to use by anyone who's been trained to operate it."<sup>1</sup>

The Virginia Department of Health's Office of Emergency Services (OEMS) labels "Public Access Defibrillation" (PAD) an "important public health initiative in the Commonwealth and across the nation. The primary goal of PAD is to increase survival from out-of-hospital sudden cardiac arrest

by shortening the time to defibrillation. Virginia is attempting to accomplish this by encouraging the development of Early Defibrillation Services (EDS) in local communities. These programs strive to increase the number of . . . AEDs in communities, increase the number of persons recognized by national organizations to use AEDs and increase the number of persons trained in CPR and the use of AEDs."<sup>2</sup>

Proponents of increased availability and use of AEDs cite their safety, accuracy, ease of maintenance, and relatively low cost. There are presently seven companies in the United States that manufacture AEDs approved by the Food and Drug Administration.<sup>3</sup> AEDs are regulated as medical devices

by the FDA and are classified as "restricted medical devices" in Virginia.

Despite claims of safety and ease of use, what are the risks of legal liability? As the ever-cautious attorney, you cannot guarantee that the Company's purchase of an AED and the establishment of a program for its use will be free of liability.<sup>4</sup> You can say, however, that there is statutory protection for those who follow the applicable regulations.

As a threshold matter, a person may not operate or maintain an AED for public use without OEMS registration.<sup>5</sup> Virginia

*"Despite claims of safety and ease of use, what are the risks of legal liability? As the ever-cautious attorney, you cannot guarantee that the Company's purchase of an AED and the establishment of a program for its use will be free of liability. You can say, however, that there is statutory protection for those who follow the applicable regulations."*

Code § 8.01-225.A.6 (part of the "Good Samaritan" statute) provides that a person who has successfully completed a state-approved CPR course and renders emergency cardiac defibrillation shall be deemed qualified to administer such emergency treatments and procedures and shall not be liable for acts or omissions resulting from the rendering of the emergency treatments or procedures. Virginia Code § 8.01-225.A.7 provides immunity from civil liability for any personal injury resulting from an act or omission in the emergency use of an AED where the use is in compliance with Virginia Code § 32.1-111.14:1 (the registration statute) and the person who uses the AED "acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances." The statute does not provide immunity from civil liability for injury arising from gross negligence or willful or wanton misconduct. There are similar federal protections in Section 404 of the Cardiac Arrest Survival Act, enacted in 2000.<sup>6</sup>

Virginia Code § 32.1-111.14:1 provides that an AED "may be used to save or attempt to save the life of a person who is in cardiac arrest upon being registered in accordance with this Section and the Board's regulations." The statute provides that each AED must be separately registered with the Virginia Board of Health and that requirements for registration and use include the following:

- All operators of the AED must receive and successfully complete training in CPR and in the use of the AED in a course approved by the Board of Health.
- The registrant must insure that the defibrillator is maintained and tested in compliance with the manufacturers operational guidelines and Board regulations, and must keep written records of such maintenance and testing.
- At least one licensed physician ("Service Medical Director") is required to supervise the defibrillation program, which would include provisions for personnel training, coordination with local emergency medical services, protocol approval, deployment strategies, and equipment maintenance plan and records.

*"The regulations require, among other things, that the registrant have written policies and procedures for the operation and maintenance of the service and for the responsibilities of personnel associated with the service, and that the registrant maintain records and reports for a period of not less than five years."*

The Board of Health has adopted regulations applicable to AEDs and the Early Defibrillation Service, which went into effect on January 15, 2003. There is an AED registration fee of \$25, and registration is effective for four years, at which time it must be renewed. Registration and regulation of AEDs is handled through the Office of Emergency Medical Services of the Board of Health ("OEMS"). OEMS uses the term "Early Defibrillation Service" to define persons, organizations, and/or programs authorized through registration to operate AEDs. The Registration to Operate Certificate issued by OEMS must be displayed in a public area of the Early Defibrillation Service.

The regulations require, among other things, that the registrant have written policies and procedures for the operation and maintenance of the service and for the responsibilities of personnel associated with the service, and that the registrant maintain records and reports for a period of not less than five years with respect to (i) current personnel records of each employee trained and qualified to use the AED, (ii) maintenance and safety inspection records for each AED currently in use, (iii) records of AED use, and (iv) AED "Incident Reports" for each instance where the AED is actually used on a patient.

The use of the Early Defibrillation Service is limited to a suspected cardiac or respiratory arrest for the delivery of life support until the arrival of trained EMS or other qualified medical personnel. The Early Defibrillation Service must keep the local EMS, emergency services dispatch office, and OEMS notified and current as to its location and extent of operations. It must notify OEMS of any changes in its trained personnel, acquisition of additional AEDs, or changes in Service Medical Directors.

Records that must be maintained and kept for at least five years include:

- training and qualifications of all personnel who would use the AED;
- maintenance and safety inspections for each AED in use;
- all Early Defibrillation Service activity; and

- Incident Reports for each instance where an AED is deployed and applied to a patient.

As noted above, the Early Defibrillation Service is required to have at least one Medical Services Director, who must be a Virginia licensed physician. The responsibilities of the Medical Services Director include:

- development and approval of service protocols;
- establishment of cooperative agreements between the Early Defibrillation Service and local EMS agencies; and
- planning, scheduling, and participation in training and continuing education programs for the service's personnel.

Some manufacturers and distributors of AEDs provide assistance to purchasers by providing contacts to physicians willing to serve as the Service Medical Director. They may also provide written materials that can be used a starting point for drafting the policies and procedures for a company's AED program, which would be modified to incorporate the requirements in Virginia's statutes and regulations.

In addition to statutory immunity, which for the owner's purposes depends upon its compliance with the registration statute and regulations, the manufacturer/seller of the AED may offer indemnification to the owner from damages arising directly from personal injuries to patients, where such injuries are directly caused by design or manufacturing defect in the AED.

Although you cannot guarantee absence of legal liability for your clients, if they follow the procedures set forth in the Virginia statutes and regulations, you can certainly say the risks are minimal and should not deter implementation of an important public service.

<sup>1</sup>American Heart Association's Emergency Cardiovascular Care Programs Web site at [http://www.cpr-ecc.org/cpr\\_aed/cpr\\_aed\\_menu.htm](http://www.cpr-ecc.org/cpr_aed/cpr_aed_menu.htm). Among useful publications available through this site are: "Quick Overview on Establishing a PAD Program"; "Using and Maintaining and AED"; and "Public Access Defibrillation: Physician Oversight Guide."

<sup>2</sup>See the OEMS web site at [http://www.vdh.state.va.us/oems/AED/Pad\\_aed.htm#Overview](http://www.vdh.state.va.us/oems/AED/Pad_aed.htm#Overview).

<sup>3</sup>The companies are: Access CardioSystems, Cardiac Science, Inc., Laerdal Medical Corporation, Medical Research Laboratories, Inc., Medtronic Physio-Control Corporation, Philips Medical Systems, and Zoll Medical Corporation. See the Web site of the National Center for Early Defibrillation at <http://www.early-defib.org> for further information and links to the Web sites of the manufacturers.

<sup>4</sup>For an extended discussion of legal liability issues involving AEDs, see Richard Lazar, "Understanding Legal Issues," National Center for Early Defibrillation Web site, [http://www.early-defib.org/03\\_06\\_02.html](http://www.early-defib.org/03_06_02.html). Mr. Lazar concludes that "liability risks associated with early defibrillation programs are quite remote" and that "liability fears should not deter those considering the purchase and use of AEDs."

<sup>5</sup>12 VAC 5-31-2100.A. Regulations governing use and registration of AEDs in Virginia became effective January 15, 2003. See 12 VAC 5-31-2100 to -2260.

<sup>6</sup>42 U.S.C. 201, et seq.

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# Legislative Activities of Virginia Bar Association's Health Law Section

*By Patrick C. Devine, Jr.  
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Thanks to Delegate John O'Bannon's leadership, the insight and energy of our lobbyist, Rob Jones, and the stellar drafting suggestions and testimony of our fine Virginia Bar Association team (including Jon Joseph, Bill Quirey, Tom Brown, Braxton McKee, Steve Rosenthal, Bill Hall, Mark Hedberg, Scott Johnson, Jim Daniels, Chris Bostwick, and Jeanne Franklin), the Health Law Session enjoyed an extremely successful 2003 Session.

Delegate O'Bannon served as Patron for the following four Bills requested by the VBA's Health Law Section, all of which passed by wide margins:

- (i) HB 1864 (amending §8.01-581.1 to include independent contractors in the definition of "provider"),
- (ii) HB 1863 (amending §13.1-546 and 1107 to permit independent contractors to perform professional services for professional corporation and professional limited liability companies),
- (iii) HB 1869 (amending §32.1-315 to add federal anti-kickback exceptions to the Medicaid self-referred statute), and
- (iv) HB 2463 (amending the medical record subpoena provision of §32.1-127.1:03 to make it HIPAA compliant).

The most far-reaching of these Bills likely was HB 2463 which amends the medical record subpoena statute. This HIPAA compliance measure likely will need to be followed in 2004 with further changes to Virginia medical records and confidentiality laws to address HIPAA preemption issues. Informal but insightful suggestions by Allyson Tysinger and Jane Hickey from the Attorney General's Office (and from a host of private VBA attorneys), along with Bill Quirey's precise drafting of the Bill, were critical to this Bill passing with wide support and should place the VBA in good stead for tackling other HIPAA issues next year.

Delegate O'Bannon also served as Patron for HB 1870 which proposed to amend §54.1-2405 to clarify that practitioners are not required to destroy medical records at a patient's request on sale of a practice. While that change survived the Bill being conformed with SB 799, the other provisions of SB 799 added a requirement that the notice also be provided whenever a practice is "relocated." Unfortunately, SB 799 was signed into law without a clarifying amendment which was proposed by the VBA and supported by Delegate O'Bannon and the Patron of SB 799 which would have defined a practice "relocation." Hopefully, the VBA can address this issue in the 2004 Session.

During the 2003 Session, the Health Law Section worked actively with representatives of the State Corporation Commission and the Virginia Bar Association's Business Law Section to temper SB 879 which added §13.1-542.1 and 1101.1 to the Virginia Code and, as originally proposed, raised important corporate practice of medicine issues.

We also remained available to assist the Medical Society of Virginia and the Virginia Hospital & Healthcare Association as needed with HB 1441 which addressed a number of important and well-publicized issues affecting the Department of Health Profession's Regulatory Boards.

All Virginia State Bar Health Law Section members should feel free to call me if you have any legislative issues which you believe should be addressed by the VBA at the 2004 Session or if you want to work with other VBA members in addressing legislative issues during the 2004 Session.

Patrick C. Devine, Jr. is a principal with the law firm of Hofheimer Nusbaum, P.C. in Norfolk. 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 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](mailto:pdevine@hnlaw.com).