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All the latest developments in health care law

By W. Eugene Basanta, Andrew Roszak and Michael Sinha

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Cases

Federal decisions

Seventh Circuit rejects False Claims Act suit

Relator, a pharmacist employed by the defendants, filed a qui tam suit under the False Claims Act , 31 U.S.C. 3729 et seq. (FCA) alleging that the defendant-pharmacy corporation and its subsidiary had violated the FCA. The defendants provided prescription drugs to nursing home residents, many of whom where Medicaid patients. As an employed pharmacist, the plaintiff alleged multiple improprieties in the defendants' operations. For example, when unused prescription drugs were return to the pharmacy after a patient died, later prescriptions would be filed with these unused drugs in violation of state and federal law.

In 1998, following a law enforcement raid, criminal charges were filed against the pharmacist in charge of the operation and the defendants in the present case for violating various federal drug statutes. The pharmacist was eventually sentenced to prison, while the corporate defendant paid restitution. Thereafter, in 1999, the plaintiff in the present case filed her qui tam suit seeking to assert her claim as a whistleblower after the raid of the pharmacy and after she had stopped working there. The district court granted defendants summary judgment finding that the relator had not presented evidence of any specific claim by the defendants that was false.

On appeal, the Seventh Circuit noted that, in order to successfully bring a qui tam action, the realtor must show (1) the defendant made a statement in order to receive money from the government, (2) the statement was false, and (3) the defendant knew it was false. 31 U.S.C. 3729(a)(2). The relator argued that all the claims for recycled and redispensed medications submitted by the defendants were necessarily false claims. However, the relator could provide no evidence linking the pharmacy's practices with a single specific false claim. Relying on decisions from other federal circuits, including *United States ex rel. Quinn v. Omnicare, Inc.*, 382 F.3d 432 (3d Cir. 2004), Judge Kanne, in his opinion for the Seventh Circuit, ruled that it was not enough for the relator in a qui tam action to alleged the particulars of an improper scheme and then to argue that false claims must surely have been submitted. Rather, the relator has the burden "to establish, in at least one instance, that a given pharmaceutical had been paid for by Medicaid, returned to the pharmacy, and then redispensed and rebilled to Medicaid."

With respect to the relator's action based upon the defendants' alleged failure to refund government payments for returned medications, the court again noted that she failed to present any evidence to support her claim. Further, she cited no statutory or regulatory authority that required a credit once a medication has been returned. Therefore, based upon its analysis, the appeals court upheld summary judgment for the defendants. *U.S. ex rel. Crews v. NCS Healthcare of Illinois, Inc.*, No. 04-4000 (7th Cir., Aug. 17, 2006).

Illinois decisions

Illinois Supreme Court applies apparent agency standards

Plaintiff-physician brought suit against an anesthesiologist, the professional corporation that employed him, and the hospital where he practiced, alleging negligence. The plaintiff was injured by the improper administration of anesthesia in connection with knee surgery. Specifically, the plaintiff assert-

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ed that the anesthesiologist had inserted the needle too high on the plaintiff's spine, which caused the needle to pierce the spinal cord, resulting in the loss of the use of plaintiff's right leg, and the loss of bladder and bowel control. The evidence showed that the plaintiff had previous knee surgeries and decided to have this particular surgery performed at the defendant-hospital based upon the recommendation of his son, an anesthesia resident at the hospital. The evidence also showed that, while the plaintiff specifically sought out and selected the surgeon who performed the surgery, he did not know who would provide anesthesia services during the surgery and "assumed the [hospital] would select" the anesthesiologist.

Based upon the jury's verdict, the trial court awarded the plaintiff and his wife $12.6 million for professional negligence and loss of consortium. The appellate court affirmed the judgment against all three defendants. *York v. El-Ganzouri*, 353 Ill. App. 3d 1; 817 N.E.2d 1179 (1st Dist. 2004). The Illinois Supreme Court granted the hospital's petition for leave to appeal, but denied the petitions of the anesthesiologist and the professional corporation. The issue the supreme court addressed on appeal was whether the hospital could be held liable for the anesthesiologist's negligence on the theory of apparent agency where he was not a hospital employee.

For several reasons, the majority of the supreme court held that the hospital could be held liable under the theory of apparent agency for the actions of the attending anesthesiologist in injuring the plaintiff. The court noted that under *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511, 622 N.E.2d 788 (1993) a three part test was developed to be used in such cases to determine the vicarious liability of a hospital under the doctrine of apparent agency. First, the patient must reasonably conclude that the negligent individual was a hospital employee. Second, the plaintiff must demonstrate that the hospital acquiesced in the apparently authoritative actions conducted by the independently contracted physician. Finally, the plaintiff must show that he reasonably relied on the conduct of the hospital and its agent. The focus of much of the discussion in this case was on this reliance element.

The court indicated that, by wearing scrubs embroidered with the hospital's name and by maintaining offices at the hospital, the average patient would be led to believe that the anesthesiologist was a hospital employee and not an independent contractor. In addition, the treatment consent form signed by the plaintiff stated that his treatment would be managed by "physicians or employees of the hospital." It did not state that the anesthesiologist was an independent contractor. Because hospitals commonly solicit and advertise for patients, the court held that a patient may reasonably select a particular hospital for its recognition or prestige, trusting that physicians practicing there are agents of the hospital and not independent contractors. Substantial testimony from the plaintiff, his son, and others provided the jury with reasonable evidence to infer that the plaintiff chose this hospital as the locale for his treatment based upon his son's recommendations. His son, a resident in the anesthesia program at the hospital, had encouraged his father to come from Florida for treatment there. The majority held that the fact the plaintiff chose the surgeon who performed the operation did not change the reliance analysis in this case. "If . . . a patient . . . select[s] a particular physician to perform certain procedures within the hospital setting, this does not alter the fact that a patient may nevertheless still reasonably rely upon the hospital to provide the remainder of the support services necessary to complete the patient's treatment." Disagreeing with this view, Justice Garman dissented from the majority's decision to uphold the trial court's judgment. *York v. Rush-Presbyterian-St. Luke's Medical Center*, No. 99507 (Ill. Sup. June 22, 2006).

Appellate court upholds anesthesia rules

The regulation of anesthesia services as provided by certified registered nurse anesthetists (CRNAs) has been the source of controversy for sometime. So-called "turf battles" between CRNAs and physician-anesthesiologists have focused on both quality of care and economic concerns over the years. Recently in Illinois this conflict has been played out in the context of regulations regarding the delivery of anesthesia services by CRNAs in physician offices. In particular, the question arose as to the need for physician supervision in such cases and what sorts of training might be required of a physician working with a CRNA in his or her medical office practice. A recent decision from the First District Appellate Court addressed a challenge to regulations in this area adopted by the Illinois Department of Professional Regulation, now known as the Illinois Department of Financial and Professional Regulation-Division of Professional Regulation (Department).

In 1999, the Illinois General Assembly amended the Illinois Nursing and Advanced Practice Nursing Act (Nursing Act) to include a section concerning CRNAs, 225 ILCS 65/15-25. The amendment was designed to codify current practices for the delivery of anesthesia services in Illinois and was based on a consensus reached among various professional associations representing physicians, nurses, and other professionals. Under the amendment, a CRNA could provide anesthesia services "pursuant to the order of a licensed physician" in "the office of a physician," provided that the physician "participate through discussion of and agreement with the anesthesia plan and . . . remain physically present and . . . available on the premises during the delivery of anesthesia services for diagnosis, consultation, and treatment of emergency medical conditions." In 2002 (during pending litigation) the Department adopted amended regulations (68 Ill. Adm. Code 1305.45(e)) specifying that, "In a physician's office, the certified registered nurse anesthetist may only provide anesthesia services if the physician has training and experience in the delivery of anesthesia services to patients. The physician's training and experience shall be documented in the written practice agreement and the training and experience shall meet the requirements set forth in 68 Ill. Adm. Code 1285.340." Section 1285.340 sets out specific training requirements for physicians providing anesthesia services in their offices either directly themselves or through CRNAs. Where anesthesia is provided by an anesthesiologist however, the physician is not required to have any added training.

Suit was filed challenging these rules on the grounds that they were inconsistent with and beyond the scope of the Nursing Act and because the Department had allegedly acted arbitrarily and capriciously in promulgating them. Following a trial, the circuit court

permanently enjoined the Department from enforcing section 1305.45(e) of the Nursing Act regulations. The court found that Nursing Act provisions pertaining to advanced practice nurses, "[do] not expressly provide for the Department to promulgate regulations requiring physicians to undergo additional anesthesia training when they work with nurse anesthetists in an office setting." The trial court also found no language in the Nursing Act giving the Department authority to impose additional training on licensed physicians. In the trial court's view the regulations were invalid as a matter of law. The Department appealed.

Initially, the appellate court agreed with the Department that the physician anesthesia training rules set out in 68 Ill. Adm. Code 1285.340 were valid under the Department's statutory authority to regulate physicians under the Medical Practice Act. As the court noted, section 1304.45(e) of the Nursing Act rules merely cross-referenced these Medical Practice Act rules. The court then went on to consider if these Medical Practice Act rules were in some fashion inconsistent with the provisions of the Nursing Act. After examining the relevant Nursing Act sections, the court found no inconsistency. In the court's view, the Department had the statutory authority to adopt section 1305.45(e). The court stated as follows: "[T]he Nursing Act does place restrictions on a CRNA who provides anesthesia services in an office setting by requiring that the CRNA work with physicians who have the capacity to confer with the CRNA and that the CRNA and physician agree to an anesthesia plan. By requiring a CRNA to work only with a physician who has received additional training and experience in the delivery of anesthesia services, as required by section 1285.340(a) of the rules for the Medical Practice Act, section 1305.45(e) of the Nursing Act rules is consistent with [225 ILCS 65/15-25] of the Nursing Act because it ensures that CRNAs will only work with office-based physicians who have the requisite knowledge to devise a treatment plan and the ability to provide diagnosis, consultation and treatment of emergency medical conditions that may arise during the delivery of anesthesia services."

Finally, the court held that the Department's physician training rules for working with CRNAs were not arbitrary and capricious. The plaintiff faulted the Department for not conducting any study to evaluate patient outcomes where a physician works with a CRNA, as opposed to an anesthesiologist, and failed to consider the economic impact of its restrictive rules. The court observed, however, that there is no requirement that the Department undertake any such studies or evaluations before adopting regulations. Further, the court noted, the General Assembly, not the Department, had differentiated between anesthesiologists and CRNAs in the relevant statutes. The Department's rules simply reflected this legislative policy. In the end, the court said it was "not persuaded that the Department's regulation is arbitrary or capricious where it is consistent with the purpose of the Nursing Act to protect the health, safety, and welfare of the public. . . . Further, plaintiff has not shown that enforcement of section 1305.45(e) has created an economic hardship." As a result, the court concluded that the evidence did not support a finding that the Department had acted in an arbitrary or capricious manner, "where the Department offered plausible explanations for requiring office-based physicians to complete additional training in anesthesia before delivering anesthesia services or working with a CRNA who delivers anesthesia services." *Pollachek v. Department of Professional Regulation*, Nos. 1-05-1337 & 1-05-1401 (Ill. App. 1st Dist., Aug. 17, 2006).

No private cause of action for failure to report child abuse

Physicians, as well as various other specified persons (including residents and nurses), are required to report suspected instances of child abuse or neglect encountered in their professional capacity to the Illinois Department of Children and Family Services (DCFS) under the Abused and Neglected Child Reporting Act, 325 ILCS 5/4. Does this statutory responsibility carry with it a legal duty, such that a physician who fails to detect and report abuse can be held liable for injuries from subsequent abuse? In August, the First District Appellate Court said no.

In this case, an infant was brought by his young mother to the defendant-hospital's emergency room and seen by an emergency physician employed by the medical group under contract to provide emergency services for the hospital. Both the physician and the group were also named as defendants in the case. The ER visit was prompted by the fact that the infant had difficulty breathing and increased crying since noon the previous day, when his mother had started him on a new infant formula with iron. The defendant-physician examined the infant and found nothing of concern other than a "moderately distended" abdomen. A chest x-ray was done and the physician did not observe any apparent problems. Consistent with hospital protocol, the x-ray was sent to radiology for an official interpretation and the infant was sent home. When the x-ray was examined by a radiologist, he noted in his written report evidence of a prior rib fracture. This was admittedly a warning sign of abuse. Despite hospital procedures, the defendant-physician did not receive this report, nor did the evidence show who, if anyone in the emergency department did.

Subsequently, the infant was again brought to the hospital emergency room where personnel discovered he had a subdural hematoma and multiple rib fractures in various stages of healing. Abuse ("shaken baby syndrome") was suspected, a report was filed with DCFS, and after investigation, the infant's father confessed to abusing him both prior to and after the first ER visit. The infant and his mother then filed suit against the defendants alleging that by failing to detect and report suspected child abuse, the defendants had violated the Abused and Neglected Child Reporting Act. The trial court granted the defendant-physician's motion to dismiss on the grounds that the Act does not create a private cause of action for its violation. Thereafter, with the court's permission, the complaint was amended to assert breach of a common law duty of care by failing to diagnose and report the abuse. The trial court granted the defendants' summary judgment motion and the plaintiffs appealed.

On appeal, the plaintiffs argued that they were not seeking to establish a duty under the Reporting Act, but rather were asserting a common law duty of care own by the physician to his patient. The appellate court was not persuaded. The court noted that in *Doe 1 v. North Central Behavioral Health Systems, Inc.*, 352 Ill. App. 3d

284, 816 N.E.2d 4 (3rd Dist. 2004) the court ruled that the Reporting Act does not recognize a cause of action for a failure to report abuse. The court then observed that, "it would be illogical to argue that although the Illinois legislature has not expressly or impliedly created a private right of action for violation of the Reporting Act. . . individuals may nevertheless assert a private right of action for violation of the Reporting Act, so long as those individuals allege they are proceeding at common law rather than on a statutory basis." The court distinguished the cases relied upon by the plaintiffs, in particular *Doe v. Dimovski*, 336 Ill. App. 3d 292, 783 N.E.2d 193 (2d Dist. 2003) and *Cuyler v. United States*, 362 F.3d 949 (7th Cir. 2004). In the court's view, it was simply inappropriate to impose liability on physicians based on an alleged failure to detect or diagnose abuse. Summary judgment for the defendants was therefore proper. *Varela v. St. Elizabeth's Hospital of Chicago, Inc.*, No. 1-05-3718 (Ill. App. 1st Dist., Aug. 7, 2006)

Nurse's notes subject to discovery

In an Illinois medical malpractice case, the plaintiff was seriously injured in a skydiving accident and sought treatment at the defendant-hospital for multiple fractures. The plaintiff alleged that, as a result of negligent care by the hospital and its staff, he suffered permanent spinal damage.

Interrogatories served upon the hospital revealed that one of the staff nurses attending to the plaintiff prepared notes related to his care, detailing the events leading up to the alleged injury and the nurse's conduct toward him. Plaintiff requested production of the nurse's notes, but the hospital objected, claiming that the notes were protected based upon attorney-client and work product privileges. The hospital, in lieu of the notes, provided the plaintiff with a copy of the nurse's deposition and affidavit. The nurse further testified that the notes were entirely factual in content.

The trial court ruled that the notes were not protected by either the attorney-client privilege or the work product privilege and ordered the plaintiff's attorney to turn over the notes. The attorney objected and was held in contempt of court. This appeal followed.

The appellate court noted several criteria in Illinois for both privileges to be invoked. The attorney-client privilege requires a demonstration that, (1) a statement originated in confidence, (2) was made to an attorney for legal advice or services, and (3) remained confidential. The work product privilege is broader, protecting the right of an attorney to adequately prepare a case without being required to provide preparatory materials to a less diligent attorney upon request. The hospital asserted that the nurse's notes were kept confidential until given to an attorney, and further, because the notes were made in reasonable anticipation of potential litigation, that they were protected by the work product privilege.

The Second District Appellate Court agreed with the trial court in concluding that neither privilege applied. The court looked to *Rounds v. Jackson Park Hospital & Medical Center*, 319 Ill. App. 3d 280, 745 N.E.2d 561 (1st Dist. 2001) where the First District found that the hospital had not demonstrated that the nurse's notes were anything more than merely predictive. As in the present case, the notes in *Rounds* had not been created after a lawsuit had been brought, or at the direction of an attorney. In addition, because the nurse's notes in the case at bar were primarily factual, they were within the realm of discovery and should have been turned over to the plaintiff's counsel. Finally, given that the notes did not "contain or disclose the theories, mental impressions, or litigation plans of the party's attorney," they were not protected by the work product privilege. The trial court's ruling was affirmed, the order holding the attorney in contempt was upheld, and the case was remanded for further proceedings. *Cangelosi v. Capasso*, ___ Ill. App. 3d ___, 851 N.E.2d 954 (2d Dist. 2006).

Florida expert unqualified to testify in suit against Chicago paramedics

Suit was filed by the plaintiff-administrator against various parties after a child, suffering an asthma attack, died. Among the defendants was the City of Chicago whose paramedics allegedly failed to timely respond to the emergency call and treat the child in accordance with the city's paramedic standards. The trial court granted the city's motion in limine to bar plaintiff's expert witness who was to opine that the paramedics did not comply with the standard of care for the situation. Thereafter,

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OFFICE
Illinois Bar Center
424 S. 2nd Street
Springfield, IL 62701
Phones: (217) 525-1760 OR 800-252-8908

Web site: www.isba.org

Editor
W. Eugene Basanta
SIU School of Law, Lesar Law Bldg.
Carbondale, IL 62901-6804

Associate Editors
Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

Thomas P. Conley
120 S. Riverside Plaza, Ste. 1200
Chicago, IL 60606-3910

Diane Gilbert Jacoby
316 E. 18th St.
Chicago, IL 60616-1539

John M. Lagattuta
1406 W. Talcott Rd.
Park Ridge, IL 60068

Herbert Sohn
4640 N. Marine Dr.
Chicago, IL 60640-5788

Managing Editor/Production
Katie Underwood
kunderwood@isba.org

POSTMASTER: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

the trial court directed a verdict for the city because plaintiff no longer had an expert to establish the standard of care.

The expert named by the plaintiff was a paramedic currently working for a city in Florida. He had never worked in the Chicago area. Although the expert testified, in his deposition, that he had been involved in treating asthma attacks in Florida, he acknowledged that there was no national certification for paramedics and that each state is different. He stated that he was unable to testify about paramedic certification processes in Illinois or Chicago.

Prior to trial, the city filed its motion in limine to bar the testimony of this expert based upon his admission that there was no national standard of care and his lack of familiarity with Chicago area practice. The trial court found that, although the witness was a licensed paramedic, it was clear he was unfamiliar with the local standard of care, and thus, he did not meet the standard of competency to testify to the standard of care applicable to the paramedics in the case. Thereafter, the directed verdict was entered.

On appeal, the court stated that, "To qualify as an expert in the medical field, the witness must be a licensed member of the school of medicine about which he intends to testify and he must be familiar with the methods, procedures, and treatments ordinarily observed in the defendant's community or similar community." In this case, there was no question that the plaintiff's expert was a duly licensed paramedic. However, as the court noted, the proffered expert was a paramedic licensed in Florida, working in a community wholly unlike Chicago, who had admitted that he did not know the local paramedic standard of care. As to the plaintiff's effort to utilize the city's own paramedic protocols, the appellate court agreed with the trial court that these protocols were not conclusive evidence of the standard of care and that the expert lacked sufficient familiarity with the city's practices and standard to establish his competency as an expert. The trial court's decision was upheld. *Ruiz v. City of Chicago*, ___ Ill. App. 3d ___, 852 N.E.2d 424 (1st Dist. 2006).

Hospital liable for negligent drug test

The plaintiff worked as a school bus driver. As required by the U.S. Department of Transportation (DOT), she underwent a routine drug test at the defendant-hospital. The test results were positive for cannabis and, despite the plaintiff's willingness to repeat the test to demonstrate false-positivity, her driving privileges were revoked by the secretary of state, rendering her unable to drive during the upcoming school year. A second drug test performed two weeks later was negative.

In addition to lost income, the plaintiff allegedly suffered several emotional injuries, including single episode severe major depression and post-traumatic stress disorder. She lost weight, became reclusive, and was hospitalized for attempted suicide on one occasion. Her psychiatrist prescribed an antidepressant and treated the plaintiff on several occasions with psychotherapy.

Plaintiff filed suit against the hospital claiming negligence in the administration of the drug test. Evidence showed that the defendant had failed to follow DOT regulations for administering such tests. An unknown woman's sample, it was alleged, was mistakenly presented as the plaintiff's own, because there were two cups present in the collection restroom. The trial court found for the plaintiff, but reduced the recovery by 20 percent due to the plaintiff's contributory negligence. The damages were calculated according to her physicians' estimates of future costs for prescription medication, therapeutic consultations, and the potential for concomitant hospitalization associated with her disorder.

The defendant-hospital presented several theories in appealing the negligence claim, each of which was rejected by the appellate court. The court upheld the verdict on the negligence claim, indicating that (1) the defendant's alleged negligence in failing to properly administer the drug test according to DOT regulations proximately caused the plaintiff's claimed damages under both the "but-for" and "substantial factor" tests, (2) expert testimony was not required to establish negligence in this case where a competent jury could easily comprehend and deliberate on the merits without specialized knowledge, (3) the record supported the jury's verdict, (4) an amended claim for consumer fraud that did not reference the plaintiff's negligence claim did not bar the negligence action, and (5) jury instructions, without specific contentions as to impropriety, could not be deemed inappropriate.

The plaintiff also brought a claim under the Illinois Consumer Fraud Act, 815 ILCS 505/1 et seq., alleging that the defendant failed to follow appropriate guidelines for administering the drug test and received a favorable verdict in the trial court. The appellate court reversed this outcome, holding that none of the elements of a cause of action under the Consumer Fraud Act were met by the plaintiff in this case. *Kindernay v. Hillsboro Area Hospital*, ___ Ill. App. 3d ___, 851 N.E.2d 866 (5th Dist. 2006).

Court rejects loss of chance claim

The patient, a 54 year old man with a history of chronic asthma and heart disease, was admitted to the emergency room complaining of chest tightness, angina, shortness of breath, and a cold sweat. After an abnormal work-up, including a stress test, the patient was discharged with directions to follow up with his treating cardiologist. An angiogram, if administered earlier, might have revealed the need for interventive therapy, and coronary artery bypass surgery could have been performed sooner. The defendant- cardiologist noted in the patient's chart that an angiogram would be beneficial, but did not pass this information directly on to the patient. As such, the patient visited his treating cardiologist, but not within the week as suggested by the defendant. Further, the patient did not receive an angiogram during that visit. The patient suffered a heart attack shortly thereafter and died 6 weeks later of multiple organ failure after unsuccessful angioplasty, stent placement, and cardiac bypass surgery.

The patient's wife, on behalf of her husband's estate, brought suit against the defendant-cardiologist, asserting that the defendant's negligence caused her husband the loss of a chance for earlier diagnosis, which would likely have prevented the fatal heart attack. The defendant countered that he was not required to recommend an angiogram, or inform the decedent that he was at some immediate great risk – he deemed that the decedent was in no greater risk when he left the hospital as when he arrived at the hospital. The jury found for the plaintiff and awarded $500,000 in damages. The defendant moved for a judgment not withstanding the verdict and requested a setoff based

on prior recoveries from other sources. The j.n.o.v. was denied, but the award was reduced by roughly one-half due to the plaintiff's previous recoveries from other defendants.

The First District Appellate Court reversed the trial court's judgment and found for the defendant. The defendant, the court determined, did not cost the decedent to lose a chance to receive earlier, potentially lifesaving treatment, according to the standards promulgated by the Illinois courts.

According to the First District, Illinois courts have a fairly liberal standard for the loss of a chance, requiring that a plaintiff demonstrate "that the defendant's malpractice, to a reasonable degree of medical certainty, proximately caused [an] increased risk of harm or lost chance of recovery." In this case, the nexus was not created to a reasonable degree of medical certainty. The plaintiff-wife noted that a series of potentially related events, under the requisite environment, might have saved her husband's life. However, in those Illinois cases that have found liability under similar circumstances, the plaintiffs proved that failure to timely diagnose the patient cost him/her the loss of a chance for a better result. Here, the plaintiff could not meet this burden of proof. In fact, there was no evidence indicating that the decedent's treating cardiologist did not have the requisite information in hand to make an informed decision and order an angiogram per his own volition. The appeals court reversed and found for the defendant cardiologist. *Krivanec v. Abramowitz*, ___ Ill. App. 3d ___, 851 N.E.2d 849 (1st Dist. 2006).

Trial court improperly admitted video animation evidence

During a trial for medical malpractice involving the death of a patient with a pulmonary embolism, the plaintiff, the decedent's husband, sought to introduce a video animation to show what a pulmonary embolism is and to help plaintiff's expert explain the plaintiff's version of what caused the death of his wife.

The plaintiff did not inform the defendants of his intent to use the video animation until the day of opening statements, and was not able to show the animation to the trial judge or defense counsel until three days later. Initially the trial court granted the defendants' motion to bar admission of the video, but later that decision was reversed. The trial court then denied reconsideration of the ruling, alternate relief, and two motions by the defense for a mistrial. The jury deliberated and returned a verdict for the plaintiff for nearly $17,000,000. Defendants appealed.

On appeal, the court ruled that the video animation should not have been admitted because it was neither timely disclosed nor a general demonstrative aid. Further, the animation ignored evidence that was presented to the contrary and presented facts that were not supported in the record. The court followed the ruling in *French v. City of Springfield*, 65 Ill. 2d 74, 357 N.E.2d 438 (1976), in which the Illinois Supreme Court held that a movie that "preconditioned the minds of the jurors to accept the plaintiff's theory because of what the plaintiff claimed, rather than the facts adduced at trial" was inadmissible. In conclusion, the court ruled a new trial was warranted. *Spyrka v. County of Cook*, ___ Ill. App. 3d ___, 851 N.E.2d 800 (1st Dist. 2006).

Manufacturer not liable for improper outpatient insertion of pacemaker

A negligence action was brought against a pacemaker manufacturer seeking damages for alleged injury and wrongful death following the incorrect implantation of a non-defective cardiac pacemaker. Rather then being performed in a hospital, the procedure at issue in this case was performed by the physician in his new outpatient clinic. It was later found the pacemaker had been improperly inserted by the physician. The plaintiff's complaint alleged that the manufacturer was negligent in the sale of the pacemaker and through its participation and assistance in the pacemaker implanting process. Evidence showed that a nurse who had worked as a clinical specialist for the manufacturer for approximately eight years, was present during the surgery. She provided technical support to ensure the lead parameters for the pacemaker were correctly calibrated and the lead was functioning properly. The trial court granted summary judgment for the manufacturer. On appeal, the plaintiff argued that the trail court erred because the manufacturer owed the decedent a duty of care.

The plaintiff asserted that the pacemaker manufacturer owed decedent three duties: (1) to refrain from providing a pacemaker to the physician and from participating in the insertion of the pacemaker in an outpatient setting, (2) to warn of the dangers inherent in proceeding with the surgery under such conditions, and (3) to assist with the insertion in a reasonable manner once it voluntarily undertook to participate.

The pacemaker manufacturer responded by stating that it had no duty to prevent physician malpractice or to guarantee against it. Further, the manufacturer stated that under the learned intermediary doctrine it was exempt from having to warn decedent or his family of any dangers in proceeding with the surgery on an outpatient basis.

The appeals court rejected the plaintiff's claim citing the absence of the four factors for establishing a duty, specifically, (1) the reasonable foreseeability of injury, (2) the likelihood of injury, (3) the burden of guarding against injury, and (4) the consequences of placing that burden on the defendant, and the substantial burden of imposing a duty on the pacemaker manufacturer. The court also stated that the limited roll the pacemaker manufacturer assumed through its nurse-employee during the procedure did not cause the pacemaker manufacturer to voluntarily assume a duty. *Kennedy v. Medtronic, Inc.*, ___ Ill. App. 3d ___, 851 N.E.2d 778 (1st Dist. 2006.

Amendment to malpractice claim does not relate back and is time barred

The Illinois statute of limitations for a medical malpractice action is two years after the date on which the claimant knew, or through the use of reasonable diligence should have known, of the existence of the injury or death for which damages are sought. 735 ILCS 5/13-212. In the present case, the plaintiff was injured in July of 2000, filed suit in June of 2002 (within the statute of limitations), and later, in 2004, attempted to amend the complaint to add a defendant. The plaintiff argued that the statute of limitations should not apply because of the language in 735 ILCS 5/2-616. Specifically, subsection b of 2-616 states that the statute of limitations shall not apply if the cause of action asserted grew out of the same transaction or occurrence as in the original pleading. The trial court dismissed the amended complaint with prejudice stating that the amended count did not relate back to the original complaint, and was thus barred by the statute of

limitations. The plaintiff appealed.

In this case, the plaintiff sought treatment in 2000 for mental health problems from the defendant hospital and several health care professionals working at the hospital. Subsequently, in 2002 she filed suit against the defendants for negligent care and treatment after she had suicidal tendencies, went out on the roof of her home, and fell to the ground in 2000. In 2004 the plaintiff sought to amend her complaint to include another of the hospital's mental health professionals who cared for her in the hospital after the accident, alleging the care she received after the fall was negligent.

On appeal, the court looked to subsection d of 2-616 in terms of the standards to apply to determine if a plaintiff may add a defendant in an action after the time period has run. Subsection d states that the plaintiff must prove that the original complaint was timely filed and that the cause of action asserted in the amended complaint grew out of the same transaction or occurrence as the original complaint. Also, the plaintiff must demonstrate that the newly added defendant had notice of the commencement of the action and should have known that, but for the mistake concerning the identity of the proper party, the action would have been brought against him.

As to subsection b of 2-616, the court ruled that the plaintiff's claims for treatment after the fall were separate and distinct from the claims of the original complaint, which only focused on treatment before the fall. The plaintiff asserted that *Figueora v. Illinois Masonic Medical Center*, 288 Ill. App. 3d 921, 681 N.E.2d 64 (1st Dist. 1997), would allow for the amended complaint. In *Figueora*, the plaintiff originally filed a complaint alleging negligence after the delivery of her baby. She successfully amended her complaint, after the statute of limitations, to include allegations of negligence in the treatment she received during labor and delivery. The court distinguished *Figueora* on the grounds that it involved a single hospital stay during a very compressed time frame. In the present case, the plaintiff's mental health care was spread out over different visits during a two-month time period.

The Plaintiff also relied on *Castro v. Belluci*, 338 Ill. App. 3d 386, 789 N.E.2d 784 (1st Dist. 2003), where an amended complaint was allowed, adding new charges of negligence and new defendants, because the symptoms and lack of care for those symptoms did not change. The court here distinguished the cases on the basis that the treatment received by the plaintiff was during separate and distinct periods (pre and post fall) and because nothing in the amended complaint suggested that her post-fall care was negligent or caused the plaintiff an injury.

Regarding subsection d of 2-616, the plaintiff asserted that the new defendant was alerted to the substance of her amended claims because she disputed the billing for her treatment. However the court stated that a physician or hospital is not put on notice that they may be charged with negligence in regards to treatment merely because a patient refuses to pay the bill.

The appeals court affirmed, holding that the amended compliant did not relate back to the filing of the original complaint and was therefore barred by the statute of limitations. *Weininger v. Siomopoulos*, ___ Ill. App. 3d ___, 851 N.E.2d 1249 (1st Dist. 2006).

Evidence shows husband acted as wife's agent in decision not to use forceps

In a malpractice suit, the plaintiffs, a husband and wife, alleged that the death of their baby was due to the defendant-physician's negligence. The case involved a vaginal birth after cesarean (VBAC) where the physician indicated that if the VBAC failed, he would perform a cesarean section. When complications arose during the delivery, a cesarean section was performed, but the infant was severely damaged. During the trial it became clear that the couple had refused the use of forceps during delivery, which contributed to the death of the infant. The jury returned a verdict for the physician after two days of deliberations. On appeal, the plaintiffs argued that the court should have excluded evidence of the husband's actions because the defendant failed to present evidence that could support a finding that the husband acted as the wife's agent for medical decisions.

The admitted evidence included the following. First, when the defendant-physician told the wife that he needed to use the forceps to deliver the baby, the husband intervened and asked the physician to perform a cesarean section instead. The wife remained silent. Second, the husband had specifically forbidden the use of the forceps, telling the physician that, if forceps were used a lawsuit would be filed. Third, when the physician first discovered the baby's heart tones were down, he stated that the baby needed to come out and told the wife he would use the forceps. At that time, the husband stepped between the physician and the wife and stated he would physically assault the physician if he did not perform a cesarean section.

The plaintiffs relied on *Fetts, Love & Sieben, Inc. v. Simon*, 46 Ill. App. 2d 232, 196 N.E.2d 700 (1st Dist. 1964), in which the court held that the mere existence of a marital relation does not establish the husband's agency for his wife. In this case however, the appeals court ruled that the evidence showed that the husband had acted as his wife's agent for several reasons.

The court noted that because the wife admitted she heard her husband make the request that forceps not be used and offered no response, a reasonable person might conclude that her silence was seen as an authorization for her husband to speak on her behalf. The court also ruled that the trial judge did not abuse his discretion by admitting the physician's testimony concerning the behavior of the husband. *Strino v. Premier Healthcare Associates, P.C.*, ___ Ill. App. 3d ___, 850 N.E.2d 221 (1st Dist. 2006).

Workers' compensation changes for health care providers

*By Rick L. Hindmand**

Public Act 94-0277 amended the Illinois Workers' Compensation Act and the Workers' Occupational Diseases Act to address employer concerns about escalating medical costs and employee concerns about benefit levels and liability for medical bills, as well as other issues. Some of the provisions took effect upon the July 20, 2005, signing by Governor Blagojevich, while other provisions took effect on February 1, 2006.

This article discusses the following changes which are of particular relevance to health care providers:

- Adoption of a medical fee schedule;
- Requirement of payment within 60 days of the submission of a clean claim;
- Prohibition on balance billing;
- Establishment of standards and registration requirements for utilization review; and
- The addition of an antifraud provision.

Fee schedule

PA 94-0277 created new Section 8.2 of the Workers' Compensation Act, which established a fee schedule for medical procedures, treatments and services rendered on or after February 1, 2006. Section 8.2 sets forth a procedure for the determination of the initial fee schedule based on 90 percent of the 80th percentile of historical charges and provides for annual updates to reflect changes in the Consumer Price Index. PA 94-0277 also established a Workers' Compensation Medical Fee Advisory Board.

The Workers' Compensation Commission adopted fee schedule regulations on June 22, 2006. A prior version of this rule had been adopted as an emergency rule on January 27, 2006.

The fee schedule does not preempt negotiated rates, which will prevail if a contract is in effect between a health care provider and the employer or other payor. In the absence of a contract the employer is required to pay the lesser of the fee schedule rate or the provider's actual charge.

Fees are designated by geozip (first three zip code digits) based on the location where the services are provided. The fee schedule is available at <http://iwcc.ingenixonline.com/IWCC.asp>.

The fee schedule covers hospital inpatient and outpatient services, emergency room services, ambulatory surgical treatment centers and professional services. If the fee schedule does not set forth a specific fee and the services are covered by the fee schedule the reimbursement will be at 76 percent of the actual charge, except for certain items and services which will be reimbursed at 65 percent of the billed charge. Ambulatory surgical center, emergency room and hospital inpatient and outpatient services are generally reimbursed at 76 percent of charges.

The fees for professional services performed in a hospital setting will be determined in part by whether the services are billed by the hospital using its tax ID number or by a professional practice. For example, professional services delivered in the emergency room are reimbursed under the HCPCS and professional service fee schedule if billed under the health care professional's tax identification number and at 76 percent of the actual charge if billed by the facility using its tax identification number.

Some services are excluded from the fee schedule, such as pharmacy, outpatient renal dialysis, home health agency services, psychiatric hospitals and skilled nursing facilities, and are reimbursed at usual and customary rates. Independent medical examinations (IMEs) are not covered under the fee schedule.

Direct billing and prompt payment

Section 8.2(d) requires the provider to bill the employer directly if the patient notifies the provider that the injury or illness is work-related, and requires payment within 60 days after receipt of a claim which contains substantially all required data elements necessary to adjudicate the claim. The provider is entitled to interest at 1 percent per month on amounts not paid within this 60-day period.

PA 94-0277 amended Section 19(l) of the Workers' Compensation Act to outline a procedure for assessing additional compensation for delays in payment. If the employee makes a written demand for payment, the employer will then have 14 days after the later of the demand or the expiration of the 60 day prompt payment period to provide a written explanation of the reason for the delay. If there is no "good and just cause" for the delay employee will be entitled to additional compensation of $30 per day (not to exceed $10,000). This section continues to provide that a delay of 14 days in payment will create a rebuttable presumption of unreasonable delay.

PA 94-0277 added provisions to Section 19(b) of the Workers' Compensation Act setting forth procedures for expedited hearings regarding payment for medical services or benefits.

Balance billing prohibition

Section 8.2(e) of the Workers' Compensation Act states that employees will not be liable for the cost of services which are not disputed by the employer, and prohibits providers from billing the employee for the difference between the provider's charge and the amount paid by the employer or insurer (i.e. balance billing). This prohibition, however, is subject to qualifications, some of which are discussed below.

If the employer notifies the provider that the employer does not consider the illness or injury to be compensable under the Workers' Compensation Act or that the employer will pay only a portion of the bill the provider is allowed to seek payment from the employee. The provider must cease all collection efforts, however, if the employee informs the provider that an application was filed with the Workers' Compensation Commission regarding the charges.

While a case is pending a provider

is allowed to mail reminders to the employee, but the reminders must satisfy standards specified in Section 8.2(e-15) and may not be provided to any credit rating agency. A reminder may also request information about the proceeding. A provider may resume collection efforts if the employee fails to respond or to provide the requested information within 90 days.

If a claim is covered by a group health plan the employee's responsibility will be limited to any deductibles, copayments or coinsurance.

Utilization review

PA 94-0277 added Section 8.7 to the Workers' Compensation Act relating to utilization review. This section does not require employers to implement utilization review, but establishes standards for workers' compensation utilization programs, requires registration of workers' compensation utilization review organizations and addresses the evidentiary value of a utilization review determination.

Section 8.7 defines utilization review as the evaluation of health care services to determine medical necessity and quality, and specifically includes prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations and retrospective review. Retrospective review applies only to services rendered after July 20, 2005.

Any person conducting a workers' compensation utilization review program is required to register with the Illinois Department of Financial and Professional Regulation ("DFPR"). DFPR issued regulations on March 29, 2006, establishing a registration process based on the registration procedures for health care utilization review organizations under the Managed Care Reform and Patient Rights Act. Utilization review organizations which were already registered under the Managed Care Reform and Patient Rights Act and also perform workers' compensation utilization review were required to revise their application forms by July 1, 2006.

Section 8.7(b) requires certification of compliance with specified URAC standards or alternative utilization review standards certified by DFPR, although employers, insurers and their subcontractors are not required to become URAC accredited. Organizations which are not URAC accredited pay a higher fee than those which are accredited.

Section 8.7(e) provides that only health care professionals are allowed to make utilization review determinations regarding medical necessity. Retrospective reviews must be based solely on medical information available to the attending physician or ordering provider at the time the health care services were performed.

Section 8.7(f) directs DFPR to issue a corrective action plan if it finds that a utilization review program is not in compliance and sets forth a procedure for cease and desist orders.

An employer who denies payment based on utilization review programs conducted in compliance with Section 8.7 will be entitled to a rebuttable presumption that it is not responsible for additional damages under Section 19(k) of the Workers' Compensation Act for unreasonable or vexatious delay in payment.

Anti-fraud provisions

PA 94-0277 added a fraud provision, Section 25.5, to the Workers' Compensation Act. Prohibited conduct includes intentionally presenting any false or fraudulent claim, intentionally making any fraudulent material statement or representation, and assisting any person to violate this section.

Violation of Section 25.5 is a Class 4 felony requiring the payment of complete restitution in addition to any other fine or sentence. Section 25.5(g) also provides a civil remedy for triple the value of the benefits wrongfully obtained or twice the value of the benefits attempted to be obtained, plus reasonable attorney fees.

Section 25.5(c) directs the Department of Insurance of DFPR to establish a fraud and insurance noncompliance unit to investigate violations of Section 25.5 and to report violations to the Attorney General or State's Attorney, who are authorized to prosecute violations.

Conclusion

The adoption of the medical fee schedule, billing procedures, the balance billing prohibition and prompt payment standards may provide a more standardized and streamlined reimbursement process for health care providers. These changes, as well as the utilization review provisions, will create potential administrative burdens for providers, payors, employees and their representatives.

While cost containment was one of the objectives of employers in supporting PA 94-0277, it is uncertain whether employers will recognize substantial cost savings. Section 8.2(g) of the Workers' Compensation Act requires the Workers' Compensation Commission to provide a report to the Governor and General Assembly regarding the fee schedule by January 1, 2010.

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Philip L. Pomerance, is a partner in the Health Care Law Group of Kamensky, Rubenstein, Hochman & Delott. He represents physicians and physician groups, independent practice associations and physician-hospital organizations, pharmacies, senior living providers, health care management companies, and other health care providers and their owners and managers in matters of health care, regulatory, corporate, not-for-profit and administrative law.

Mr. Pomerance's expertise includes advising parties to business ventures and mergers and acquisitions in the health care industry, and providing counsel in the increasingly complex regulation of the business of health care. He practices in the area of health care fraud and abuse regulation and defense, and he provides advice to lawyers and health care providers on ethical issues.

In 2004 and again in 2005, Nightingale's Healthcare News named Mr. Pomerance one of the outstanding physician practice lawyers in the United States. His peers have also selected him as a "Leading Lawyer" in health law and as an "Illinois Super Lawyer."

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By W. Eugene Basanta, Andrew Roszak and Michael Sinha

Cases

Federal decisions

Appeals court rejects EMTALA claim

A recent decision from the Seventh Circuit considers a claim under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd. For several reasons, the appeals court affirmed dismissal of the plaintiff's EMTALA claims.

This suit arose following the death of the plaintiff's mother. After suffering an acute asthma attack, the mother was taken by ambulance to the defendant-hospital. She was seen and treated in the emergency room where she was intubated. When she then went into cardiac arrest, the ER physicians resuscitated her. While she remained unconscious, she was admitted to the hospital and treated there for three weeks. Eventually, the mother was transferred to a nursing home where she was diagnosed with pneumonia. She was then admitted to another hospital. The physicians at this second hospital told the plaintiff that his mother had been misdiagnosed and improperly treated at the defendant hospital. Following his mother's death, the plaintiff filed suit. Among his claims was one for violating EMTALA.

Following dismissal of his claim, the plaintiff appealed. As the court noted, EMTALA was enacted to address the problem of so-called "patient dumping" where hospitals refuse to provide emergency care to indigent patients. "EMTALA requires hospitals receiving federal funds to screen for an emergency medical condition any patient who comes to the hospital; if an emergency condition exists, the patient may not be transferred to another hospital or discharged until he or she has received stabilizing treatment." From this perspective, the court concluded that the plaintiff's claim was clearly without merit because they reflected a situation where the hospital had provided emergency care and stabilization as called for in EMTALA. As the court then observed, "That the treatment provided was ineffective—that it may even have involved a misdiagnosis or malpractice—does not violate EMTALA so long as she was stabilized. EMTALA is not a federal malpractice statute." Additionally, the Seventh Circuit found that the plaintiff's EMTALA claims were properly dismissed as time-barred. EMTALA requires that an action must be brought within two years of the date of the alleged violation. Here the plaintiff filed suit five months too late. *Curry v. Advocate Bethany Hosp.*, No. 05-3967 (7th Cir., Nov. 1, 2006).

Summary judgment upheld on physician's antitrust claim

Over the years, exclusive contracts for various hospital services, such as anesthesiology, have been the focus of considerable antitrust litigation. Often a physician who has been unsuccessful in bidding for an exclusive contract or who has lost an exclusive contract to another physician or medical group will assert that the contract constitutes an unreasonable restraint of trade in violation of the Sherman Act, 15 U.S.C. 1 et seq. Such a case, involving an Indiana physician, was recently decided by the Seventh Circuit Court of Appeals. The court concluded that the plaintiff failed to establish an antitrust injury and lacked antitrust standing, thereby precluding her claim.

In this case, the plaintiff-physician initially practiced anesthesiology at two independent hospitals located in Lafayette, Indiana from 1985 to 1994. Subsequently, in 1994, one of the hospitals entered into an exclusive contract with the defendant-anesthesiology group. The plaintiff, however, continued to provide services at this hospital until 1998 under a subcontract with this medical group. In 1998, the two hospitals in Lafayette merged and the resulting corporation contracted with another medical group, of which plaintiff was a member, to provide anesthesia services at the other hospital. Thus, beginning

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in 1998, each hospital, while under common ownership, had an exclusive anesthesia contract with a different group. At this same time, in response to her decreasing anesthesiology practice, the plaintiff began to practice in a new specialty, pain management. By 2000, she was practicing pain management full time. Then, in 2001, the hospital corporation decided to have a single anesthesia provider for both hospitals and contracted with the group of which the plaintiff was not a member. As a result, the plaintiff was precluded from practicing anesthesiology at either hospital and filed an antitrust suit against the hospital corporation, its CEO, and the exclusive anesthesia group. The trial court granted the defendants summary judgment. *Kochert v. Greater Lafayette Health Services, Inc*., 372 F. Supp. 2d 509 (N.D. Ind. 2004). The plaintiff appealed.

On appeal, the Seventh Circuit focused its attention on whether the plaintiff had sustained an "antitrust injury" and had "antitrust standing." As to the injury question, the court explained that a plaintiff must show that their injuries are of a type antitrust laws are designed to prevent and are the product of anticompetitive acts. Here, by 2001, when the defendant-medical group had secured its exclusive contract at both hospitals, the evidence showed that the plaintiff was no longer practicing anesthesiology, but was instead practicing pain management full time. Rejecting the plaintiff's contrary arguments, the court found that the alleged anticompetitive actions in 2001 "did not injure [the plaintiff's] anesthesiology practice because it was nonexistent by this point."

Further, the court concluded that the plaintiff lacked "antitrust standing." Other potential plaintiffs, such as the excluded anesthesiology group, insurers, and patients, were in a better position to "efficiently vindicate the purposes of the antitrust laws" by bringing suit, thus making plaintiff's claim unnecessary to prevent anticompetitive behavior by the defendants. *Kochert v. Greater Lafayette Health Services, Inc*., 463 F.3d 710 (7th Cir. 2006).

Suit involving constitutionality of emergency contraception rule allowed to proceed

In April of 2005, at the behest of the Governor, an emergency rule was promulgated by the Illinois Department of Financial and Professional Regulation (Department) requiring pharmacies to dispense "without delay" any properly prescribed contraceptive, including "all FDA-approved drugs or devices that prevent pregnancy." This rule became final in August of 2005. 68 Ill. Admin. Code 1330.91(j). In a September decision, the federal district court considered a constitutional challenge to this rule.

The plaintiffs in this action included pharmacists who had worked at a national chain pharmacy in Illinois and who claimed they had lost their jobs because they had refused to dispense emergency contraceptives, the so-called "morning-after pill," under the Illinois rule based on their personal religious beliefs. They asserted that the Illinois rule unconstitutionally interfered with their First Amendment free exercise rights. Additionally, the chain pharmacy intervened as a plaintiff seeking declaratory and injunctive relief. The defendants, including the Governor and various administrative officials moved to dismiss the suit. The federal district court denied the motion.

The district judge began by outlining certain basic analytical principles regarding the First Amendment's free exercise provisions and the problem to be addressed in this case.

> State laws designed to discriminate against individuals because of their religious practices and beliefs are subject to strict scrutiny. The state must demonstrate that the laws serve a compelling state interest and are narrowly tailored to advance that compelling interest . . . Religious beliefs and practices, however, are varied and many laws unintentionally impinge on those beliefs and practices. If every law that affected religion were subject to strict scrutiny, then virtually all laws would be subject to strict scrutiny. The Supreme Court has, thus, determined that religiously neutral state laws of general applicability are not subject to strict scrutiny even if they inadvertently affect someone's religious beliefs or practices. The issue here is whether the Plaintiffs have alleged sufficient facts which, if true, would establish that the Rule is not a neutral regulation of general applicability, and if so, whether the Rule fails to meet the standard of strict scrutiny.

The judge concluded that, given the procedural posture of the case, the plaintiffs had allegations were sufficient to call for strict scrutiny. "The Plaintiffs' allegations, if true, may establish that the object of the Rule is to target pharmacists, such as the Plaintiffs, who have religious objections to Emergency Contraceptives, for the purpose of forcing them either to compromise their religious beliefs or to leave the practice of pharmacy. Such an object is not religiously neutral. If so, the Rule may be subject to strict scrutiny." From this perspective, the court concluded that the rule would not meet constitutional requirements. "[W]hen viewed in the light most favorable to the Plaintiffs, the Plaintiffs sufficiently allege that the Rule fails to be narrowly tailored to advance a compelling state interest. The Plaintiffs state a claim that the Rule violates the First Amendment Free Exercise clause [italics in original]." The court also found that the plaintiffs had sufficiently alleged that the rule violated Title VII, 42 U.S.C. 2000e-2(a)(1) prohibiting religious discrimination in employment.

Given this analysis the court denied the defendants' motion to dismiss. *Menges v. Blagojevich,* 451 F. Supp. 2d 992 (C.D. Ill. 2006.

Illinois decisions

Illinois Supreme Court decides fee-splitting case

In September, the Illinois Supreme Court decided a case involving the fee-splitting provisions of the Medical Practice Act of 1987, 225 ILCS 60/22(A)(14).The case involved an arrangement between the defendant, a managed care entity, and the plaintiffs, an individual physician and a medical group, whereby physicians could become participants in the defendant's network and would in turn pay the defendant an "administrative fee" for its services. Initially, the fee was set at five percent of the amount paid the physician under the defendant's rate schedule. However, after a 2002 Illinois Attorney General opinion (2002 Ill. Att'y Op. No. 02-005) found this arrangement violative of 22(A)(14), the fee provision was modified to a flat amount based on the physician's specialty and volume of his or her claims in the prior year. In a unanimous opinion authored by Justice Karmeier, the

court concluded that the percentage fee did violate the Medical Practice Act, but that the flat fee did not. The court also rejected the plaintiffs' claim to recover the percentage fee payments.

As noted, the basis of the suit here was section 22(A)(14) of the Medical Practice Act of 1987. This section, in relevant part, states as follows:

> (A) The Department [of Professional Regulation] may revoke, suspend, place on probationary status, or take any other disciplinary action . . .with regard to the license . . . of any person issued under this Act to practice medicine . . .upon any of the following grounds: . . . (14) Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company, or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered.

Justice Karmeier looked to a series of prior appellate court opinions which had interpreted and applied this provision in various situations. The court concluded that, "Under the interpretation of section 22(A)(14) which we have now adopted, the conduct which the legislature seeks to prohibit is the agreement by a licensee to share a percentage of the fees he or she earned for 'professional services . . . actually and personally rendered,' with 'anyone,' 'other than physicians with whom the licensee practices.'" Based on this interpretation of 22(A)(14), Justice Karmeier concluded that the percentage fee arrangement was improper. However, the flat fee provision later substituted by the defendant to pay its administrative costs, based not on the volume of revenue, but rather on the volume of claims, was allowable under the Act.

The plaintiffs argued that, given that the percentage fee provision had violated the Act, they were entitled to recover back the amounts paid under this arrangement. The court, applying the principle of in pari delicto (in equal fault), found that the plaintiffs were not entitled to recover the fees paid. As the court stated, "'the law will not aid either party to an illegal act, but will leave them without remedy as against each other,' with the caveat that they are of equal knowledge, wilfulness and wrongful intent. . . ." The court was unpersuaded by the plaintiffs' claim that they had "coerced" into the improper arrangement with the defendant. "[W]e see nothing of record to suggest that the agreements were anything other than arm's-length transactions between [the parties]. . . Further, it is the plaintiffs, as licensees under the Act, who have violated section 22(A)(14), not [defendant]." In light of this analysis, the appellate court's judgment was affirmed in part and reversed in part, and the trial court's judgment was affirmed. *Vine Street Clinic v. HealthLink, Inc*., 222 Ill. 2d 276, 856 N.E.2d 422 (2006).

Court denies access to names of prior patients in liability suit

Plaintiffs, husband and wife, sued the defendant-physician and his medical group for damages suffered as a result of negligent medical treatment stemming from a retropubic Burch colposuspension procedure (Burch procedure). A Burch procedure is one method of treating urinary stress incontinence. After the procedure, the plaintiff-wife alleged, among other things, that the physician failed to advise her of his limited experience in performing the procedure. During the deposition of the physician, he stated that he had performed approximately 20 Burch procedures prior to performing the procedure on the plaintiff.

Following the physician's deposition, the plaintiffs delivered a set of interrogatories which included a question asking for the name, address, and phone number of the 20 individuals on which the defendant had performed the Burch procedure prior to the plaintiff. The interrogatory also asked for the dates and places where the prior procedures had been performed, a list of all persons who had knowledge of the physician performing the procedure on that individual person, and all the medical records regarding these procedures.

The defendants objected to the requests, citing the physician-patient privilege, 735 ILCS 5-8-802. The trial court however, ordered the defendants to produce the names and addresses of the previous patients, but stayed production based upon the defendants' contempt of court request. The defendants were held in contempt and fined $25. The defendants then timely appealed under Supreme Court Rule 304(b)(5).

Before the appellate court, the plaintiffs argued that the production of names did not violate the physician-patient privilege because the information could be obtained from other avenues, namely the defendants accounting records. The plaintiffs relied on *House v. Swedish American Hospital*, 206 Ill. App. 3d 437, 564 N.E.2d 922 (2d Dist. 1990), which held that a mere disclosure of a patient's name does not violate the physician-patient privilege. The *House* case involved a plaintiff who was attacked at a hospital lounge and sought disclosure of medical records to learn the identity of his attacker.

The appellate court distinguished the instant case from *House,* stating that, "here, we are dealing with more than the mere disclosure of the patient's name." The court pointed out that the information sought here directly related to the nonparty's medical records, because in order to be included in this discovery request the nonparty had to have undergone the Burch procedure. Thus, the court held that this type of disclosure would be "in clear contravention of the physician-patient privilege." Therefore, the appellate court reversed the order compelling the disclosure of the names and addresses of the prior patients and reversed the order holding the defendants in contempt. *Defilippis v. Gardner,* No. 2-06-0019 (Ill. App. 2d Dist., Nov. 21, 2006).

Consumer Fraud Act does not apply to negligent dental services

The plaintiff sued the defendant-dentist and his professional business organizations for (1) professional negligence and (2) violating the Illinois Consumer Fraud and Deceptive Business Practices Act, 815 ILCS 505/1 et seq. In particular, the second count was based on allegations that the defendants advised plaintiff and other patients to undergo unnecessary and extensive dental care in order to increase their fees, and thereby, their profits. Additionally, the plaintiff alleged that care misrepresented as necessary and for which defendants received payment was either not performed or performed poorly. The trial court dismissed the second claim because dental services did not qualify as "trade or commerce" under the Act. The trial court found that the Consumer

Fraud Act does not apply to medicine, dentistry, or law because these are not "ordinary commercial enterprises." The plaintiff appealed to the First District Appellate Court under Illinois Supreme Court Rule 304(a). The appellate court affirmed the judgment dismissing the claim.

The appellate court agreed with the trial court's analysis, noting that "trade or commerce" under the Act is not so broadly construed as to include every sort of business transaction. The court identified three elements of a claim under the Act: (1) a deceptive act or practice (2) intended to deceive the plaintiff (3) in the course of conduct involving trade or commerce. The practice of dentistry (as well as the practice of law and medicine) has been distinguished from "trade or commerce" in the First District Appellate Court's own previous decisions including *Frahm v. Urkovich*, 113 Ill. App. 3d 580, 447 N.E.2d 1007 (1st Dist. 1983); *Feldstein v. Guinan*, 148 Ill. App. 3d 610, 499 N.E.2d 535 (1st Dist. 1986); and *Baksh v. Human Rights Commission*, 304 Ill. App. 3d 995, 711 N.E.2d 416 (1st Dist. 1989).

Additionally, the court rejected the plaintiff's argument that "the allegations contained in count II establish violations of the Act with respect to the business aspects of defendants' dental practice." While the court acknowledged precedent that has applied the Act to the business aspects of a professional practice, such as *Gadson v. Newman*, 807 F.Supp. 1412 (C.D. Ill., 1992), here the plaintiff's claims under the Consumer Fraud Act were identical to those made in the professional negligence claim. As such, because the Consumer Fraud Act "is not broad enough to allow the imposition of statutory liability for misconduct that amounts to professional malpractice," this claim was properly rejected.

The court emphasized that professionals are already extensively regulated, both in training and practice, and that tort law permits recovery for injuries caused by a deviation from standard practice. The Consumer Fraud Act, on the other hand, protects the consumer in the realm of trade or commerce that is less highly regulated (in particular, not subject to professional regulation), for which a remedy is not as easily accessible.

In a separate concurrence, Justice Greiman opined that, although the language of the Act currently precluded this claim, the law ought to be modified to extend to professionals such as the defendants. *Tkacz v. Weiner*, No. 1-05-3861 (Ill. App. 1st Dist., Nov. 1, 2006).

No claim against hospital for billing practices under Illinois Consumer Fraud

The Second District Appellate Court also was recently asked to consider a claim under the Illinois Consumer Fraud and Deceptive Business Practices Act, 855 ILCS 505/1 et seq. In a case that, in part, reflects the current controversy surrounding billing by not-for-profit hospitals, the plaintiff-hospital sued the defendant-couple seeking payment for care furnished to their four children–defendants allegedly failed to submit payment for the excess charges not covered by their insurance carrier. The defendants counterclaimed both independently and on behalf of those similarly situated, alleging that the hospital's pricing schemes violated the Illinois Consumer Fraud and Deceptive Business Practices Act. Defendants alleged that the hospital concealed charges and billing practices, charged excessively, and charged for services not rendered. The trial court dismissed the consumer fraud allegation for failure to state a claim and granted summary judgment for the hospital. The trial court also granted the defendants' request for an interlocutory appeal and the suit came to the Second District Appellate Court. The appellate court affirmed.

The court initially identified four elements of a prima facie cause of action under the Illinois Consumer Fraud Act: (1) a deceptive act or deceptive practice, (2) upon which the defendant intended the plaintiff to rely, (3) occurring within the ordinary course of trade or commerce, (4) that proximately caused the plaintiff's injury. The court also distinguished between unfair and deceptive conduct, and noted that plaintiffs may recover under the Act on both causes of action. It indicated that excess charges would qualify as unfair conduct, whereas concealing facts qualifies as deceptive conduct.

The court found that the couple failed had to show, beyond a mere act or omission on the part of the hospital, that it knew its rates were in excess of customary industry charges. In order to engage in deceptive practices actionable under the Act, the hospital must

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OFFICE
Illinois Bar Center
424 S. 2nd Street
Springfield, IL 62701
Phones: (217) 525-1760 OR 800-252-8908

Web site: www.isba.org

Editor
W. Eugene Basanta
SIU School of Law, Lesar Law Bldg.
Carbondale, IL 62901-6804

Associate Editors
Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

Thomas P. Conley
120 S. Riverside Plaza, Ste. 1200
Chicago, IL 60606-3910

Diane Gilbert Jacoby
316 E. 18th St.
Chicago, IL 60616-1539

John M. Lagattuta
1406 W. Talcott Rd.
Park Ridge, IL 60068

Herbert Sohn
4640 N. Marine Dr.
Chicago, IL 60640-5788

Managing Editor/Production
Katie Underwood
kunderwood@isba.org

POSTMASTER: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

have known of the variation in rates and intended that the couple rely on misrepresentations of excess charges as customary. The defendants failed to show any evidence that the hospital knew of any such deviation in charges in excess of industry standards. Additionally, the defendants failed to state with particularity the charges levied that corresponded to treatment not received. Bare assertions that a party was charged for services not rendered, without more, are not sufficient to justify a cause of action against the business under the Act. Finally, only if charges are "so oppressive that … the consumer [is left with] little alternative except to submit to it" are those charges unfair– the defendants could not meet this standard. The court also affirmed the dismissal of the class action because the failure to state a claim in the direct claim precluded the class action as well. *Rockford Memorial Hospital v. Havrilesko*, No. 2-06-0230 (Ill. App. 2d Dist., Oct. 20, 2006).

Appellate court considers claim of emotional distress for HIV misdiagnosis

Plaintiff-patient saw the defendant-physician in 1992 and was examined for sexually transmitted diseases. The plaintiff had a history of genital warts and had also been complaining of genital-related problems at the time of the visit. HIV antibody testing and confirmatory Western blot analysis were performed by another laboratory, and the report was sent back to the physician as "inconclusive." The physician examined the results and independently made the determination that the plaintiff was HIV positive. After informing the plaintiff, the physician sought to monitor his general health using baseline testing. In particular, the physician asserted that a referral to an infectious diseases specialist had been given, but that the plaintiff failed to follow through. Two years later, the plaintiff followed up with a different physician, who informed him that he was not HIV positive and that the prior test was a false positive. The plaintiff received a $350,000 jury verdict for the emotional distress caused by the false positive test based in part on his claim that he had become involved in gang violence and delinquent behavior as a result of the improper diagnosis.

The defendant-physician appealed asserting that the circuit court failed (1) to bar testimony as irrelevant involving the physician's failure to pass board-certification; (2) to allow evidence from before 1992 showing previous delinquent and criminal behavior by the plaintiff; and (3) to issue jury instructions relating to mitigation of damages. The appellate court reversed and remanded.

The appellate court first found that testimony relating to board-certification is generally allowed as evidence only for those physicians who appear as expert witnesses. Only when the physician testifies relating to the standard of medical care is his or her board-certification status relevant. In addition, evidence of a criminal record prior to the misdiagnosis weakened the patient's claim that the misdiagnosis prompted his involvement in criminal activity, was relevant, and should have been admitted. Finally, the court distinguished between contributory negligence and mitigation of damages, and agreed with the physician that a directed verdict on mitigation of damages was improper. The evidence presented by the defendant attested to the existence of a substantial factual dispute. In closing, the court addressed the question of whether a plaintiff is required to show evidence of a physical injury in order to recover damages for an emotional distress tort claim, even though neither party raised the issue at trial. The court directed the circuit court, on remand, to address this issue.

Justice Campbell dissented. He argued that the defendant-physician waived the issue of failing the board examination, and further, did not meet the narrow exception of "plain error" review justifying appellate review on this issue. Additionally, the evidence the physician sought to present as to the plaintiff's earlier involvement in criminal activities included police reports, which Justice Campbell said are inadmissible as evidence in Illinois courts as hearsay. Justice Campbell agreed that mitigation of damages was a relevant issue—in fact, the most important one on appeal—but did not find a substantial factual dispute when considering the evidence at bar. Finally, the dissent offered more guidance to the circuit court for consideration of physical injury and emotional distress damages, indicating that the Illinois Supreme Court had previously allowed recovery in such a case. *Jones v. Rallos*, No. 1-04-2979 (Ill. App. 1st Dist., Oct. 12, 2006).

HIV misrepresentation claim should have been rejected

After the plaintiff learned she had contracted HIV from her fiancé, she brought an action against the fiancé's parents for fraudulent and negligent misrepresentation. Plaintiff's claim was based on the statements of the parents, which indicated that the fiancé suffered from heavy metal poisoning and lyme disease, when in fact, the fiancé had been diagnosed with both HIV and AIDS. Plaintiff stated that she relied on these false representations, which caused her injury because she delayed HIV testing and treatment.

A directed verdict was entered in favor of the parents by the trial court on the fraudulent misrepresentation claim. A mistrial was later declared due to a hung jury with respect to negligent misrepresentation claim. At the close of the evidence at the second trial, the court granted a directed verdict in favor of the parents on the negligent misrepresentation claim (which had originally ended in a mistrial). The trial court submitted the fraudulent misrepresentation count to the jury, which returned a $2 million verdict in favor of the plaintiff.

The defendant-parents appealed, stating that the trial judge at the second trial had erred in submitting the fraudulent misrepresentation count to the jury because the judge during the first trial had already directed a verdict in the defendants favor on that particular count. The defendants further argued that because the plaintiff did not file a post trial motion after the first trial, the directed verdict became final and thus the second judge did not have the power to alter it. The defendants based their rationale on 735 ILCS 5/2-1202c, arguing that after 30 days the trial court lost its jurisdiction to vacate or modify the directed verdict. The plaintiff, citing Illinois Supreme Court Rule 304(a), argued that a post trial motion is not a requirement for a trial court to retain the jurisdiction needed to vacate or modify a directed verdict when other claims remain pending and undetermined.

The First District Appellate Court stated that Rule 304(a) makes clear that when a judgment does not dispose of all claims, the power to revise a prior final order that disposed of a definite part of litigation is still vested in the trial court, unless the court certifies the order to be final and appealable. The appellate court further stated that the

directed verdict on the count of fraudulent misrepresentation was interlocutory in nature, thus allowing it to be modified or vacated any time before final judgment is entered. In the alternative, the appeals court stated that even if the lower court lost jurisdiction, the parties themselves revested jurisdiction by actively participating without objection in the submission of the count to the jury at the second trial.

After rejecting defendants' procedural claims, the court moved to the substantive merits of the case. The defendants argued that they were entitled to a directed verdict on the fraudulent misrepresentation count because plaintiff had not established the elements of fraudulent misrepresentation. The appeals court held that a fraudulent misrepresentation claim can be used in a noncommercial or non-transactional setting, especially if physical harm is involved. However, particularized scrutiny must be given to the elements comprising fraudulent misrepresentation, especially whether the person alleging the misrepresentation was justified in their reliance on the truthfulness of the asserted statements. In order to determine whether a person is justified in relying upon the representations of another, the court looked to *Gerill Corp. v. Jack L. Hargrove Builders, Inc*. 128 Ill. 2d 179, 538 N.E.2d 530 (1989), among other cases.

Under these precedents, the court said, it was necessary to consider all of the facts within the plaintiff's knowledge, as well as those facts which would have been discovered by the plaintiff with the exercise of ordinary prudence. Applying this rationale, the court held that the plaintiff should have been on notice of her own condition. The court observed that, based on the undisputed facts, the plaintiff was aware of her fiancé's declining health condition before meeting his parents for first time. Also, the record indicated that the plaintiff had stated to the fiancé's mother that he looked like someone with AIDS. Further, the plaintiff had reported experiencing flu-like illness after engaging in unprotected sex with her fiancé (which occurred before meeting the parents).

The court stated that, given the availability of HIV testing and consultation with health care professionals, it was unreasonable for plaintiff to rely on the statements of the fiancés parents in order to determine her own health status.

In closing, the appellate court noted that, while normally the reliance of a plaintiff is a question to be decided by the trier of fact, where, as in this case, it is apparent that only one conclusion can be drawn from the undisputed facts, the question can be answered by the court. The appeals court therefore vacated the judgment entered by the trial court on the jury's verdict. *Doe v. Dilling*, No. 1-04-2372 (Ill. App. 1st Dist., Sept. 1, 2006).

Court finds continuous course of treatment rule applied to dental care

A claim was filed against a dentist for professional negligence. Summary judgment was granted to the defendant-dentist by the trial court because the court ruled the claim was barred by the four year statute of repose found in 735 ILCS 5/13-212(a). On appeal, the plaintiff alleged the statute of repose should not apply because the negligent care was part of a continuing course of treatment.

In its analysis, the Fourth District Appellate Court looked to the criteria laid out by the Illinois Supreme Court in *Cunningham v. Huffman*, 154 Ill. 2d 398, 609 N.E. 321 (1993), to determine whether or not the facts of this case qualified as a course of continuous medical treatment, thus tolling the statute of repose. As stated in *Cunningham*, "the plaintiff must demonstrate that (1) there was a continuous and unbroken course of negligent treatment and (2) the treatment was so related as to constitute one continuing wrong."

The appellate court also reiterated the distinction between a statute of repose and a statute of limitations, as discussed in *Ferrara v. Wall*, 323 Ill. App. 3d 751, 753 N.E.2d 1179 (2d Dist. 2001). As the court explained, the statute of limitations under 13-212(a) begins to run when the patient discovers the injury. In contrast, the repose period begins at the time of the defendant's wrongful act or omission that caused the injury or the last date of negligent treatment (if the injury was a product of continued negligence). Citing *Jones v. Dettro*, 308 Ill. App 3d 494, 720 N.E.2d 343 (4th Dist.1999), the appellate court noted that the burden to prove a factual basis to toll the period of limitation or repose falls on the plaintiff.

In this case, the plaintiff had used the defendant as her exclusive dentist for over eight years. The record also showed that during those eight years the plaintiff had over 48 appointments. The plaintiff then moved out of state and sought services from a new dentist, who advised her that all of the previous dental work performed by the defendant was inadequate and wrong. The new dentist also opined that the state of the plaintiff's dental condition was equivalent to that of a patient who had not seen a dentist in 15 or more years.

Justice McCullough, writing for the court, ruled that these allegations raised a question of fact as to whether or not the dental treatment would fall under the continuing course of negligent treatment exception to the statute of repose. Therefore, the court reversed the summary judgment and remanded the case for consideration by the jury. *Follis v. Watkins*, 367 Ill.App.3d 548, 855 N.E.2d 579 (4rh Dist. 2006).

Consumer-Directed Health Plans: Early enrollee experiences with Health Savings Accounts and eligible health plans

[Editor's Note: The June, 2006 issue of the Health Care Lawyer included a summary of a Government Accountability Office report released in April of 2006 entitled "Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage" GAO-06-514. On August 9, 2006 the GAO released another report addressing consumer-directed health care plans, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans" GAO-06-798. Given the level of current interest in consumer-directed health plans as an alternative approach to how health care is financed, this most recent GAO report provides useful information in terms of enrollee experiences and attitudes toward such plans].

Why GAO Did This Study

Health savings accounts (HSA) and the high-deductible health insurance plans that are eligible to be coupled with them are a new type of consumer-directed health plan attracting interest among employers and consumers. Employers and plan enrollees may contribute to tax-advantaged HSAs, and enrollees can use the accounts to pay for health care expenses. Because HSAs and HSA-eligible plans are new, there is interest in the experiences of plan enrollees, as well as in comparing the plan features and enrollee characteristics with those of traditional plans, such as preferred provider organization (PPO) plans.

GAO reviewed (1) the financial features of HSA-eligible plans in comparison with those of traditional plans, (2) the characteristics of HSA-eligible plan enrollees in comparison with those of traditional plan enrollees, (3) HSA funding and use, and (4) enrollees' experiences with HSA-eligible plans. GAO analyzed data regarding HSA-eligible and traditional plans and enrollees from national employer health benefits surveys, three selected employers, and a national broker of health insurance. GAO compared Internal Revenue Service (IRS) data for tax filers reporting HSA contributions with corresponding data for all tax filers under 65 years old. GAO also conducted focus groups with employees of the three employers.

What GAO Found

In 2005, HSA-eligible plans had different financial features than traditional plans—such as lower premiums and higher deductibles—but both plan types covered similar health care services, including preventive services, and used similar provider networks. For the three employers' health plans GAO reviewed to illustrate enrollees' potential health care costs, GAO estimated that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive use of health care, but would incur lower annual costs than PPO plan enrollees for low to moderate use of health care.

HSA-eligible plan enrollees generally had higher incomes than comparison groups, but data on age differences were inconclusive. In 2004, 51 percent of tax filers reporting an HSA contribution had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under 65 years old. Two of the three employers GAO reviewed and a national broker of health insurance also reported that HSA-eligible plan enrollees had higher incomes than traditional plan enrollees in 2005. GAO's data sources did not conclusively indicate whether HSA-eligible plan enrollees were older or younger than individuals and enrollees in comparison groups.

Just over half of all HSA-eligible plan enrollees and most employers contributed to HSAs, and account holders used their HSA funds to pay for current medical care and to accumulate savings. About 55 percent of HSA-eligible plan enrollees reported HSA contributions to IRS in 2004. Tax filers claimed an average deduction of about $2,100 for their HSA contributions in 2004, and the average amount increased with income. About two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs, and the average employer HSA contribution was about $1,064 in 2004. About 45 percent of tax filers reporting 2004 HSA contributions also reported that they withdrew funds in 2004, and 90 percent of these funds were withdrawn for qualified medical expenses. The other 55 percent of those reporting HSA contributions in 2004 did not withdraw any funds from their HSA in 2004.

HSA-eligible plan enrollees who participated in GAO's focus groups generally reported positive experiences, but most would not recommend the plans to all consumers. Participants enrolled in the plans generally understood the key attributes of their plan. Few participants reported researching cost before obtaining health care services, although many researched the cost of prescription drugs. Most participants were satisfied with their HSA-eligible plan and would recommend these plans to healthy consumers, but not to those who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible. GAO received technical comments from IRS and a national broker of health insurance and incorporated the comments as appropriate.

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Cases

Federal decisions

Seventh Circuit affirms dismissal of pharmacist's claim under Title VII

A Wisconsin pharmacist, who had been fired from a retail pharmacy, brought suit alleging that his termination violated Title VII of the Civil Rights Act of 1964, 42 U.S.C. §2000e et seq. Specifically he claimed that he had been let go due to his religious-based refusal to have any form of interaction, no matter how slight, with anyone seeking birth control. The trial court had dismissed the suit finding that the store had offered reasonable accommodations to the plaintiff-pharmacist, and that he was simply not entitled to any further accommodations under Title VII.

On appeal, the Seventh Circuit agreed. As the court noted, "Title VII of the 1964 Civil Rights Act requires employers to make reasonable accommodations for their employees' religious beliefs and practices unless doing so would result in undue hardship to the employer. . . . A reasonable accommodation is one that 'eliminates the conflict between employment requirements and religious practices.'" Here the store had been willing to adjust the plaintiff's work duties in a variety of ways to address his concerns regarding birth control. However, the plaintiff insisted that the only reasonable accommodation was to relieve him of all telephone and counter duties. The appeals court found that this would impose an undue hardship on the pharmacy. The district court's decision was therefore affirmed. *Noesen v. Medical Staff Networking, Inc.*, No. 06-2831 (7th Cir., May 2, 2007).

Court rejects removal based on ERISA "complete preemption"

An Illinois federal district court in May decided that a defendant-HMO's effort to remove a medical liability case from state to federal court based on preemption under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001 et seq. should be rejected. The case was remanded to the Illinois state court.

The plaintiff, who was a member of the defendant-HMO, was injured while playing basketball. He went to the emergency room of a hospital that he knew was part of the HMO plan and asked that his HMO primary care physician (PCP), also a defendant, be contacted to approve care for his injury. The plaintiff's complaint alleged that the PCP, thinking that plaintiff had simply sprained his ankle, instructed the ER staff to take an X-ray, send the plaintiff home, and not treat or admit him to the hospital. In fact, plaintiff had a severed artery and an aneurysm in his ankle. Claiming that the PCP and other providers were negligent in providing care, plaintiff sued for the permanent injuries he suffered. The complaint also alleged that the PCP denied care to the plaintiff "to maximize the profitability" of the HMO. Included with the plaintiff's state medical malpractice suit against the PCP was a count against the HMO on a respondeat superior theory.

After the suit had been pending for several years in the Illinois trial court, the plaintiff provided the defendants with a supplemental expert disclosure. This disclosure included a statement that, "It was a deviation of acceptable practice" for the PCP as the HMO's agent "to deny payment for [plaintiff's] examination and treatment" and that in doing so the PCP and the HMO "violated accepted standards of care which required the insurance company to pay for a procedure which was required under EMTALA." Based upon this expert's statement, the HMO sought to remove the case to federal court arguing that the disclosure "reveals that Plaintiff's claims are within the scope of [29 U.S.C. §1132(a)(1)(B)], which completely preempts Plaintiff's state law claims." The HMO further argued

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that "the expert's supplemental disclosure reveals a federal question under the Emergency Medical Treatment and Active Labor Act. . . ."

The basis for the HMO's "complete preemption" claim was 29 U.S.C. §1132(a)(1)(B) which provides that, "A civil action may be brought (1) by a [plan] participant or beneficiary. . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." In determining the propriety of the HMO's preemption claim, the district court noted that the Seventh Circuit has set out a three-part test under §1132 (a): "(1) whether the plaintiff is eligible to bring a claim under that section; (2) whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via [§1132(a)]; and (3) whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law." Referring to *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) and *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), the court in the present case concluded as follows: "[T]his case involves a medical negligence claim against a plan administrator based on respondeat superior. Plaintiff alleges that [the HMO] is vicariously liable for the negligent medical treatment of its providers. . . . This claim, brought against a plan administrator for vicarious liability of an actual or apparent agent, is not subject to the jurisdictional doctrine of 'complete preemption' under [§1132(a)]." Thus, the court concluded, "as a matter of the factual record in this case, the supplemental expert disclosure adds nothing materially new to Plaintiff's claims, and therefore does not provide a basis for removal. . . . It follows that this Court lacks subject matter jurisdiction over these claims and must remand to state court. . . ." *Badal v. Hinsdale Memorial Hospital*, No. 06 C 7164 (N.D. Ill., May 8, 2007).

Illinois decisions

Wrongful death action based on failure to warn may proceed

The Fifth District Appellate Court ruled in May that a wrongful death and survival action was improperly dismissed by the trial court for failure to allege a duty on the part of the defendants. The action was brought on behalf of the decedent-wife's estate and her children against several health care providers alleging that they breached their duties to warn and to protect the decedent from foreseeable violent acts of her husband.

The facts as alleged in the plaintiffs' complaint were that the husband had a history of depression and panic attacks, as well as suicidal thoughts. Further, it was alleged that he was convinced that his wife was having an affair, that she was trying to poison him and their children, and that he had thoughts of killing her and himself. Over a period of several weeks, beginning in May of 2003, the husband saw, at various times, the defendant-health care providers. The decedent-wife accompanied him on many of these visits and often spoke with the providers about her fears for her own safety. In early June, the husband strangled the decedent. Suit was brought against the defendants on theories of direct and transferred negligence for their failure to act to protect the decedent from her husband. The trial court dismissed the action with prejudice on the ground that the amended complaint failed to allege a recognized duty owed by any of the defendants to the decedent.

The appellate court began its analysis by noting the requisite elements of a negligence claim. The "plaintiff must allege facts that establish the existence of a duty owed by the defendant to the plaintiff, a breach of that duty, and an injury that was proximately caused by the breach." The claim in this case was based on a failure of the defendants to warn the decedent of her husband's potential violent acts. "In such an action, a plaintiff must establish the following elements relating to the alleged duty: (a) the patient made a specific threat of violence, (b) the threat was directed toward a specific and identifiable victim, and (c) there was a direct physician-patient relationship between the defendant and the plaintiff or a special relationship between the patient and the plaintiff." Here the question for the court was one of a duty either to warn and protect the decedent under sections 315 and 324A of the Restatement (Second) of Torts or to appropriately evaluate, treat, and supervise the husband for the care and benefit of the decedent under a transferred negligence theory.

The appellate court first found that, because the facts alleged did not show that the husband had been committed to the custody and control of the defendants, no duty could be imposed on this basis under sections 315 and 319 of the Restatement (Second) of Torts. However, the court found that Illinois has allowed for liability based on a voluntary undertaking, implicitly recognizing section 324 of the Restatement (Second) of Torts. "Pursuant to the voluntary-undertaking theory, one who gratuitously undertakes to render service to another is subject to liability for bodily harm caused to the other if he fails to exercise due care or to act with the competence and skill that he possesses while performing the undertaking." Based on this theory, the appeals court found the complaint sufficient to avoid dismissal.

Citing *Renslow v. Mennonite Hospital*, 67 Ill. 2d 348, 367 N.E.2d 1250 (1977), the court also ruled that the complaint was sufficient to allege a claim of "transferred negligence." According to the court, this concept involves situations where there is a special, intimate relationship (e.g., mother and child) between the parties harmed such that a nonpatient, third party injured as a result of a negligent act performed against a patient can maintain an action against the medical care providers. The question for the court was whether the relationship of husband and wife under the circumstances of this case should be viewed as such a "special relationship." The court held that it should be.

"In this case, the plaintiffs have alleged that [decedent] and her husband shared an intimate, marital relationship and that [decedent] was an active participant in his medical care, providing the defendants with information regarding her husband's changeable moods and behaviors and consulting with the defendants regarding her concerns about whether her husband would act on his ideas and threats and do her harm. In our view, the relationship, as alleged, between [decedent and her husband] reaches the level of personal, familial intimacy that was present in *Renslow*."

Based on this analysis, the appellate court held that the "complaint sets forth sufficient factual allegations to establish a cause of action based on theories of a voluntary undertaking and transferred

negligence and that the trial court erred in dismissing the action." *Tedrick v. Community Resource Center, Inc.*, No. 5-06-0065 (Ill. App., 5th Dist., May 17, 2007).

Second District rules current licensure not required to serve as a medical expert

In a medical malpractice action, the plaintiff appealed the judgment of the circuit court that barred the testimony of his expert witness regarding the standard of care applicable to defendant-physician's medical treatment of plaintiff's broken leg. The Second District Appellate Court affirmed.

In this case, the plaintiff's proposed expert had been licensed to practice medicine in Wisconsin, but his license there had been suspended due to drug abuse problems he had experienced following a back injury. He went on to explain that, in fact, the suspension had been stayed for several years until December of 2004 when he surrendered his license after the Wisconsin medical licensing board found that he had obtained medications by forging prescriptions. He was not licensed elsewhere.

Just prior to trial in May of 2005, the defendant filed a motion in limine to exclude from evidence the portions of the expert's evidence deposition in which he testified as to the standard of care applicable to defendant's medical treatment of plaintiff and as to whether defendant's treatment met that standard. The defendant argued that because the expert lacked a medical license at the time of his evidence deposition, his qualifications did not meet the requisite standards for medical experts.

The appellate court initially noted that 735 ILCS 5/8-2501 specifies the criteria a trial court is to apply in determining whether a witness qualifies as a medical expert. Under subsection (c), one of the relevant criteria is "whether the witness is licensed by any state or the District of Columbia in the same profession as the defendant. . . ." In the court's view, however, this provision did not require an expert to be currently licensed in order to testify. "The plain language of section 8-2501 does not impose a mandatory licensure requirement. Instead, the statute leaves the admission of the expert's testimony to the determination and discretion of the trial court. The legislature could have imposed a mandatory licensure requirement had it wished to do so, and we will not read such a requirement into the statute."

In its analysis, the court distinguished the Illinois Supreme Court's decision in *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 806 N.E.2d 645 (2004) where the court had barred a physician from testifying as to the applicable nursing standard of care because the physician was not licensed as a nurse. The court in the present case was of the view that, in *Sullivan*, the court sought to prevent inappropriate testimony regarding the standard of care by experts who were not similarly situated to the defendants. "Preventing the testimony of someone who had never been licensed in the school of medicine at issue or, especially, someone licensed in a different school of medicine clearly would tend to prevent the imposition of an improper standard. We fail to see how allowing the testimony of an expert who had been licensed in the appropriate school of medicine, but who was no longer so licensed, would result in the harm that *Sullivan* identified." The court held that the proper analysis in this case was to be found in *Thompson v. Gordon*, 221 Ill. 2d 414, 851 N.E. 2d 1231 (2006), which held that the licensure of an expert is only one factor to be considered by the trial court.

Having concluded that the licensure issue was not alone dispositive, the court recognized that the question of whether to admit an expert's testimony rests with the sound discretion of the trial court. Therefore, the appellate court was required to examine whether the trial court acted arbitrarily in rejecting the plaintiff's expert in this case. After viewing the record in its totality, the court held that the trial court had not abuse its discretion. "Here, the trial court could have reasonably concluded that [the physician] was not qualified to testify as an expert due to the surrender of his medical license and due to the other findings made by the Wisconsin board of medical examiners."

In a special concurrence, Justice O'Malley was of the view that "the supreme court was clear in stating in Sullivan that licensure is a 'foundational requirement'" to qualify as a medical expert and that *Thompson v. Gordon*, involving the qualifications of an engineering expert, was simply not applicable in this case. Thus, Justice O'Malley would have upheld the trial court's decision on this basis alone. *Somers v. Quinn*, No. 2-05-0619 (Ill. App. 2d Dist., April 25, 2007).

Out-of-state fitness center not subject to suit in Illinois

The plaintiff, an Illinois resident, sued the defendant-fitness center, a Missouri corporation, in an Illinois state court. Plaintiff sought damages for physical injuries caused during the defendant's provision of athletic training services in Missouri. The circuit court initially returned a verdict for the plaintiff, awarding close to a half-million dollars in damages. The defendant moved to dismiss for lack of personal jurisdiction before and during the trial; these were denied. The defendant filed a timely motion to vacate the judgment, asking the court to reconsider its ruling on personal jurisdiction. Upon rehearing, the circuit court vacated the earlier judgment, and dismissed the case for lack of jurisdiction. The plaintiff appealed.

The defendant's principal place of business and corporate headquarters was in Missouri. It had no facilities or property in Illinois, was not registered to do business in Illinois, transacted no business in Illinois, and conducted its activities primarily at its Missouri location. The plaintiff however, pointed to an interactive Web site accessible in Illinois, as well as to instances of distributing flyers in Illinois and making a presentation at an Illinois high school (after the instant case had commenced) as a basis for jurisdiction.

The appellate court initially determined that the question of personal jurisdiction was subject to direct or collateral attack at any time. Because the circuit court made no evidentiary findings on the issue of personal jurisdiction, the appellate court reviewed the personal jurisdiction issue de novo. The burden was on the plaintiff, the court said, to demonstrate that the defendant met the requisite minimum contacts standard to justify jurisdiction in Illinois.

In the court's view, the defendant, as a Missouri corporation with its principal place of business in Missouri, could not reasonably foresee that it would be hailed into court in Illinois. Its contacts with Illinois were not continuous or systematic to the extent that it could foresee liability in the Illinois courts. The court declined to address

defendant's visit to the Illinois high school since it had occurred outside the relevant timeframe. In addition, the court declined to adopt the "sliding scale" test of interactivity followed in *Zippo Manufacturing Co. v. Zippo Dot Com, Inc.*, 952 F. Supp. 1119 (W.D. Pa. 1997) which judges a party's Web site based on its interactive nature to determine whether jurisdiction exists. The Illinois court reasoned instead that, the level of interactivity of a Web site is irrelevant, since it is no different than other traditional forms of advertising or soliciting business. Under Illinois law, mere advertisement or solicitation, as in the instant case, is not sufficient to warrant personal jurisdiction in an Illinois state court over an out-of-state defendant. *Howard v. Missouri Joint and Bone Center, Inc.*, NO. 5-05-0476 (Ill. App. 5th Dist., April 24, 2007).

For another recent health law related case involving an issue of personal jurisdiction, see *Morton Grove Pharmaceuticals, Inc. v. The National Pediculosis Association, Inc.*, No. 06 C 3815 (N.D. Ill., May 3, 2007).

Pathologist fails to qualify as expert

After their two-month-old baby died following surgery to correct a cleft lip and palate, her parents brought suit alleging medical malpractice. The plaintiff-parents claimed that the defendants, plastic surgeons and an anesthesiologist, had provided their baby with improper postoperative care and had improperly discharged her from the hospital. The defendants filed a motion in limine seeking to prohibit the plaintiff's expert, a pathologist, from testifying to opinions outside his expertise. The trial court granted the motion. After pointing out that the plaintiff's expert was a pathologist, not a plastic surgeon or anesthesiologist, the First District Appellate Court affirmed the trial court's decision to bar the testimony. The appeals court analyzed the case under the framework established by the Illinois Supreme Court in *Purtill v. Hess*, 111 Ill. 2d 229, 489 N.E.2d 867 (1986).

In *Purtill*, the supreme court established a three-part analysis for determining whether to allow a medical expert to testify as follows; "(1) the expert must be a licensed member of the school of medicine about which the expert proposes to express an opinion; (2) the expert must be familiar with the methods, procedures, and treatments ordinarily observed by other physicians; and (3) the trial court has the discretion to determine whether the physician is qualified and competent to state his opinion regarding the standard of care."

In the present case the second factor was disputed; was the plaintiff's expert familiar with the methods, procedures, and treatments ordinarily observed by other physicians, including the defendants? Admittedly, the plaintiff's expert, as a pathologist, was not an expert in plastic surgery, general surgery, or anesthesia. This fact, coupled with the fact that the proposed expert had not evaluated a live patient since 1978, lead the court to uphold the trial court's ruling.

Even assuming arguendo that the plaintiff's proposed expert met the *Purtill* familiarity requirements, the appeals court stated that it would nevertheless uphold the trial court's decision that the expert was not qualified to render an opinion as to the standard of care. This conclusion was based upon the testimony of the expert during his deposition. There, the expert could not identify the standard of care for a postoperative patient with the deceased child's condition. Also, the expert stated he could not recall ever discharging a patient from the hospital. *Alm v. Loyola University Medical Center*, No. 1-06-0067 (Ill. App. 1st Dist., April 20, 2007).

Collateral source rule does not apply to Medicare/Medicaid payments

The Fourth District Appellate Court recently addressed what application the "collateral source rule" should have in a tort action brought by an injured plaintiff who has received payments under Medicare and Medicaid for needed medical services. The collateral source rule applies in personal injury actions and bars the jury from learning about collateral resources, such as an insurance policy, that are held by a plaintiff and which pay for some or all of the injuries the plaintiff sustained. This allows the plaintiff to recover the total amount billed for medical care, not the total amount the plaintiff actually paid for such care. The theory behind the rule is that a defendant should not be allowed to benefit from the expenditures by the plaintiff, such as insurance policy payments. However, in this case the plaintiff was on Medicare and Medicaid, which paid for care and for which the plaintiff, as a needy individu-

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Illinois Bar Center
424 S. 2nd Street
Springfield, IL 62701
Phones: (217) 525-1760 OR 800-252-8908

Web site: www.isba.org

Editor
W. Eugene Basanta
SIU School of Law, Lesar Law Bldg.
Carbondale, IL 62901-6804

Associate Editors
Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

Thomas P. Conley
120 S. Riverside Plaza, Ste. 1200
Chicago, IL 60606-3910

Diane Gilbert Jacoby
316 E. 18th St.
Chicago, IL 60616-1539

John M. Lagattuta
1406 W. Talcott Rd.
Park Ridge, IL 60068

Herbert Sohn
4640 N. Marine Dr.
Chicago, IL 60640-5788

Managing Editor/Production
Katie Underwood
kunderwood@isba.org

Postmaster: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

al, had not had to pay any money.

Taking this into account, the court compared the holdings of *Arthur v. Catour*, 216 Ill. 2d 72, 833 N.E.2d 847 (2005), and *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill. 2d 353, 392 N.E.2d 1 (1979). In *Arthur*, the plaintiff had a contractual agreement with a private insurance company under which the insurer had negotiated significant discounts with the medical services providers. The supreme court allowed the total amount billed to be introduced into evidence despite the fee discounts negotiated by the insurer. Conversely, in *Peterson*, the plaintiff had received free medical care donated by a hospital. Since the medical care was free, the court denied the admission of the total amount billed into evidence. Considering *Arthur* and *Peterson* together, the court concluded that without some expenditure by the plaintiff, the collateral source rule should not apply.

Noting that other states are split on this issue, applying *Peterson* to the facts of the current case, (and over the dissent of Justice Cook), the court affirmed the trial court's ruling to reduce the award for medical expenses from the amount billed to the total amount actually paid by Medicare and Medicaid on the plaintiff's behalf. *Wills v. Foster*, No. 4-06-0674 (Ill. App. 4th Dist., April 18, 2007).

Court denies newspapers access to patient names in sealed record

After a publicly-owned hospital suspended the privileges of a physician, a suit challenging the validity of the suspension followed. The hospital and the physician eventually settled the suit and submitted the agreement to the court. The hospital then requested that the agreement be placed under seal. Two newspapers subsequently attempted to obtain the details of the settlement agreement. However, because the agreement was under seal, they were unable to do so. In an attempt to gain access to the sealed order, the newspapers filed an action as interveners.

In the course of litigation it was revealed that the sealed order contained the names of seven patients who were allegedly provided substandard care. These patients were nonparties to the instant case. Eventually, the sealed order was amended to allow access to all information except for the names of these seven patients. The newspapers however, were not satisfied with the modified order and sought access to the entire agreement including the patients' names. The trial court denied the request to unseal the names ruling that revealing the patients' names would constitute a violation of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d-2 (HIPAA).

On review, the Fifth District Appellate Court held that the trial court erred as a matter of law in concluding that HIPAA would be violated if the names were revealed. In addressing the HIPAA violation, the appellate court held that the judiciary is not a "covered entity" subject to HIPAA's privacy rule. However, the appellate court affirmed the decision to keep the patients' names under seal citing the public policy of a patient's right to privacy.

In his dissent, Justice Spomer stated that he would order the entire agreement unsealed. His position was primarily based on the fact that a compelling reason to keep the agreement under seal was never advanced. Absent a showing of such a compelling reason, the strong presumption that favors open access to court files should control. *Coy v. Washington County Hosp. Dist.*, No. 5-06-0140 (Ill. App. 5th Dist., April 9, 2007).

Pharmacists lack standing to challenge emergency contraceptive rule

An administrative rule effective in August of 2005 requires pharmacies to dispense Plan B, the so called "morning after pill," to all patients seeking to fill prescriptions for this birth control drug. Specifically, the Rule requires a pharmacy, when it receives a valid prescription for a contraceptive, to dispense that contraceptive or a suitable alternative to the patient. The pharmacy cannot delay, and must seek to order the contraceptive in a timely manner if it is out of stock.

Plaintiffs, two pharmacists and three Illinois corporations that own and operate pharmacies, filed suit seeking injunctive and declaratory relief. The plaintiffs alleged that the Rule violates federal and state law because it forces pharmacists and pharmacies to dispense Plan B, even though doing so goes against their religious beliefs and consciences. The trial court dismissed the claim with prejudice, because the plaintiffs lacked standing, the claim was not ripe, and the plaintiffs failed to exhaust administrative remedies before seeking judicial review. The Fourth District Appellate Court of Illinois affirmed.

The appeals court noted that standing requires an actual controversy between adverse parties, and that the party seeking a declaratory judgment must be interested in the controversy. Though the trial court had not indicated which of the two requirements the plaintiffs failed to meet, the parties' briefs focused on the "actual controversy" requirement.

The Supreme Court decision in *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967) requires a reviewing court in the context of a declaratory judgment action, "to evaluate both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." The plaintiffs cited several cases to support their argument, but most of them dealt with challenges to statutes or municipal ordinances, not challenges to administrative rules. The plaintiffs, although they had received prescriptions for emergency contraception in the past, did not indicate that they had received any such prescription since the Rule had gone into effect. Nothing in the record indicated that the plaintiffs were directly and immediately impacted by the Rule in a manner sufficient to warrant judicial review.

Justice Turner in dissent argued that the Illinois Right of Conscience Act, 745 ILCS 70/1 et seq., protects the rights of anyone engaged in health care services to avoid activities that are against their conscience or religious convictions. Public officials should not be permitted to discriminate against individuals for "conscientious refusal to participate in any way in any particular form of health care services contrary to his or her conscience." This Act, in the dissent's view, prevents governmental coercion to alter those beliefs, and therefore, prevents the state from insisting that pharmacists "must fill prescriptions [such as Plan B] without making moral judgments." *Morr-Fitz v. Blagojevich*, No. 4-05-1050 (Ill. App. 4th Dist., March 19, 2007).

Court finds no physician-patient relationship created by scheduling appointment

An emergency room patient sought

treatment for his deteriorating mental state. During the ER visit, the ER physician contacted the on-call psychiatrist to arrange for a follow-up visit with the patient. As he testified, this was the only purpose of the call, and not to obtain an opinion in the case from the psychiatrist. The on-call psychiatrist did not physically examine or see the patient. The communication between the ER physician and the psychiatrist last approximately five minutes and only concerned arranging follow-up care for the patient.

After receiving treatment at the emergency room, but before attending the follow- up visit with the on-call psychiatrist, the patient committed suicide. The patient's estate brought suit against the on-call psychiatrist alleging medical malpractice and wrongful death. The plaintiff asserted that a physician-patient relationship had been formed between the on-call psychiatrist and the patient.

The trial court granted summary judgment in favor of the psychiatrist, finding that no physician-patient relationship existed. On appeal, the court noted that a physician-patient relationship can exist even where the physician and the patient do not physically meet each other. However, in the instant case, the psychiatrist had not formed any clinical impression and had not provided any treatment to the patient. Therefore, no special relationship existed between the on-call psychiatrist and the patient. Thus, the appellate court affirmed the trial court's ruling granting summary judgment for the psychiatrist. *Weiss v. Rush North Shore Medical Center*, ___ Ill. App. 3d ___, 865 N.E.2d 555 (1st Dist. 2007).

Wrongful death action may be brought for aborted fetus

A decision from the First District Appellate Court involves a claim by a woman who was three months pregnant when she was injured in an automobile collision. Though her fetus was not directly harmed by the collision, the plaintiff fractured her pelvis and hip. She was advised by three physicians that her fractured pelvis and hip would leave her bedridden should she choose to maintain the pregnancy. Additionally, bones might have to be re-broken to facilitate delivery, and as a result, she might not ever walk properly. The fetus, furthermore, could be harmed by the repeated exposure to X-ray radiation during the follow-up care required to manage the plaintiff's injuries. An abortion, physicians counseled, would be the best way to ensure that the plaintiff recovered optimally from her injuries.

The plaintiff underwent the abortion, and subsequently filed suit seeking damages for (1) her own injuries; (2) the wrongful death of the fetus under the Wrongful Death Act, 740 ILCS 180/1 et seq.; (3) negligent infliction of emotional distress; and (4) injuries sustained by the fetus before the abortion under the Survival Act, 755 ILCS 5/27-6. The defendant, who caused the collision, argued that the abortion was therapeutic rather than medical. As such, it was an intervening event breaking the chain of causation, thereby relieving him of liability for wrongful death of the fetus. The trial court granted summary judgment as to the wrongful death count and survival count, but not for the emotional distress count. The plaintiff appealed to the First District Appellate Court which reversed summary judgment as to the wrongful death count, but affirmed as to the survival count.

In order to sustain a wrongful death claim on behalf of the fetus, the plaintiff is required to show that, "but for" the defendant's negligence, she would not have been forced to undergo an abortion. Additionally, the plaintiff must show that the abortion was a foreseeable consequence of the defendant's negligence. The Illinois Wrongful Death Act permits wrongful death claims to be brought on behalf of the unborn. The trial court determined that the plaintiff could have continued the pregnancy, waiting until after birth to address her own injuries, but rather "chose to receive medical treatment at the sacrifice of her fetus, thereby, terminating her pregnancy." As such, the decision to terminate the pregnancy was a superseding cause of the fetus's death, and relieved the defendant of liability.

The appeals court emphasized that the proper analytical focus was on proximate cause, and not on the morality of the abortion procedure itself. The court found a factual analogy in a Georgia case, *Shirley v. Bacon*, 154 Ga. App. 203; 267 S.E.2d 809 (1980) which found that the plaintiff's abortion in that case was required because of the negligence of the defendants. Additional cases cited by the court would have been meritorious wrongful death cases, but unborn fetuses were not recognized as persons under the applicable wrongful death acts. The Illinois Wrongful Death Act stipulates however, that, "[t]he state of gestation or development of a human being when an injury is caused, when an injury takes effect, or at death, shall not foreclose maintenance of a cause of action under the law of this State arising from the death of a human being caused by wrongful act, neglect, or default." 740 ILCS 180/2.2.

In light of this provision and the potential medical problems that could have arisen for the plaintiff had she chosen to continue the pregnancy, the court determined that she could maintain a wrongful death action on behalf of the unborn child. The decision to abort the fetus was "closely and reasonably associated with the immediate consequences of the defendant's act, and a normal part of its aftermath." The court also upheld the trial court's dismissal of plaintiff's Survival Act claim since that Act does not classify the unborn as individuals permitted to recover.

The dissent by Justice Cahill, focused on the fact that the fetus was not directly harmed in the automobile accident. As such, the plaintiff's decision to voluntarily abort could not be attributed to the defendant's negligence. The majority responded to the dissent by noting that direct injury to the fetus was not required for a wrongful death action to be maintained. Indeed, absent explicit language to that effect in the Illinois Wrongful Death Act, the court opted not to judicially create such a limitation, leaving this instead to the General Assembly. *Williams v. Manchester*, ___ Ill. App. 3d ___, 864 N.E.2d 963 (1st Dist. 2007).

Bagent v. Blessing Care Corporation: How to avoid a hospital's potential liability for wrongful disclosure of confidential patient information by an employee

By Michael F. Dahlen

A. Introduction

In its recent decision in *Bagent v. Blessing Care Corporation*, 224 Ill.2d 154, 862 N.E.2d 985 (2007), the Illinois Supreme Court held, in a case of first impression, that a hospital was not vicariously liable for the wrongful disclosure of confidential patient medical information by an employee phlebotomist because the disclosure was outside the scope of the employee's employment. Applying the criteria of Section 228 of the Restatement of Agency (Second), the supreme court held that: "All three criteria of Section 228 of the Second Restatement of Agency must be met to conclude that an employee was acting within the scope of employment." *Bagent*, 224 Ill 2d at 165, 862 N.E.2d at 992.

The *Bagent* decision is extremely instructive to hospitals and other medical care employers and employees because the supreme court's holding, in part, was determined by the nature and extent of the actions taken by the hospital in the education, training, and testing of its employees.

Finally, although not specifically addressed by the supreme court, the case suggests the various causes of action that are available against a hospital for the wrongful disclosure of the patient's confidential medical information.

B. Facts

The plaintiff filed a multi-count complaint against the two defendants, Blessing Care Corp. d/b/a Illini Community Hospital and its employee, Misty Young. The plaintiff alleged that she was a patient at Quincy Medical Group and that blood samples and records were sent to the hospital where they were examined by Young. Subsequently, Young revealed to the plaintiff's sister the results of these records while off-duty at a tavern. The plaintiff alleged: (1) a breach of health care practitioner/patient confidentiality, (2) invasion of privacy, (3) negligent infliction of emotional distress and (4) intentional infliction of emotional distress against the employee, Young. These claims were based upon violations of the Hospital Licensing Act, 210 ILCS 85/1 et seq., the Managed Care Reform and Patient's Right Act, 215 ILCS 134/1 et seq., and Article I, Section 12 of the Illinois Constitution, Ill. Const. 1970, Art. I, § 12. Three counts were directed solely against the hospital: (1) breach of health care practitioner/patient confidentiality, (2) invasion of privacy and (3) negligent infliction of emotional distress.

Young was a phlebotomist, a person trained in drawing blood. The hospital required her to attend training sessions regarding a patient's privacy rights. She also signed the hospital's confidentiality policy and its code of conduct which acknowledged that information she obtained while at the hospital was to remain confidential. *Bagent*, 224 Ill.2d at 157, 862 N.E.2d at 988. As part of her employment responsibilities, she received a fax from the Quincy Medical Group containing the results of plaintiff's blood test which indicated that the plaintiff was pregnant. Later, she went to a tavern on a weekend with several others. While at the tavern she met plaintiff's sister who was a waitress. She inquired as to how plaintiff's sister was doing. Sara Bagent, the plaintiff's sister, asked her what she meant. She stated that she did not know that her sister was pregnant. Young immediately apologized for the disclosure. Id. at 158, 862 N.E.2d at 988–89.

In the hospital's answer, it admitted that Young revealed a fact about the plaintiff, discovered from her medical records, to plaintiff's sister at a tavern. However, the hospital alleged that, at the time of disclosure, Young was not acting within the scope of her employment with the hospital. Id. at 159, 862 N.E.2d at 989. Young filed a separate answer admitting that she was an employee of the hospital at the time of occurrence and that she had inadvertently revealed the test results in a private conversation with plaintiff's sister. Id. at 159–60, 862 N.E.2d at 989.

The hospital filed a motion for summary judgment asserting that Young's statement was not attributable to it because Young's actions were not within the scope of her employment; she was trained in confidentiality; and she knew that she had violated plaintiff's rights as soon as she had told the plaintiff's sister about plaintiff's pregnancy. Young filed a separate motion for summary judgment.

The court granted summary judgment in favor of the hospital and Young on the statutory causes of action, finding that the statutes did not authorize a private right of action. Id. at 160, 862 N.E.2d at 989–90. The court also granted the hospital's motion for summary judgment finding that Young was not acting within the scope of her employment for the hospital at the time of the disclosure. Accordingly, the hospital was not vicariously liable for Young's disclosure. However, the court held that the plaintiff stated a common law cause of action against Young for invasion of privacy. Id. at 160, 862 N.E.2d at 990. The court also granted plaintiff's cross-motion for partial summary judgment as to liability against Young regarding whether Young improperly revealed confidential information. Finally, the court declined to enter a summary judgment against Young and in favor of the plaintiff regarding the negligent and intentional infliction of emotional distress counts. It reserved those counts for trial. Id at 160, 862 N.E.2d at 989–90.

On appeal, the Illinois Appellate Court, Fourth District, reversed the hospital's summary judgment, finding that although the disclosure of plaintiff's medical information was not the kind that the employee, Young, was employed to perform, nor was she was working as a phlebotomist at the time of the prohibited disclosure, a question of fact existed as to whether the

purpose of her disclosure was to serve her employer, the hospital. *Bagent v. Blessing Care Corporation*, 363 Ill. App.3rd 916, 844 N.E.2d 469 (4th Dist. 2006). The dissent observed that the only interpretation that could be given to the undisputed facts was that the employee's conduct was not motivated by a purpose to serve the hospital.

On appeal, the supreme court reversed the judgment of the appellate court and affirmed the summary judgment of the circuit court in favor of the hospital. The key issue on appeal was whether all three criteria of Section 228 of the Second Restatement of Agency must be met before an employee can be found to be acting within the scope of his or her employment. The Restatement of Agency (Second), Section 228, provides that the conduct of a servant is within the scope of employment if: (1) it is the kind that he is employed to performed; (2) it occurs substantially within the authorized time and space limits; (3) it is actuated, at least in part, by a purpose to serve the master; and (4) if a force is intentionally used by the servant against another, the use of force is not un-expectable by the master. Since force was not an issue in *Bagent*, the issue was whether all three remaining criteria had to be met before liability could be imposed.

In holding that all three criteria of Section 228 of the Restatement had to be met before there could be a finding that an employee was acting within the scope of employment, the supreme court held that the plaintiff failed to establish that Young's disclosure of her medical information was the kind of conduct which she was employed to perform and, therefore, criterion one was not met. *Bagent*, 224 Ill.2d at 167–68, 862 N.E.2d at 994. As the court noted "Young was not employed to divulge confidential patient information while off-duty and after-hours in a tavern." Id. at 167, 862 N.E.2d at 993. The court went on to say that the fact that the hospital "expressly forbade Young to reveal patient information bolsters our conclusion." Id. at 167, 862 N.E.2d at 994.

Regarding the second criterion, whether the conduct occurred substantially within the authorized time and space limits of the employment, the appellate court had noted that Young was not working as a phlebotomist at the time of her disclosure. In observing that the appellate court held that "in effect, for purposes of patient confidentiality, Young was on duty 24 hours a day, seven days a week," the supreme court held, "[I]t is clear that the first and third criteria of Section 228 of the Second Restatement of Agency are absent from the case. Accordingly, we need not discuss the second criterion and do not express an opinion on the correctness of the appellate court's analysis with respect thereto." Id. at 169, 862 N.E.2d at 994. The supreme court declined to specifically address whether a hospital employee with access to confidential information would be considered on-duty 24 hours a day, seven days a week, and, accordingly, negate the second criterion that the conduct occurs substantially within the authorized time and space limits of his or her employment.

Regarding this second criterion, the appellate court had stated, "our appellate court has dealt with a similar view of the extended scope of the master-servant relationship with regard to police officers." *Bagent*, 363 Ill.App.3d at 923, 844 N.E.2d at 476. Relying on the decision in *Gaffney v. City of Chicago*, 302 Ill.App.3d 41, 706 N.E.2d 914 (1st Dist. 1998), the appellate court stated:

> Just as the police officer in *Gaffney* had a continuing off-shift duty to possess and maintain his service weapon so that he could protect the public, Young had a continuing off-shift duty to maintain the confidentiality of patient records. This duty derived not only from the hospital's rules of employment, but also from the patient's right of privacy. As the *Gaffney* court noted, even the violation of a master's direction does not obviate the liability of the master under a theory of respondant superior. 363 Ill. App.3d at 923, 844 N.E.2d at 476.

In his dissent, Judge Turner, succinctly rejected this analogy. He observed:

> The majority also fires a blank in attempting to liken the facts before us with cases involving off-duty police officers. Young was not employed to use the confidential information for the purpose of idle chit-chat in a tavern; in contrast to a police officer who might use a gun in an emergency while 'off-shift.' At the tavern, Young did not identify herself as working for Illini Hospital or representing her employer's interest. The fact that she was committing a serious breach of confidentiality, for which she later resigned, indicates that the act was not one that follows within the scope of employment. Id. at 924, 844 N.E.2d at 478.

This point was also addressed by the three amicus curiae briefs filed on behalf of the hospital by the Illinois Association of Defense Trial Counsel, Cook County, and the Illinois Hospital Association (IHA's motion for leave to file an amicus was denied). As observed by the amicus filed by the Association of Defense Trial Counsel, the appellate court's decision stood for the proposition that any business maintaining confidential information could be vicariously liable for an employee's unauthorized and improper disclosure even though it occurred at an off-premises location during non-working hours, and when it did not further any legitimate business purposes of the employer. In effect, the appellate court's decision essentially imposed "strict liability" in that liability could be imposed regardless of the best internal controls in handling confidential information.

In addressing the Fourth District's "24/7" analogy, Cook County's brief argued that this analogy was fatally defective. Although police officers have a continuing duty to serve and protect the public while off-duty, a healthcare employee had no such responsibility. Unlike a police officer, a healthcare employee does not serve and protect the public, particularly while conversing in a tavern. In addition, in *Bagent*, the employee served absolutely no purpose for the hospital by this prohibited disclosure. So too, the Illinois Hospital Association's amicus brief pointed out that the appellate court's decision threatened to make hospitals strictly liable for the acts of its employees 24 hours a days, seven days a week. In addressing this same theme, the amicus brief filed on behalf of the plaintiff by the Illinois Trial Lawyers Association argued that it was only "fair that the loss resulting from the employee's acts should be considered as one of the normal risks to be borne by the hospital." Amicus brief at 8.

A hospital will be hard pressed to argue that confidentiality should not be maintained "24/7." However, liability is not automatically imposed where

an employee improperly discloses this information, unless the hospital violated some independent duty owed to the patient concerning its administrative or managerial obligations, such as failure to train or supervise employees. *Advincula v. United Blood Services*, 176 Ill.2d 1, 678 N.E.2d 1009 (1996); *Jones v. Chicago HMO Limited, Ltd., of Illinois*, 191 Ill. 2d 278, 730 N.E.2d 1119 (2000).

In *Bagent,* the supreme court held that all three criteria of Section 228 of the Second Restatement of Agency had to be met. *Bagent*, 224 Ill.2d at 165, 862 N.E.2d at 992. Since it agreed with the appellate court that the first criterion was not met, there was obviously no need to analyze the second or third criteria. Nevertheless, the supreme court acknowledged the second criterion, regarding time and space, but stated that it did not need to discuss it since it was "clear that the first and third criteria of Section 228 of the Second Restatement of Agency are absent from this case." Id. at 169, 862 N.E.2d at 994. If all three criteria had to be met and the first criterion was absent (the conduct was the kind he was employed to perform), why was there a need to even refer to the second or third criteria?

Perhaps the supreme court addressed the third criterion, although not required to do so, based upon its finding that "the appellate court clearly misapprehend the import of the third criterion of Section 228 of the Second Restatement of Agency." Id. at 169, 862 N.E.2d at 995. The appellate court focused its analysis on the "state of mind" of the business, i.e., were the needs and requirements of the business being satisfied or met by the employee's actions? The appellate court held that "the duty not to [disclose confidential information] is actuated by the needs and requirements of the employer." 366 Ill.App.3d at 924, 844 N.E.2d at 475. As pointed out by the supreme court, however, "it is the state of mind of the employee that is material." 224 Ill.2d at 170, 862 N.E.2d at 995. The third criterion requires that the conduct be actuated, at least in part, by a purpose to serve the master. "However, it is only from the manifestations of the employee and the surrounding circumstances that, ordinarily, the employee's intent can be determined." Id. at 170, 862 N.E.2d at 995. The court then went on to conclude that there was no genuine issue of material fact as to Young's motivation for disclosing plaintiff's confidential medical information. She was in no way motivated to serve the hospital. By her own admissions, Young's motivation was personal, not professional, when she made the disclosure.

Although the supreme court cited two foreign jurisdictions that dealt with the third criterion, whether an employee's conduct was actuated, at least in part, by a purpose to serve the master, *Hentges v. Thomford*, 569 N.W.2d 424, 427–29, (Minn. App. 1997) and *Snilsberg v. Lake Washington Club*, 614 N.W.2d 738 (Minn. App. 2000), it did not cite the decisions of other jurisdictions that also held that a medical employer is not liable for an employee's unauthorized disclosure of confidential information. For example, in *Jones v. Baisch*, 40 F.3d 252 (8th Cir. 1994) the Eighth Circuit addressed the same issue. In that case, Region West, a pediatric institution, employed Joyce Hallgren and her daughter, Jenni, as a nurse and nurse's assistant, respectively. Jones, a patient at Region West, sought treatment for genital herpes. Joyce discovered Jones' diagnosis and warned her daughter, Jenni, during a family discussion regarding sexuality. After confirming the diagnosis with Jones' medical records, Jenni informed her friends and some of Jones' friends about his herpes. Jones brought suit against the nurses and Region West under a respondant superior theory. In applying Nebraska law (which also adopted Section 228 of the Restatement (Second) of Agency), the court held, as a matter of law, that this conduct fell outside the scope of employment because the nurses were not authorized to reveal the patient's medical records; the disclosure of the herpes did not occur within the authorized work time and space limits; and the disclosure was not actuated by a purpose to serve Region West. The court relied on Region West's handbook which specifically forbade disclosure of medical records and Region West's immediate reprimand of the nurses.

In *Korntved v. Advanced Healthcare, S.C.*, 286 Wis.2d 499, 704 N.W.2d 597 (Wis. App. 2005), the plaintiffs, Sherry Korntved and her daughter, Amanda Howell, sued Lu Anne Howell and her employer, Advanced Healthcare, alleging that Lu Anne Howell, who was a lab technician, improperly accessed and disclosed their medical records. The disclosure was made to Lu Anne Howell's husband who was the father of the plaintiff, Amanda Howell. The employer was sued on a vicarious liability theory for the alleged acts of its employee, Lu Anne Howell. The employer's motion for summary judgment was granted and the plaintiffs appealed asserting that there was a genuine issue of material fact as to whether the employee was acting within the scope of her employment at the time of the disclosure.

The court discussed the standard used to determine if an employee was acting within the scope of the employment. The court considered whether accessing and disclosing the records was authorized by the employer and if it benefited the employer's business. In concluding that neither of these requirements were met, the court stated that "there is nothing in the record, as of the time of the summary judgment motion, to support an inference that Lu Anne (the employee) was attempting to benefit or serve her employer when she accessed the medical records. The hospital also had a policy which specifically forbade the very actions of the employee for which the plaintiff was attempting to hold the hospital liable. Because the policy "undisputedly and expressly" prohibited accessing a patient's record for non-work purposes, the employee's conduct was in contradiction of the employer's policy and found to be outside the scope of employment. 286 Wis. 2d at 512–13, 704 N.W.2d at 604.

Conclusion? It is clear that all criteria of Section 228 of the Restatement of Agency (Second) must be met before an employee can be found to be acting within the scope of his or her employment in order to impose vicarious liability on the part of the employer.

What other lessons can be learned from *Bagent*?

C. Causes of Action Which are Applicable to Disclosure of Confidential Information

As the supreme court noted in *Bagent*, the plaintiff pleaded several statutory causes of action including:

1. Breach of health care practitioner/patient confidentiality;
2. Invasion of privacy.

These causes of action were based upon alleged violations of the Hospital Licensing Act, 210 ILCS 85/1 et seq., the Manage Care Reform and Patient

Rights Act, 215 ILCS 134/1 et seq., and Article I, Section 12, of the Illinois Constitution, Ill. Const. 1970, Article I, §12.

In addition, the plaintiff also pleaded the following common law causes of action:

1. Negligent infliction of emotional distress (against the hospital and Young);
2. Intentional infliction of emotional distress (against Young only).

The circuit court dismissed the statutory causes of action. On appeal to the supreme court, the plaintiff did not raise any issues as to whether the Constitution or the various statutes created a private cause of action. Accordingly, this was never an issue addressed by the supreme court. However, the supreme court did address the issue of vicarious liability based upon the remaining counts that the circuit court did not strike as a matter of law, i.e., a common law right to privacy and negligent and intentional infliction of emotional distress.

The court observed that the circuit court invited the plaintiff to amend her complaint to allege a cause of action for negligent hiring or negligent training. 224 Ill.2d at 161, 862 N.E.2d at 990. The plaintiff declined to do so. In her supreme court brief, the plaintiff stated that she, "concedes that the issues of negligent hiring or training are not before this court."

Illinois recognizes two theories upon which a hospital can be liable: respondeat superior and an independent duty owed by the hospital to a patient. See *Lo v. Provena Covenant Medical Center*, 342 Ill.App.3d 975, 796 N.E.2d 607 (4th Dist. 2003). This independent duty has been referred to as "institutional" or "corporate" negligence and concerns the hospital's administrative and managerial obligations. *Advincula v. United Blood Services*, 176 Ill.2d 1, 678 N.E.2d 1009 (1996); *Jones v. Chicago HMO Limited, Ltd. of Illinois*, 191 Ill.2d 278, 730 N.E.2d 1119 (2000). "Liability [under the theory of institutional negligence] is predicated on the hospital's own negligence not the negligence of the physician [or employee]." *Jones*, 191 Ill.2d at 292, 730 N.E.2d at 1128.

The supreme court in its analysis of the first criterion (whether the conduct was the kind Young was employed to perform) expressly acknowledged the hospital's extensive training, instruction, supervision and testing. However, if it can be established that the disclosure of confidential medical information was the result of a hospital's failure to: (1) institute appropriate policies or procedures; (2) properly train employees; or (3) supervise employees regarding privacy issues or the non-disclosure of medical records, the hospital could be found liable under an institutional negligence theory which was not argued by the plaintiff in *Bagent*.

These two theories provide an appropriate balance of a patient's right to privacy and a hospital's responsibility to properly train and supervise its employees. Institutional negligence affords protection for a patient who has been injured as a result of the hospital's own wrongful acts. Adherence to this theory also provides protection to hospitals for actions taken by employees who choose to deliberately or negligently ignore the hospital's established policies despite having been properly instructed and trained concerning the confidentiality of patient records and information.

D. Steps to Avoid Vicarious Liability for Improper Disclosure of Confidential Information By Employees

The outcome of *Bagent* was reached, in part, due to the hospital's extensive training, education and testing of its employees. If anything, the *Bagent* decision reaffirms the need for a hospital (or any employer) to properly train, supervise, educate and test its employees. As the supreme court noted in *Bagent*, Illini Hospital required its employees to attend a training session regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104 – 191, 110 Stat. 1936) and its privacy provisions. "Young attended the session and signed the hospital's confidentiality policy and code of conduct, acknowledging in each document that she understood and accepted its terms. Attendees at the training session received a motto to remember: 'What you see here, and what you hear here, remains here.'" 224 Ill.2d at 157, 862 N.E.2d at 988.

Although not set forth in detail in the supreme court's decision, the record reflects the hospital's extensive training of Misty Young. She was employed for approximately two years, from August 2, 2001 to October 14, 2003. When she began work at the hospital, the administrative director of human resources conducted an orientation session with Ms. Young. At that time, she instructed Ms. Young that what she saw or heard at the hospital was confidential and could not be shared with a patient's family members, friends or third persons, either inside or outside the hospital.

During Young's first month as a phlebotomist, her supervisor provided her with orientation which included reviewing matters that were included on an orientation checklist. Issues concerning confidentiality of patient's records and health information were discussed and reviewed in this orientation, as well as in subsequent evaluations and meetings. She signed a confidentiality agreement when she was first employed. She specifically understood that this agreement provided that "everything is confidential."

In 2003, after HIPAA was passed, but before it took effect, posters were displayed throughout the hospital concerning confidentiality of patient records and health information. These posters were a constant reminder to employees that what they saw or heard at the hospital was never to be disclosed.

Misty Young attended a hospital training session on HIPAA privacy rules and requirements. Prior to that session and other sessions, each employee was given a packet of material containing information regarding the privacy rule, its scope, its requirements and the obligations of employees who had access to patient information. The employees were asked to review the information which was reviewed and discussed during training sessions.

During these training sessions, employees were shown a video tape regarding patient confidentiality. After the video tape was shown, the "privacy officer" for the hospital presented a slide program that served as an outline for the privacy rule, its scope, its requirements and the obligations of employees who had access to such information. Each employee was provided with a copy of the hospital's confidentiality policy which included a confidentiality agreement that each employee was required to sign.

The policy provided:

> Although the use of confidential information may be needed for individual job performance, it must not be shared with others unless there is a legitimate need to know. Employees don't

> automatically have a right to see or hear confidential patient or business information. To see such information, an employee must need it to provide care or perform his/her job (billing, record keeping, care delivery).
>
> It shall be a violation of this policy to willfully participate in or knowingly permit, either access to, or dissemination of patient, employee, physician or business information data to unauthorized parties. Violation of these policies may result in immediate discharge ....

The confidentiality agreement which Young signed provided:

> I hereby agree that I will not at any time, during my employment, ... or after my employment ... ends, access or use personal or corporate health information, or reveal or disclose to any person(s) within or outside the Blessing system, any personal health or corporation information except as may be required in the course of any duties and responsibilities and in accordance with applicable Legislation and internal policies governing proper disclosure of information.

After signing the confidentiality agreement, the employees were given an eight-page code of conduct. The last page included an acknowledgment form which the employee signed and returned. After Ms. Young participated in one training session, the administrative director of human resources tested her by going to the lab where Ms. Young was working and asking to see medical records of the director's sister who was seriously ill at the time. The director tried to convince Ms. Young that it would be okay if she looked at her sister's records since her sister would not care and since the doctor specifically told her that she could look at the records. Ms. Young, in compliance with her training, continually refused to allow her to review her sister's medical records. The administrative director then tested another employee of the lab who allowed her to access her sister's records. After these tests, the administrative director met with Ms. Young and the other employee and explained to them that Ms. Young had done exactly what she was suppose to do, i.e., refuse to allow the director access to the medical records.

As these facts reveal, a hospital is well advised to provide extensive training, supervision and testing to ensure that it meets its obligation regarding protecting a patient's confidential medical records.

E. Coverage Issues

Generally a hospital's medical malpractice insurance will cover its employees who are acting within the scope of their employment when the alleged negligent act or omission occurred. In *Bagent*, Misty Young was an employee of the hospital. However, the disclosure of confidential medical information obviously did not occur within the scope of her employment. When this infraction was brought to the attention of the hospital, Ms. Young was given the opportunity to resign rather then being terminated. She resigned.

Based upon the fact that Ms. Young was not acting within the scope of her employment when she disclosed the confidential information after hours at a tavern, and was terminated, the insurer declined to provide a defense. Ms. Young retained separate counsel who subsequently withdrew.

Generally, an insurer is obligated to defend an insured even if the allegations may be false. *Thorton v. Paul*, 74 Ill.2d 132, 384 N.E.2d 335 (1978). An insurer may refuse to defend if it is clear from the face of the allegations that they do not state facts which would bring the case potentially within coverage. *Conway v. Country Casualty Insurance*, 92 Ill.2d 388, 442 N.E.2d 245 (1982). In *Bagent*, a decision was made that the disclosure of the confidential information was not within policy coverage because it was not made during or within the scope of Young's employment. Although an insurer must defend even if only one of several theories of causes of action fall within policy coverage, *Maryland Casualty v. Peppers*, 64 Ill.2d 187, 355 N.E.2d 24 (1976), if the alleged causes of action did not occur within one's scope of employment, there should be no duty to defend.

A hospital insurer's decision not to defend cannot be made lightly. For example, in *Bagent,* during the plaintiff's appeal from the summary judgment in favor of the hospital, the trial court set a hearing for prove-up of plaintiff's damages against Misty Young. The circuit court had previously granted plaintiff's motion for partial summary judgment against Young for improperly revealing plaintiff's confidential information. However, the issue of damages was reserved for trial. At the hearing, the plaintiff did not testify. Rather, her attorney submitted affidavits of the plaintiff and her sister. The co-defendant, Misty Young, appeared pro se. The court entered a judgment in favor of the plaintiff and against the defendant, Misty Young, in the amount of $700,000. The affidavits of Suzanne and Anne Bagent where immediately "impounded."

A citation to discover assets was subsequently served on Misty Young. Following a hearing on plaintiff's citation to discover assets, the court ordered Young to execute an "assignment." The citation to discover assets was then dismissed. The contents of the assignment are unknown because it was not made part of the court record, i.e., no copy of the assignment was ever filed with the circuit court nor was a court reporter present to transcribe the proceedings. It can only be assumed that Misty Young assigned her potential cause of action against the hospital's insurer for failure to defend her.

The point is clear, care must be taken before a final determination is made by the insurer for the hospital or medical employer to deny coverage where there is a question as to whether an employee was acting within the scope of employment when confidential medical information was disclosed.

F. Conclusion

To avoid vicarious liability for an employee's disclosure of confidential patient information, the disclosure by the employee must be outside the scope of his or her employment. Further, in order to avoid liability for institutional negligence, education, training and testing of employees are mandatory. A confidentiality policy and code of conduct are extremely helpful. Failure to do so may subject the employer to liability for negligent hiring or training.

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1. Michael F. Dahlen is a partner with Feirich/Mager/Green/Ryan, Carbondale, Illinois. He represented the appellant-hospital before the Illinois Supreme Court in the Bagent case.

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Cases

Federal decisions

Seventh Circuit rejects defamation suit against expert witness

Medical malpractice litigation has been and continues to be rough on the litigating parties, including in particular physicians who are sued. A recent diversity-based decision from the Seventh Circuit Court of Appeals shows what can happen after a physician is confronted with adverse and apparently mistaken expert testimony from a fellow physician—a defamation suit. In the end however, the plaintiff-physician's suit failed.

The plaintiff-physician had performed an anterior cervical discectomy on a patient who later sued her for malpractice in an Illinois state court. The defendant testified as an expert witness for the patient in her suit. Apparently, during the operation, the patient's esophagus had been punctured. She alleged that the puncture was due to the plaintiff-physician's negligence. In his deposition, the defendant-expert testified that the plaintiff-physician was negligent and was responsible for the puncture. He testified that plaintiff had misplaced the surgical retractors. However, the plaintiff-physician alleged that according to all evidence and the consensus views of other surgeons, the retractors had not been improperly positioned. After the trial court granted her summary judgment, the plaintiff-physician filed this suit under Illinois law claiming defamation and breach of contract. The federal district court dismissed and the plaintiff appealed.

On appeal, the Seventh Circuit looked to established Illinois law in ruling that the defendant-expert's testimony was protected by an absolute privilege. As Judge Posner observed in his opinion, "The privilege mainly protects against suits for defamation; however reckless or dishonest the testimony, the witness cannot be sued because of its defamatory content." Judge Posner acknowledged a limited and inapplicable exception for "defamatory testimony [that] is unarguably irrelevant to the case in which it was given." In the court's view, the best way to address the problems associated with abusive expert testimony in medical malpractice actions is through active screening by trial judges, and not by allowing for defamation suits such as this.

The plaintiff-physician also advanced a breach of contract claim based on the expert testimony rules of the American Association of Neurological Surgeons. Both parties had been members of this professional group, although the defendant has been expelled for violating its rules. The Association's rules, in relevant part, require that members, as expert witnesses, "shall represent and testify as to the practice behavior of a prudent neurological surgeon giving different viewpoints if such there are" and "shall identify as such any personal opinions that vary significantly from generally accepted neurological practice." The plaintiff argued that by joining the Association, the defendant had agreed to be bound by these rules and had waived his testimonial privilege. In turn, the plaintiff claimed that as a member of the Association, she was a third party beneficiary of this contract between the Association and the defendant, and could enforce these rules. The court disagreed and upheld dismissal of the suit. *MacGregor v. Rutberg*, No. 06-2829 (7th Cir., Feb. 27, 2007)

Whistleblower retaliation claim rejected

The Seventh Circuit Court of Appeals has upheld a district court ruling dismissing an employee's claim that she had been fired for being a "whistleblower" with respect to alleged government fraud at a university medical faculty practice foundation.

The employee had contacted the Federal Bureau of Investigation (FBI) to report that the defendant, facing substantial debt, had lied to federal authorities in order to obtain a federal loan and

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to protect its bond rating. The employee did not have access to the defendant's financial records and had based her accusations on a magazine article and workplace rumors. As the appeals court observed, "neither [plaintiff] nor anyone who passed the gossip on to her knew about any concrete false statement made to the Federal Reserve or any other federal agency, and neither a federal prosecution nor a qui tam action under the False Claims Act, 31 U.S.C. §3730, ensued."

The plaintiff-employee was later terminated, the defendant said, because the grant that paid for her position had come to an end. Claiming that she had lost her job for contacting the FBI, the plaintiff sued under §3730(h) of the False Claims Act which gives employees a civil remedy should retaliation occur on account of "lawful acts done by the employee on behalf of the employee or others in furtherance of an action under [§3730], including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under [§3730]. . . ." Because there was no action filed or to be filed in this case under the False Claims Act, the trial court ruled there could be no remedy for the plaintiff-employee under §3730(h). The Seventh Circuit found the trial judge's ruling in this regard was "spot on" and affirmed the dismissal of her claim. In the appeals court's view, what the plaintiff "actually believed [regarding the defendant's actions] is irrelevant, for people believe the most fantastic things in perfect good faith; a kind heart but empty head is not enough. The right question is whether her belief had a reasonable objective basis, and sensible jurors could not find that it did."

The court closed noting, as to the plaintiff's claims under state law, that "Illinois law likewise protects only objectively reasonable reports, so the district judge properly dismissed [her] state-law claim of retaliatory discharge" as well. *Lang v. Northwestern University*, No. 06-1515 (7th Cir., Dec. 28, 2006).

Federal district court allows consumer fraud claim for hospital billing practices

Over the last several years, plaintiffs throughout the nation have challenged the billing practices of tax-exempt hospitals in terms of uninsured patients. As discussed in the December, 2006 issue of the Health Care Lawyer, the Second District Appellate Court in *Rockford Memorial Hosp. v. Havrilesko*, 368 Ill. App.3d 115, 858 N.E.2d 56 (2d Dist. 2006) rejected such a claim under the Illinois Consumer Fraud and Deceptive Business Practices Act (Consumer Fraud Act), 855 ILCS 505/1 et seq. In a recent decision, the Federal District Court for the Northern District of Illinois reached a different decision.

The plaintiff was uninsured, with little in the way of income or assets, when she received care at the defendant, a tax-exempt, not-for-profit hospital. She alleged she was billed nearly $900 by the hospital, an amount she claimed was significantly higher than what would have been charged to an insured patient. When the plaintiff failed to pay her bill, the hospital turned her account over to a collection agency. The plaintiff also alleged that she was never told of the hospital's charity care policy and received no response to her request for a charity care write-off application form. As a result, the plaintiff filed suit against the hospital under the Consumer Fraud Act, as well as on contract and unconscionability theories. The hospital filed a motion to dismiss. The district court granted the motion with respect to the contract claim, but otherwise refused to dismiss the remainder of the complaint.

As to the claim under the Consumer Fraud Act, the court began by noting that the Act prohibits unfair acts in connection with any trade or commerce. To establish unfairness under the Consumer Fraud Act, a plaintiff must show that the activity in question, "(1) violates public policy; (2) is immoral, unethical, oppressive or unscrupulous; or (3) substantially harms consumers." Further, the court observed that, "A practice may be unfair because of the degree to which it meets one of the criteria or because to a lesser extent it meets all three." The plaintiff argued, and the court agreed, that her allegations against the hospital were sufficient to meet all three factors because its actions (1) violated public policy as expressed in the Illinois Revenue Code's charitable organization exemption; (2) forced ill, indigent people to accept the high billing rates or forego treatment; and (3) injured uninsured consumers, who are required to pay up to three times more than insured consumers for the same medical services. The court rejected the hospital's argument that its billing practices were not a commercial activity within the scope of the Consumer Fraud Act.

The court also found that the plaintiff's complaint was sufficient to state a claim under the theory of unconscionability. In the court's words, this theory provides grounds, "for nullifying a contract or one of its terms if it 'is so difficult to find, read or understand that the plaintiff cannot fairly be said to have been aware [s]he was agreeing to it' or 'inordinately one-sided in one party's favor.'" *Hill v. Sisters of St. Francis Health Services, Inc.*, No. 06 C 1488 (N.D. Ill., Dec. 20, 2006).

Court refuses to dismiss EMTALA claim

A federal district court in December refused to dismiss a plaintiff's claim under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd. In the case, the plaintiff alleged that, when she appeared at the defendant-hospital's emergency room in labor, the hospital neither provided an appropriate medical screening examination nor care to stabilize her condition as required by EMTALA. She joined a state law claim for intentional infliction of emotional distress with her EMTALA claim.

The hospital sought to dismiss the suit in part on the basis that the plaintiff had failed to meet the requirements of 735 ILCS 5/2-622 in that she did not include with her complaint an affidavit stating that her attorney had consulted a health care professional, and that this professional has determined that "there is a reasonable and meritorious cause for the filing of such action . . . ." In the court's view, 2-622's state medical malpractice claim requirement, was wholly inapplicable to the plaintiff's federal suit. The court also found the requirements of 2-622 inapplicable to the plaintiff's intentional infliction of emotional distress claim based on the hospital's alleged EMTALA violation. The court concluded that the plaintiff had properly pled a claim under EMTALA and that the hospital's motion to dismiss should be denied. *Barrios v. Sherman Hospital*, 06 C 2853 (N.D. Ill., Dec. 15, 2006).

Illinois decisions

Off duty employee not within the scope of employment when disclosing medical information

In a closely watched case relating to the wrongful disclosure of confidential patient information by an off duty employee, the Illinois Supreme Court reversed the appellate court, affirmed

the circuit court, and remanded the case for further proceedings.

In this case, a hospital employee, while off-duty and at a tavern, revealed the fact of the plaintiff-patient's pregnancy to others at the tavern. In response to the patient's suit against both the employee and the hospital for this disclosure, the hospital moved for summary judgment. The trial court granted the motion, finding that the employee's disclosure was not made in the course of her employment or for the hospital-employer's purposes. On appeal, the Fourth District Appellate Court reversed.

In its analysis, the appellate court noted the basic rules of respondeat superior, including the element that, for the employer to be held liable for the acts of an employee, the acts must have been committed within the "scope of the employment." From this perspective, the court found that the hospital's, and in turn its employees' duty, to protect patient information from inappropriate disclosure is not limited in time or place. "It was [the employee's] job, at all times and in all places, to refrain from unauthorized disclosures of patients' medical information." Thus in the appellate court's view, the hospital could be held liable for the off-duty disclosure. *Bagent v. Blessing Care Corp.*, 363 Ill. App. 3d 916, 844 N.E.2d 469 (4th Dist. 2006).

The Supreme Court disagreed. It held that in order to support the conclusion that an employee is acting within their scope of employment, all three factors of section 228(1) of the Restatement (Second) of Agency must be satisfied. In relevant part, section 228(1) provides as follows:

(1) Conduct of a servant is within the scope of employment if, but only if:
   (a) it is of the kind he is employed to perform;
   (b) it occurs substantially within the authorized time and space limits; [and]
   (c) it is actuated, at least in part, by a purpose to serve the master,

In the instant case, the supreme court ruled that the first and third criteria were missing and that therefore the off duty employee could not be seen as acting within the scope of her employment, allowing the hospital to avoid liability for her disclosure. In deciding the case, the court focused on the actual duties that the employee was hired to perform. The court concluded that the disclosure of confidential information while off duty at a tavern was not incidental to the employee's employment responsibilities. The court further observed that the hospital had an explicit prohibition on such conduct. Finally, the court found that it was obvious that the employee's motivation for disclosing the information was purely personal and was in no way an attempt to serve the hospital's interests. *Bagent v. Blessing Care Corp.*, No. 102430 (Ill. Sup., Jan. 19, 2007).

Appellate court applies "rule of nonreview"

In the context of medical staff decisions by private hospitals, Illinois, like most states, has long adhered to what is referred to as the "rule of nonreview." Under this rule, a court will not review the internal medical staffing decisions of private hospitals except to assure that the hospital has followed its own bylaws when a physician's existing staff privileges are revoked, suspended, or reduced. *Garibaldi v. Applebaum*, 194 Ill. 2d 438, 742 N.E.2d 279 (2000). A February decision from the First District Appellate Court relied on this rule in upholding the dismissal of a physician's suit against a hospital and several other physicians.

In this case, the plaintiff, an orthopedic surgeon, was on the staff of the defendant-hospital. He worked there with two other orthopedic surgeons, also named as defendants, who were partners in another defendant, a limited-liability company that operated an orthopedic surgery practice at the hospital, as well as at other private hospitals and clinics.

Beginning in December of 1995, the plaintiff repeatedly voiced complaints to the defendant-surgeons and to other personnel at the hospital about his assignments and treatment as a member of the medical staff. In 2003, he initiated a formal grievance under the hospital's bylaws, raising numerous issues, including that he had not been assigned an equitable share of the emergency room hand-trauma call, did not have access to orthopedic surgery residents in his surgeries or office clinics, had not been given the opportunity to perform teaching duties in the surgery department, and had not been allowed to participate in developing proposed revisions to surgery department governance rules. Displeased with the progress of the grievance procedure, the plaintiff withdrew his grievance and filed this suit seeking damages for tortious interference with contractual relations, tortious interference with prospective economic advantage, and breach of contract. The trial court ruled that plaintiff was not required to exhaust his remedies under the hospital's grievance procedures, but that his claims should be dismissed because the conduct underlying his claims was not subject to judicial review. He then appealed.

On appeal, the court noted the rule of nonreview as stated in *Garibaldi* and other Illinois cases. The plaintiff argued however, that this rule should not apply here, because "the doctrine applies solely to staffing decisions involving hospital appointments and privileging." The appellate court rejected this view. As it stated, "*Garibaldi* did not involve the grant, denial, or discipline of the plaintiff's medical privileges, [yet] the supreme court applied the doctrine of 'nonreview' to the hospital's administrative decision to enter into the exclusive contract for open-heart surgeries. Implicit in the court's decision was the recognition that hospital staffing decisions include determinations regarding the assignment of particular tasks and responsibilities." From this perspective, the court concluded the rule of nonreview had been properly applied to the plaintiff's action by the trial court. *Goldberg v. Rush University Medical Center*, No. 1-06-1005 (Ill. App. 1st Dist., Feb. 20, 2007).

Class action can proceed against hospital records retrieval and copying service

After a private company, under contract with a hospital to provide medical record retrieval and copying services, charged a patient $34 in order to receive a copy of her six-page medical record, the patient filed suit against the company. The plaintiff's complaint alleged that the copying charges were unreasonable under common law, that the company violated the Inspection of Hospital Records Act (Hospital Records Act), 735 ILCS 5/8-2001, that the fees were deceptive and misleading in violation of the Consumer Fraud Act and Deceptive Business Practices Act (Consumer Fraud Act), 815 ILCS 505/1 et seq., and that the company was unjustly enriched due to the excessive fees.

The trial court granted summary judgment for the defendant-company

on all counts. The trial court held that the plaintiff's claims were barred by the voluntary payment doctrine. However, on appeal, the appellate court stated that this doctrine can be defeated if a plaintiff can show that the payment was not voluntary because some necessity caused the payment to be made due to compulsion. The appellate court also stated that a plaintiff need not protest the charge at the time, so long as they can demonstrate that there was duress. In order to prove duress, a plaintiff must show that the service in question is a necessity and no reasonable alternative exists.

In this case, the hospital did not allow access to medical records without utilizing the services of the defendant-company. Therefore, the appellate court held that because no reasonable alternative of obtaining medical records existed, the plaintiff's allegations were enough to raise a material issue of fact relating to duress and thus survived summary judgment.

The court stated that hospitals can use private copying services as a means to comply with the Hospital Records Act. However, the hospital must act reasonably when implementing a relationship of this nature. Excessive charges by a private record company may violate the intent of the Hospital Records Act. However, the court also held that the legislature did not intend to create a private right of action under the Hospital Records Act. As such, the appellate court affirmed the summary judgment in favor of the defendant on the issue of the Hospitals Record Act.

As to the Consumer Fraud Act claim, the court held that there was sufficient evidence to reverse the summary judgment granted by the lower court. The appellate court also reiterated that the Consumer Fraud Act should be construed liberally in order to promote its purpose.

Lastly, the appellate court, reasoning that the plaintiff's interests are the same as absent class members, determined that the plaintiff should be allowed to proceed with the suit as a class action. The court further opined that the plaintiff had sufficient interest in the matter to vigorously advocate for the cause and that a class action will not fail merely because factual differences exist between the individual class members' grievances.

Ramirez v. Smart Corp., No. 3-05-0774 (Ill. App. 3d Dist., Feb. 16, 2007).

Firm successfully appeals fee award in malpractice suit

A decision from First District Appellate Court pertains to the awarding of attorney fees in medical malpractice litigation. The plaintiff wished to sue the defendant-hospital for medical malpractice on behalf of his deceased wife. Two law firms declined to take the case, and with a few weeks remaining on the statute of limitations, a third firm accepted the case. The firm was expanding its operations to Europe, and explained to the plaintiff that the trial would be time consuming and costly. For those reasons, the firm proposed to take the case in exchange for a contingency agreement guaranteeing one-third of the verdict or settlement as its fee. The plaintiff agreed. After the liability case went to the jury, the parties entered into a high-low agreement of $2 - $5.75 million. The jury returned a verdict for the plaintiff of $12.4 million. The firm then filed a motion to approve the $5.75 million settlement and attorney fees for one-third of that amount. The trial court approved the settlement, but only awarded about twenty percent of the total amount in attorney fees. The firm appealed.

Illinois law, 735 ILCS 5/2-1114(a), prevents contingency fees in medical malpractice actions from exceeding 20 percent of a verdict of $1 million or more. The trial court had followed this limitation in awarding fees in this case. Subsection (c) does allow for contingency fees in excess of 20 percent in cases where an attorney has performed "extraordinary services." *Clay v. County of Cook*, 325 Ill. App. 3d 893, 759 N.E.2d 6 (1st Dist. 2001) established several criteria for determining when additional compensation should be awarded for medical malpractice actions: (1) time and labor, novelty and difficulty, skill; (2) likelihood of precluding other employment by the lawyer; (3) customary fees in the locality; (4) the amount involved and results obtained; (5) time limitations; (6) nature and length of professional relationship; (7) experience, reputation, and ability of the lawyer(s) performing the services; and (8) whether the fee is fixed or contingent. In Clay, the appellate court found that the trial court had not abused its discretion in refusing a one-third fee.

In the instant case, the appellate court found that the firm satisfactorily met the Clay criteria. Because the firm

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Illinois Bar Center
424 S. 2nd Street
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Phones: (217) 525-1760 OR 800-252-8908

Web site: www.isba.org

Editor
W. Eugene Basanta
SIU School of Law, Lesar Law Bldg.
Carbondale, IL 62901-6804

Associate Editors
Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

Thomas P. Conley
120 S. Riverside Plaza, Ste. 1200
Chicago, IL 60606-3910

Diane Gilbert Jacoby
316 E. 18th St.
Chicago, IL 60616-1539

John M. Lagattuta
1406 W. Talcott Rd.
Park Ridge, IL 60068

Herbert Sohn
4640 N. Marine Dr.
Chicago, IL 60640-5788

Managing Editor/Production
Katie Underwood
kunderwood@isba.org

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was expanding to Europe, an attorney stationed in Europe was in charge of the case and had to travel back and forth to handle the litigation. A vast number of depositions, expert witness interviews, motions in limine, and settlement negotiations reflected the firm's hard work on the case. The outcome was extremely favorable to the plaintiff as evidenced by the jury award. Further, neither the plaintiff nor the firm disputed the contingency fee agreement. The firm took a case that two other firms had declined, put together an actionable claim in a few weeks, and fought the case to its successful conclusion. The appellate court found that the substantial hours and costs of the trial warranted additional fees. The trial court had abused its discretion in failing to follow the contingency fee agreement—the firm had, under extreme circumstances, performed "extraordinary services" for the plaintiff. *Madalinski v. St. Alexius Medical Center*, No. 1-04-3350 (Ill. App. 1st Dist., Dec. 15, 2006).

Appellate court considers Medicaid statute and spousal support obligations

The plaintiffs, as community spouses of institutionalized spouses, sought to show that Illinois was improperly attempting to force them to support their institutionalized spouses. These institutionalized spouses, housed in long-term care facilities, had previously received or were currently receiving state Medicaid assistance. The trial court held that the plaintiffs were not required to exhaust their administrative remedies before suing in circuit court and that provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA), 42 U.S.C. §1396r-5 (2000), preempted the spousal support provisions of Illinois law, 305 ILCS 5/10-1 through 10-27. The lower court ruled that the MCCA prevented states from seeking financial support from community spouses, because it sought to prevent the community spouse from becoming impoverished. The state appealed.

The appellate court first determined that the plaintiffs were not required to exhaust their administrative remedies before seeking judicial review. This case involved purely questions of law and the interpretation of a federal statute not within the expertise of an administrative agency such as the Illinois Department of Public Aid or the Illinois Department of Human Services. Additionally, the plaintiffs did not forfeit their right to argue the constitutionality of the claim by failing to raise the issue at an administrative review proceeding. Finally, the appellate court held that the Illinois statute was not expressly or impliedly preempted by the MCCA.

The introductory language of the MCCA appears to prohibit the use of community spouse income in supporting an institutionalized spouse. However, the appellate court noted that the U.S. Supreme Court has permitted "deeming" of income available between institutionalized and community spouses as consistent with the language of the statute. Additionally, both New York and Connecticut have similar spousal support provisions detailing that a spouse can simply refuse to contribute to medical costs for the institutionalized spouse, but that the state may later recoup those costs from the community spouse. These statutes, in essence, allow the spouse to delay mandatory contribution requirements until after the institutionalized spouse has received medical care under Medicaid. The state, therefore, has the right to collect from community spouses for medical care provided under Medicaid. Thus, the appellate court reversed the trial court's holding. *Poindexter v. Illinois*, No. 4-05-0709 (Ill. App. 4th Dist., Dec. 12, 2006).

***Batson* violation warrants remand**

After a jury trial in a wrongful death and medical malpractice action involving a laparoscopic surgical procedure, judgment was entered for the defendant surgeons and hospital. The plaintiffs appealed the verdict, in part on the grounds that the defendants had violated *Batson v Kentucky*, 476 U.S. 79 (1986) by using their peremptory challenges to exclude black jurors. The plaintiffs were black.

Following selection of the jury, the plaintiffs' lawyer filed a motion under *Batson*, arguing that the defendants had employed their peremptory challenges to exclude five black jurors from the jury. As the lawyer stated to the trial court, "[e]very single juror that the defendants have stricken has been African American." The trial court denied the plaintiffs' *Batson* motion finding that the defendants had offered race-neutral reasons (e.g. body language) for excluding these jurors.

On review, the appellate court initially discussed *Batson*, observing that in that case, the U.S. Supreme Court prohibited a state prosecutor in a criminal case from using a peremptory challenge to exclude a prospective juror solely on the basis of his or her race. The court then stated that, "The rule announced in *Batson*—that the State may not use peremptory challenges to purposefully exclude jurors based on their race—applies with equal force to private litigants in civil cases."

Based upon the facts presented, the appeals court found that the plaintiffs had made a prima facie case under *Batson*, thus requiring the defendants to show that the exclusions were for non-discriminatory reasons. As noted, the trial court found that the defendants had shown race-neutral reasons for challenging these jurors based in part on their body language during questioning. From this perspective, on appeal, the question for the court was "whether the trial court's factual determination—that the plaintiffs offered valid race-neutral reasons for excluding the five African-American venirepersons—was clearly erroneous."

Upon analysis, the appeals court did not accept the proffered race neutral reasons for excluding three of the black jury members. "[G]iven the fact that the record establishes that black and white jurors nodded their heads when asked questions by the court, plaintiffs and defendants' counsel, we believe that the defendants' reasons for excluding [certain jurors] were pretextual, and hold that the trial court's finding—that the defendants were primarily concerned about the black jurors' attitudes about damages—was clearly erroneous." The court remanded the case for a new trial.

The court also took the occasion to address whether or not the jury instruction, IPI Civil No. 12.05 regarding causation, was properly given to the jury, even though a ruling on this issue was unnecessary because the *Batson* violation was enough to warrant remand. However, given that the issue could arise on retrial, the court held that the jury instruction was proper because there was conflicting testimony regarding the exact cause of the decedent's death. *Mack v. Anderson*, ___ Ill. App. 3d ___, 861 N.E.2d 280 (1st Dist. 2006).

Primary care clinic denied tax exemption

The tax-exempt status of not-for-

profit health care providers has been the subject of considerable dispute and litigation recently, both nationwide and in Illinois. In addition to potential legislative action (See, e.g. H.B. 5000, 94th Ill. Gen. Assembly (2006)), the Illinois Department of Revenue (IDR) upheld the revocation of Provena Covenant Medical Center's property tax exemption in September of 2006 and, in February of 2007 also upheld the decision of the Champaign County Board of Review disallowing Carle Foundation Hospital's tax exemption.

In a recent decision from the Third District Appellate Court, a not-for-profit, community-based primary care clinic was denied a tax exemption. The clinic applied for the property tax exemption based upon its claim that it used its property for charitable purposes. IDR denied the request, and the clinic appealed to an administrative law judge (ALJ). The ALJ upheld IDR's decision, finding that the clinic had not demonstrated that it qualified as a charitable organization or that the property was used exclusively for charitable purposes. The clinic appealed to the circuit court, which reversed the ALJ's order. The appellate court reversed the circuit court's holding and reaffirmed the ALJ's order.

The clinic presented evidence that it provided several discounts, especially for those patients below the poverty level, and showed that twenty seven percent of the clinic's patients had received some level of discounted services. The appellate court followed the six-part test established in *Methodists Old Peoples Home v. Korzen*, 39 Ill. 2d 149, 233 N.E.2d 537 (1968) to determine whether the clinic was eligible for a property tax exemption. Under Methodists Old Peoples Home, in order to be eligible for a property tax exemption, the alleged charity must show that: (1) it is set up for the benefit of an indeterminate number of persons; (2) it has no capital, capital stock, or shareholders and earns no profits or dividends; (3) it derives its funds primarily from public and private charity and holds those funds in trust for the objectives and purposes expressed in its charter; (4) it dispenses charity to all who need and apply for it, does not provide gain or profit in a private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need and would avail themselves of the charitable benefits it dispenses; (5) the property is actually and factually used exclusively for the charitable purpose, regardless of any intent expressed in the organization's charter or bylaws; and (6) charity use is the primary purpose for which the property is used and not a secondary or incidental purpose.

The court also noted that findings of fact made by an ALJ "are considered prima facie true and correct," and that an ALJ decision should stand unless "clearly erroneous." Focusing on the sixth factor in the Methodists Old Peoples Home test, the appellate court found that the clinic was not primarily used for charitable purposes. Besides showing that twenty seven percent of its patients received subsidized care, the clinic "had little concrete data to support its conclusion." As such, the appellate court upheld IDR's denial of a property tax exemption for the clinic. *Community Health Care v. Illinois Department of Revenue*, ___ Ill. App. 3d ___, 859 N.E.2d 1196 (3d Dist. 2006).

Law Ed Program – "Cutting Edge Issues in Health Care" – April 20, 2007

The Health Care Section Council's annual spring Law Ed program will be presented on Friday April 20 at the ISBA's Chicago Regional Office, 20 South Clark Stree. This full-day program, "Cutting Edge Issues in Health Care" will include an professionalism segment. For more information, see the program announcement appearing on page 11 of this issue of *The Health Care Lawyer* or call the ISBA at 800-252-8908 or 217-525-1760.

Illinois Supreme Court upholds physician restrictive covenants

*By Rick L. Hindmand**

On December 21, 2006, the Illinois Supreme Court held that restrictive covenants in the employment agreements of two physicians are enforceable and that the clinic which formerly employed the physicians was entitled to a preliminary injunction to enforce the restrictive covenants. This case, *Mohanty v. St. John Heart Clinic, S.C.*, ___ N.E.2d ___, 2006 WL 3741970, 2006 Ill Lexis 1689 (Ill 2006), is particularly significant because the Illinois Supreme Court is now on record rejecting the theory that all restrictive covenants in physician employment agreements are void as against public policy and because this is the first time since 1969 that the Illinois Supreme Court has determined whether a physician restrictive covenant is reasonable.

Prior Illinois law on the validity of physician restrictive covenants

Illinois courts have traditionally enforced physician restrictive covenants if the restrictions are deemed to be reasonable with respect to scope, territory and time considering the employer's interests, the hardship caused by the covenant and any injury to the public. In 2000, however, the Appellate Court for the Fifth District held that physician restrictive covenants violate public policy per se by interfering with patient choice and are therefore void. *Carter-Shields v. Alton Health Institute*, 317 Ill App 3d 260, 739 NE2d 569 (5th Dist 2000), affd in part and vacd in part, 201 Ill 2d 441, 777 NE2d 948 (2002). On appeal in Carter-Shields, the Illinois Supreme Court held that the employment agreement was void under the corporate practice of medicine prohibition and vacated the portions of the appellate court opinion regarding the general invalidity of physician restrictive covenants, which the court characterized as "wholly advisory." As the Illinois Supreme Court did not address the merits of the Fifth District's determination that restrictive covenants in physician employment agreements are void and appellate courts in other districts have rejected the Fifth District's reasoning the ability to enforce physician restrictive covenants had been in doubt prior to *Mohanty*.

Background of Mohanty

In 1993, the clinic entered into an employment agreement with Dr. Raghu Ramadurai containing a restrictive covenant prohibiting Dr. Ramadaruai from practicing medicine within a two mile radius of any clinic office or any of four hospitals during the three year period after terminating employment. In 2000, the clinic and Dr. Jyoti Mohanty entered into an employment agreement with a similar restrictive covenant, except that the geographic area was five miles and the restricted period was five years.

Drs. Ramadurai and Mohanty resigned in 2003 and filed complaints in the circuit court of Cook County for declaratory relief, alleging that the covenants were void as against public policy, unenforceable due to the clinic's breach of their employment agreements, and invalid because the restrictions were unnecessary to protect the interests of the clinic and its owner. The clinic and its owner filed a counterclaim for relief including preliminary and permanent injunctions to enforce the restrictive covenants.

The trial court rejected the physicians' claim that the clinic materially breached the employment agreements, but denied the clinic's request for a preliminary injunction, holding that in light of the clinic's specialty in cardiology, the prohibition on the practice of medicine was broader than necessary to protect the clinic's interests. The appellate court reversed, holding that the restrictive covenant would not cause undue hardship to the physicians and was not broader than necessary to protect the clinic's interests. In addition, the appellate court rejected the physicians' argument that all restrictive covenants in physician employment agreements are void as against public policy and held that the physicians' claim of breach was premature. *Mohanty v. St. John Heart Clinic*, S.C., 358 Ill.App.3d 902, 832 N.E.2d 940 (1st Dist. 2005).

On appeal to the Illinois Supreme Court, the physicians asserted that the restrictive covenants were unenforceable based on three separate theories: (i) that all restrictive covenants in physician employment contracts are against Illinois public policy and therefore void, (ii) that the clinic materially breached the employment contracts by failing to pay the compensation which the physicians were entitled to receive, and (iii) that the restrictive covenants were unreasonable because the restrictions were broader than necessary to protect the clinic's interests.

Physician restrictive covenants are not void as against public policy

With respect to the first theory, the Illinois Supreme Court observed that the physicians had a heavy burden of showing that physician restrictive covenants are either clearly contrary to the constitution, statutes or case law which have been declared to be public policy or that the contract is "clearly injurious to the public welfare." The physicians cited the 1998 holding of the Illinois Supreme Court in *Dowd & Dowd, Ltd. v. Gleason*, 181 Ill 2d 460, 693 N.E.2d 358 (1998), that restrictive covenants in attorney employment contracts are void as a matter of public policy, and argued that the public policy reasons for invalidating restrictive covenants are more compelling for physicians than for attorneys. The Illinois Supreme Court rejected this argument, noting that the Carter-Shields appellate court decision which the physicians cited was vacated and "stands alone in its rejection of long-standing Illinois precedent on the validity of restrictive covenants in physician employment contracts." The court distinguished *Dowd & Dowd* because that decision was based on the conflict between the restrictive covenants and Rule 5.6 of the Illinois Rules of Professional Conduct. The court found no similar expressions of public policy with regard to physician employment

contracts.

While acknowledging that some states prohibit restrictive covenants in physician employment agreements, the Illinois Supreme Court was unable to find any case in which a court prohibited restrictive covenants in the absence of legislation. Furthermore, the court noted that most states follow standards similar to the Illinois approach which focuses on whether the restrictions are reasonable.

The court then determined that the physicians failed to show that physician restrictive covenants are "manifestly injurious to the public welfare." The court pointed out that restrictive covenants protect the business interests of established physicians and encourage them to hire less experienced physicians, and that this positive impact needs to be weighed against the negative effects referenced by the physicians. The court concluded that the decision of whether to prohibit physician restrictive covenants should be left to the legislature, which can weigh the competing interests. Finally, the court affirmed the holding of the trial court that the physicians did not establish a material breach of the employment contracts.

Reasonable restrictions

The court then examined the scope of the activity restriction (the practice of medicine), the duration (five years with respect to Dr. Ramadurai) and the impact on the availability of cardiologists to provide patient care. The court rejected the physicians' argument that the restrictions were unreasonably overbroad.

The supreme court agreed with the appellate court that the restriction on the practice of medicine was not greater than necessary to protect the clinic's interests. The court reasoned that "cardiology, like other specialties, is inextricably intertwined with the practice of medicine" and that the restriction applied only within a "narrowly circumscribed area of a large metropolitan area."

The supreme court applied an objective standard for determining whether the duration was reasonable, and noted that the subjective motivations for imposing the particular time period were irrelevant. The court determined that the three- and five-year restrictions were reasonable in light of testimony that it took a minimum of three to five years for the clinic's shareholder to develop a referral base, that nearly all of the physicians' referrals came from the clinic, and evidence that it took more than 10 years for the clinic to establish a successful cardiology practice.

With regard to harm to the public the court determined that the restrictions on the physicians would not seriously diminish the number of cardiologists available to care for patients.

Justice Freeman's concurring and dissenting opinion

Justice Freeman concurred in part and dissented in part. His opinion focused on the effects on patient care, which he asserted was given "short shrift" by the majority. In particular, he argued that the enforcement of restrictive covenants disrupts continuity of care to the potential detriment of patients. He agreed with the majority that any general prohibition on physician restrictive covenants should be left to the legislature, but stated that "a strong case exists for a blanket abolition of all physician restrictive covenants in Illinois as being void against public policy" and recommended that the legislature enact such legislation.

Justice Freeman dissented with respect to the holding that the restrictive covenants were reasonable and criticized the failure to consider the impact on the physician-patient relationship and continuity of care. He would have reversed and remanded the case to the trial court because the record did not contain sufficient evidence of the hardships on the physicians' existing patients.

Implications of *Mohanty*

While physician restrictive covenants have been the subject of numerous reported decisions at the appellate court level, Justice Freeman noted in his concurring and dissenting opinion that nearly 40 years had elapsed since the Illinois Supreme Court determined whether a physician restrictive covenant was reasonable. The *Mohanty* decision provides important guidance to attorneys drafting physician restrictive covenants as well as to those involved in litigating such cases.

The opinion indicates that as a general rule a restrictive covenant can set forth a general prohibition on the practice of medicine, without limiting the scope to the specialty of the medical practice. It is possible, however, that in some circumstances this distinction could still be important. The majority opinion suggests that the relatively narrow scope of the restricted geographic areas may have been a factor in the court's determination that both the duration and scope of practice provisions were reasonable.

With respect to the issue of whether a restrictive covenant creates any public injury, the majority focused its review on whether a sufficient number of physicians (in this case cardiologists) would be available in the area to serve patients. In contrast, Justice Freeman's analysis focused on whether the restriction would create hardship to the patients of the contracting physicians.

It is now clear that there is no general prohibition on physician restrictive covenants in Illinois and that such a drastic change would require legislation. Justice Freeman urged the General Assembly to enact a prohibition on physician restrictive covenants and provided a potential roadmap of policy justifications for such legislation. Unless and until the passage of such legislation, the enforceability of physician restrictive covenants will continue to focus on whether the restrictions are reasonable.

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* Rick L. Hindmand is an attorney with McDonald Hopkins, LLC in Chicago, rhindmand@mcdonaldhopkins.com For another article discussing physician restrictive covenants in Illinois, see Andrew B. Cripe, Restrictive Covenants in Physician Contracts: An Emerging Public Policy Battleground, 20 Health Care Lawyer No. 4, at 8 (June 2004).

ILLINOIS STATE BAR ASSOCIATION

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Herbert Sohn, Strauss Surgical Group Associates, S.C, Chicago
Camela A. Gardner, Illinois Department of Human Services Legal Services, Chicago

9:00 – 9:30 a.m. The Promise of Stem Cell Research

In recognizing the ethical and legal issues surrounding human stem cell research and the need for lawyers to know the options available under law, this session will strive to empower participants with sufficient knowledge to understand and to address the ongoing developments related to stem cell research and treatment. Participants will also learn how moving toward this process will affect the treatment of many diseases and conditions and how it will change the way we develop drugs, among other matters.

John Rinehard, MD, JD, PhD., Evanston

9:30 – 10:00 a.m. Medical Spas

These controversial spas are being operated by non-medical personnel who enter employment contracts with physicians. Such ventures potentially violate the corporate practice of medicine doctrine and, as such, are illegal ventures. Other concerns which arise are medical professionals aiding and abetting the unauthorized practice of medicine. Examples include dentists employing nurses to inject botox into the patients face; nurses advertising botox injections on the Internet without a physician's order; and chiropractors doing laser treatments in the medical spa model.

Michael K.Goldberg, Goldberg & Frankenstein, LLC, Chicago

10:00 – 10:15 a.m. Break

10:15 – 10:45 a.m. Electronic Medical Records

The movement toward electronic medical information is the natural offspring of present- day technological advances. Consequently, it is important that practitioners understand the key legal issues and ramifications related to the move towards an electronic medical record. These issues include privacy, security and the impact on medical errors.

David Liebovitz, MD., Chief Medical Informatics Officer, Northwestern Medical Faculty Foundation, Medical Director, Clinical Information Systems, Northwestern Memorial Hospital, Chicago

10:45 – 11:15 a.m. Unusual, Customary, and Reasonable Billing Issues for Out-of-Network Providers

Mr. Hufford is the lead attorney representing the American Medical Association in a class action lawsuit against United Health Care, challenging the database used by United (and a host of other insurance companies and governmental agencies) to calculate "Usual, Customary, and Reasonable" payments to out-of-network providers. Mr. Hufford will present the position that the data is statistically skewed to give unreasonably low reimbursement information. Areas of interest to attendees include the proper determination of fair market value and to what extent highly discounted fees should be considered in making a fair market value determination of reimbursement.

D. Brian Hufford, Promerantz Haudek Block Grossman & Gross, LLP, Columbus, OH

11:15 a.m. – 12:15 p.m. Ethics

Lawyers representing health care providers (hospitals, physicians, etc.) must be acutely aware of ethical issues that can arise in this highly-regulated and extremely complex area of the law. For example, counseling physicians-clients about their business/professional relationship or activities raises an array of ethical and professional responsibility issues worthy of exploration.

William P. Schuman, McDermott Will & Emery, LLP, Chicago

12:15 – 1:15 p.m. Professionalism

The perceived decline in professionalism, often denoted "civility," has been the subject of increasing concern to the profession for many years. It has accurately been observed that civility in the legal profession is inextricably linked to the manner in which lawyers are perceived by the public. It is against this backdrop that we offer a program geared to combat the deteriorating public confidence of our judicial system.

Cheryl Niro, Illinois Supreme Court Commission on Professionalism, Chicago

*ISBA will apply for 2.0 PMCLE hours of Professionalism MCLE credit for segments of this program. Please note: Supreme Court Rules on MCLE require lawyers to earn at least 4 hours of Professionalism MCLE every reporting period. For additional information and to register, call the CLE registrar at 800-252-8908 or 217-525-1760, or visit www.isba.org/lawed.

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(Notice to librarians: The following issues were published in Volume 23 of this newsletter during the fiscal year ending June 30, 2007: September, No. 1; December, No. 2; April, No. 3; June, No. 4).

All the latest developments in health care law

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By W. Eugene Basanta, Andrew Roszak and Michael Sinha

Cases

Federal decisions

Seventh Circuit upholds Medicaid community living program

Part of the Illinois Medicaid plan includes the Community Integrated Living Arrangement (CILA) program. This program is for developmentally disabled Medicaid recipients who need services in their homes by nurses and other professionals. Illinois obtained a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to offer the CILA program. To qualify for CILA, as approved by CMS, an individual must meet specific "priority population criteria" established by the state. Further, the number of persons in CILA is capped by the state at 10,000.

In this case, the plaintiffs included two Medicaid recipients who were denied access to the CILA program. They claimed the denial was improper and filed suit in federal court. While one plaintiff's claim was dismissed as moot (he was later admitted to the CILA program), the other's went forward. He argued that 42 USC 1396a(a)(8) requiring that a state's Medicaid plan "provide that all individuals wishing to make application for medical assistance under the plan. . . have [the] opportunity to do so, and that such assistance. . . be furnished with reasonable promptness to all eligible individuals" was violated by the state's CILA program criteria.

While the Seventh Circuit was of the view that 1396a(a)(8) does not itself provide a private right of action, it assumed for the case that a suit could still be maintained for a violation of 1396a(a)(8) under 42 USC 1983. However, the court concluded that the Illinois CILA program, with its specific eligibility criteria and enrollment cap, did not violate any applicable standard. When CMS approved the waiver request for the program, it knew of the eligibility criteria. The plaintiff had failed to show that CMS granted the waiver in ignorance and therefore, in the court's view, the state's plan was agreeable to CMS. *Bertrand v. Maram*, No. 06-3705 (7th Cir., July 24, 2007).

Federal court applies immunity provisions of Illinois EMS Act

Based upon diversity, a medical malpractice suit was filed in federal court after a woman, eating at a restaurant, suffered a severe allergic reaction to peanuts and died. Initially, the decedent's husband took her to a "walk-in" clinic. When the clinic's personnel saw the decedent was in anaphylactic shock, an injection of epinephrine was administered by a clinic physician and EMTs from the defendant fire protection district were summoned. In the meantime, the clinic physician also began to "bag" the decedent to help her breath. When the defendant's EMTs arrived and "took over" the clinic's physician told the EMTs that the decedent needed to be intubated and offered to do so. However, the EMTs declined the offer and one of them with experience then attempted to intubate her. Because the decedent's jaw was clenched, efforts at intubation were unsuccessful until Versed, a drug to relax her jaws, was administered. While on route to the hospital, the EMTs again tried to intubate the decedent. This time they apparently succeeded. However, in the hospital ER it was discover that the endotracheal tube was in the decedent's esophagus rather than her trachea. By this time the decedent had suffered irreversible brain damage and was in

IN THIS ISSUE

a vegetative state. Two and half years later, she died.

Suit was filed by the estate against multiple defendants including the EMTs' employer, the fire protection district. A jury trial awarded the estate $1 million in a verdict against the defendant-district. Both parties appealed. The fire protection district argued that it was entitled to judgment as a matter of law. The plaintiff claimed that the estate was entitled to a larger damage award. On appeal, the Seventh Circuit reversed the judgment of the district court and entered judgment in favor of the defendant-district as a matter of law.

Applying Illinois law, the Seventh Circuit held that the immunity provisions of the Emergency Medical Services Systems Act, 210 ILCS 50/3.150(a) were applicable in this case. Under the EMS Act, an EMT "who in good faith provides emergency . . . medical services . . . in the normal course of conducting their activities, or in an emergency, shall not be civilly liable as a result of their acts or omissions in providing such services unless such acts or omissions . . . constitute willful and wanton misconduct."

The court held that the improper intubation of the patient and the EMTs' failure to ensure proper endotracheal tube placement (as required by standing medical orders) amounted only to negligence. Therefore, because no willful or wanton action had occurred, the immunity afforded by the EMS Act was applicable.

The plaintiffs also took issue with the fact that the paramedics violated standing medical orders. The court forcefully rejected this argument stating that it was "both a wrong argument and a bad one." The court reaffirmed that standing medical orders are not mandated to be followed, but rather to be used as guidelines and followed "as circumstances allow." *Fagocki v. Algonquin/Lake-in-the-Hills Fire Protection District*, No. 06-1685 (7th Cir., July 13, 2007).

Expert's testimony properly found unreliable in drug liability case

A products liability suit was filed against the defendant-drug company by a patient who, after receiving Remicade, suffered a blood clot which eventually led to the partial amputation of his leg. The federal district court granted summary judgment to the defendants after a motion in limine seeking to exclude the plaintiff's expert testimony was granted.

In affirming the district court's decision, the Seventh Circuit Court of Appeals examined the district court's ruling that the plaintiff's expert was unreliable under an abuse of discretion standard. The expert's opinion was based upon a differential diagnosis. The Seventh Circuit examined the expert and his opinion by applying Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993). Application of these standards led the Seventh Circuit to agree with the district court's finding that the expert was qualified. However, after examination of the facts, it was clear that the expert could not point to any epidemiological data or any scientifically physiological explanations that could support his conclusion. Therefore, the appeals court held that the district court had not abused its discretion in finding the expert's opinion unreliable and upheld its summary judgment ruling. *Ervin v. Johnson & Johnson, Inc.*, 492 F.3d 901 (7th Cir. 2007).

Pharmacist's religious discrimination claim may go forward

The plaintiff-pharmacist, employed at the defendant-retail pharmacy, was placed on unpaid leave because he refused to dispense, for religious reasons, the so-called "morning after" contraceptive pill. He filed suit in federal court claiming that this action violated Title VII of the Civil Rights Act, 42 USC 2000e et seq., as religious discrimination. He further claimed that the actions of the defendant violated the Illinois Health Care Right of Conscience Act, 745 ILCS 70/1 et seq.

The defendant moved to dismiss the complaint arguing that it was compelled to take this action in order to comply with a state regulation requiring pharmacies to dispense emergency contraceptives, 68 Ill. Adm. Code 1330.91(j). Additionally, the defendant argued that the Right of Conscience Act does not apply to pharmacists. The federal district court rejected both of the defendant's arguments.

The court initially ruled that the pharmacist had stated a claim for religious discrimination under Title VII. In response to the defendant's position that, as a matter of law it could not be liable under Title VII because it was complying with a state administrative rule, the court said it was not clear that the defendant would be unable to meet the obligation imposed on it to dispense contraceptives and still accommodate the plaintiff's religious beliefs. As the court noted, the dispensing rule applies to pharmacies and does not say that all or any particular pharmacists must dispense contraceptives. Whether accommodating the plaintiff's religious views would impose an undue hardship on the defendant was a fact question that barred dismissal of the suit.

As to the Right of Conscience Act, the court noted that the language of the Act precludes any "private institution" such as the defendant, from discriminating against someone for refusing to participate in any form of "health care service" as a matter of "conscience." In the court's view, the "plain meaning" of the statute applied to the facts of this case and prohibited the defendant's actions. The motion to dismiss was denied. *Vandersand v. Wal-Mart Stores, Inc.*, No. 06-3292 (C.D. Ill., July 31, 2007).

Illinois decisions

Illinois Supreme Court agrees to hear "relation back" case

In May, the Illinois Supreme Court agree to hear argument in *Porter v. Decatur Memorial Hospital,* 372 Ill. App. 3d 310, 867 N.E.2d 1049 (4th Dist. 2007) involving whether an amended medical malpractice claim relates back to the original filing. *Porter v. Decatur Memorial Hospital*, 224 Ill. 2d 593, 871 N.E.2d 61 (2007).

Insurer has no duty to defend

A patient who underwent LASIK surgery sued the eye center where the surgery was performed, as well as the physicians who performed it, as a result of injuries she sustained. In her claim against the eye center, she alleged that it had been negligent in how it managed the center and arranged the relationship between its personnel in providing care. She also alleged that the center was negligent in allowing professional personnel to perform certain tasks and in its quality oversight. When the patient learned that the eye center had a general business liability policy with the plaintiff-insurer, she sent a copy of her complaint to it. Thereafter, the insurer filed a declaratory judgment action asserting that, under the policy's "professional services" exclusion, it had no duty to defend or indemnify the eye center. The trial court agreed and granted the insurer summary judgment.

The patient appealed.

The policy at issue specifically excluded coverage for any bodily injury in rendering or failing to render any "professional service" including any supervisory service, as well as any medical, surgical, health or therapeutic service. The insurer argued that the patient's action against the eye center involved an alleged failure to use its special knowledge and skill to ensure that its personnel were qualified to provide medical services. Citing *State Street Bank & Trust Co. v. INA Insurance Co.*, 207 Ill. App. 3d 961, 567 N.E.2d 42 (4th Dist. 1991), the appellate court agreed and affirmed summary judgment for the insurer. *National Fire Insurance Co. v. Kilfoy*, No. 1-06-0415 (Ill. App. 1st Dist., Aug. 13, 2007).

Hospital liable for negligent credentialing of podiatrist

The Illinois Supreme Court in *Darling v. Charleston Memorial Hospital*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965) first recognized that a hospital could be held liable to an injured patient where the hospital was negligent in granting privileges to a physician. Based on *Darling*, the First District Appellate Court recently upheld a $6.8 million judgment against a hospital for negligently credentialing a podiatrist.

The plaintiff-patient underwent foot surgery at the defendant-hospital in 1998. The surgery was performed by the defendant-podiatrist who had been granted "category II" surgical privileges at the hospital. Allegedly as a result of the podiatrist's negligence, the plaintiff's foot was later amputated. At trial, evidence was introduced to show that, while the hospital's rules required a 12-month podiatric surgical residency and board certification by the American Board of Podiatric Surgery to qualify for category II privileges, the defendant-podiatrist had neither. Further, plaintiff's experts testified that the hospital had not acted reasonably in granting the podiatrist category II privileges and that he had been negligent in his treatment of the plaintiff. Following the jury's verdict, the hospital moved for judgment notwithstanding the verdict on several grounds, including that the plaintiff's amended complaint was time-barred as it did not relate back to her original filing, and that her negligent credentialing claim was precluded by the Medical Studies Act, 735 ILCS 5/8-2101 & 8-2102 and by the Hospital Licensing Act, 210 ILCS 85/10.2. The trial court denied the motion and entered judgment for the plaintiff. The hospital appealed.

On appeal, the court, with one judge dissenting, initially held that the plaintiff's amended complaint that included the negligent credentialing claim did relate back to her initial claim against the hospital and was thus not time-barred. The court then held that, neither the Medical Studies Act nor the Hospital Licensing Act barred the suit against the hospital.

The court set out the basic requirements for a negligent credentialing claim against a hospital as follows. The plaintiff "must prove [with expert testimony] the hospital failed to meet the standard of reasonable care in the selection of the physician it granted medical staff privileges to." The plaintiff must also show that "while practicing pursuant to negligently granted medical staff privileges, the physician breached the applicable standard of care." Lastly, the plaintiff must establish proximate causation in terms of the injuries sustained and the negligent granting of privileges. In this case, the appeals court found that the plaintiff had met each of these requirements. The lower court's judgment was affirmed. *Frigo v. Silver Cross Hospital*, No. 1-05-1240 (Ill. App. 1st Dist., July 26, 2007).

Judgment for pharmacy in suicide death upheld

A wrongful death and survival action was filed by the plaintiff-parent against the defendant-retail pharmacy after it allegedly failed to supply plaintiff's minor daughter with her full prescription. This error allegedly caused the decedent to be without her medication for four days. The medication in question was used to treat the decedent, who suffered from psychosis. On the fifth day, the decedent received a refill from the defendant and resumed her medication. However, later that day she committed suicide.

At trial, the jury returned a verdict for the plaintiff for $875,000. In response to a special interrogatory, the jury also found that the plaintiff-parent was twenty five percent contributorily negligent in her daughter's death. The circuit court granted a judgment notwithstanding the verdict in favor of the defendant-pharmacy.

On appeal, the arguments centered on the forseeability of the suicide to the pharmacy staff. Upon reviewing the record, the appeals court held that all of the evidence indicated that the suicide was not foreseeable. This conclusion was based upon the testimony of the decedent's mother and two psychiatrists, who had seen the decedent just prior to the suicide. Nothing in the record indicated that the decedent was at risk for committing suicide. Therefore, a judgment n.o.v. was appropriate because there was a total lack of evidence to prove that the pharmacy could have or should have foreseen the suicide. *Crumpton v. Walgreen Co.*, No. 1-06-0734 (Ill. App. 1st Dist., June 29, 2007).

Court addresses sanctions for plaintiff's failure to disclose witnesses

Plaintiff-patient sued the defendant-podiatrist for negligent care in treating her feet that "resulted in severe pain, scarring, and deformity." The circuit court ordered the plaintiff to complete discovery and disclose both lay witnesses (under Illinois Supreme Court Rule 213(f)(1)) and independent-expert witnesses (under Illinois Supreme Court Rule 213(f)(2)). Defendant moved to bar Rule 213(f)(1) and (2) witnesses not previously disclosed, as well as all Illinois Supreme Court Rule 213(f)(3) witnesses. The court continued the motion to bar until the next case management conference. Plaintiff failed to appear, and the circuit court entered an order barring plaintiff from "introducing at trial all Illinois Supreme Court Rule 213(f)(2) witness testimony not previously disclosed and all Illinois Supreme Court Rule 213(f)(3) witness testimony." A week later, plaintiff served defendant with a list of her Rule 213(f)(1), (2), and (3) witnesses. Plaintiff's motion to vacate the circuit court's order barring undisclosed witnesses was denied. Defendant's motion for summary judgment was then granted by the trial court because the plaintiff could not meet her burden of proof, that defendant deviated from the standard of care and caused plaintiff's injuries, absent the barred expert testimony.

Plaintiff appealed asserting that (1) the circuit court abused its discretion and was too severe in barring witnesses from testifying at trial; and (2) even if witnesses remain barred, summary judgment was improper because testimony of a previously disclosed witness

satisfied plaintiff's burden of proof in showing the existence of a genuine issue of material fact.

The appellate court held that the sanctions proscribed by the circuit court barring witness testimony were justified, because Illinois Supreme Court Rule 219(c) permits sanctions, "including barring witnesses from testifying," when a party fails to comply with court directives. In this case, plaintiff failed to timely serve defendant with a complete list of witnesses under Illinois Supreme Court Rule 213(f), violating three separate court orders setting deadlines for witness disclosure. Therefore, the sanction could not be construed as an abuse of discretion. Plaintiff had "demonstrated a deliberate and unwarranted disregard of the court's authority."

The plaintiff successfully argued, however, that testimony from a treating physician, which was not barred by the circuit court's order, should have precluded summary judgment by raising genuine issues of material fact. A treating physician is considered an independent-expert witness under Illinois Supreme Court Rule 213(f)(2), and this treating physician-witness was disclosed prior to the circuit court's order. Therefore, the circuit court's order did not preclude plaintiff from presenting expert testimony addressing the issues of breach of duty and causation. Because the required disclosures are less for Rule 213(f)(2) independent-expert witnesses than for Rule 213(f)(3) controlled expert witnesses, plaintiff's disclosure was sufficient to apprise the defendant of the subject matter and opinions of the expert witness and summary judgment was inappropriate. *Nedzvekas v. Fung*, No. 1-06-0479 (Ill. App. 1st Dist., June 26, 2007).

Fourth District reconsiders decision in *Cargill*

A 17-year-old mentally retarded ward of the state underwent an elective tonsillectomy procedure and was sent home to the defendant-facility where she resided. The next day, she suffered cardiac and respiratory failure, and ultimately died of bronchopneumonia soon after returning to the hospital. The administratrix of the deceased brought a medical malpractice action against the care facility, the hospital, and the treating physicians.

The initial complaint was filed in 2002. It included an affidavit requesting an additional ninety days to obtain a physician's report, required of all medical malpractice cases in Illinois by 735 ILCS 5/2-622(a)(1). More than 90 days passed, and the physician filed a motion to dismiss on ground that the physician's report was never filed. Before the trial court could rule on this motion, the plaintiff moved to voluntarily dismiss the case without prejudice in February 2003. This motion was granted. Thereafter, the complaint was re-filed a year and a half later, again including a request for a 90-day extension to procure the physician's written report. Defendants moved to dismiss, arguing that, under *Cargill v. Czelatdko*, 353 Ill. App. 3d 654, 818 N.E.2d 898 (4th Dist. 2004), a complaint that had been voluntarily dismissed could not be re-filed with an affidavit requesting ninety extra days to procure a physician's report. In fact, the defendants argued, a plaintiff requesting a 90-day extension was required under 2-622 to state that the case had not been previously voluntarily dismissed. The trial court agreed with the defendants and dismissed plaintiff's complaint with prejudice.

The provision in 2-622 requiring a plaintiff who requests a 90-day extension to state that the complaint had not previously been voluntarily dismissed first appeared as part of the 1995 tort reform provisions known as the Civil Justice Reform Amendments, P.A. 89-7 (Ill. Gen. Assembly, 1995). However, in *Best v. Taylor,* 179 Ill. 2d 367, 689 Ill. 2d 1057 (1997), the Illinois Supreme Court found the "core provisions" of the Civil Justice Amendments unconstitutional and voided all of the provisions of P.A. 89-7 including the changes to 2-622. As a result, the pre-1995 version of the statute, without any language regarding voluntary dismissals or any other qualifications on the 90-day extension period, remained in effect. Subsequently, in 1998, the Illinois General Assembly passed P.A.90-579. This act made specific changes to 2-622(a)(1) to include naprapathic physicians, and then repeated the Civil Justice Amendments' version of the statute, including the limitation on the ninety-day extension voided in Best. Thereafter, in *Cargill* the court ruled that P.A. 90-579 reinstated the version of 2-622 included in the Civil Justice Amendments. In the instant case, the trial court had relied on *Cargill* to dis-

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Illinois Bar Center
424 S. 2nd Street
Springfield, IL 62701
Phones: (217) 525-1760 OR 800-252-8908

Web site: www.isba.org

Editor
W. Eugene Basanta
SIU School of Law, Lesar Law Bldg.
Carbondale, IL 62901-6804

Associate Editors
Thomas P. Conley
120 S. Riverside Plaza, Ste. 1200
Chicago, IL 60606-3910

Diane Gilbert Jacoby
316 E. 18th St.
Chicago, IL 60616-1539

Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

Mary E. Lucie
240 E. Ontario St.
Ste. 500
Chicago, IL 60611

Managing Editor/Production
Katie Underwood
kunderwood@isba.org

Postmaster: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

miss the plaintiff's new complaint.

After *Cargill*, in P.A. 94-677, the Illinois legislature amended 735 ILCS 5/2-622, and specifically rejected the language from the Civil Justice Amendments concerning voluntary dismissals. Soon thereafter, plaintiff in the present case filed a motion to reconsider, asserting that *Cargill* should be overruled. The trial court denied the motion to reconsider. On appeal, the Fourth District Appellate Court reversed and remanded. It held that the voluntary dismissal language, relied upon in *Cargill*, had disappeared as a result of the court's decision in *Best* and was never re-enacted. Therefore, at no time was the language in effect, because the law was void ab initio, or from the beginning.

The trial court, in looking to *Cargill*, had relied upon the doctrine of stare decisis, but the appellate court found that the legislative amendment of the relevant statutory language was sufficient to break from the doctrine of stare decisis and re-examine *Cargill*. The language barring ninety-day extensions to cases that had previously been voluntarily dismissed was no longer valid, and therefore, plaintiff was not prohibited from requesting and receiving a 90-day extension to file the physician's medical report. One judge dissented, asserting that the recent amendment did not change the court's obligation to rely on precedent. *O'Casek v. The Children's Home and Aid Society of Illinois*, No. 4-06-0344 (Ill. App. 4th Dist., June 25, 2007).

Appellate court construes Tort Immunity and EMS Acts

On October 31, 2004, a father called 911 seeking help for his unresponsive 15-year-old son. After placing the 911 call, the father began providing CPR for his son. Firefighters and EMTs were dispatched to the scene in both a fire truck and an ambulance. Upon arrival at the scene, the boy was not examined, treated, or transported. In addition, no documentation was completed regarding the incident.

Approximately eight hours later, a second 911 call was placed by the father. This time when emergency responders arrived, the 15-year-old was in cardiac arrest. Resuscitation efforts were begun by the emergency responders and the boy was transported to a hospital for further treatment. Thereafter, the boy died from anoxic encephalopathy due to cocaine and opiate intoxication.

After the death of their son, the family filed suit against the defendant-city seeking damages for wrongful death, as well as survival and family expenses. In defense to the suit, the city claimed immunity under the Local Governmental and Governmental Employees Tort Immunity Act, 745 ILCS 10/1-101 et seq. Under Sections 6-105 and 6-106 of the Tort Immunity Act, a local public entity and public employees acting within the scope of their employment, are not liable for injury caused by the failure to make a physical or mental examination of a patient. Immunity is also provided for local public entities and their employees for injuries resulting from diagnosing or failing to diagnose a person with a mental or physical illness.

However, the family asserted that the city was not immune from suit because of the EMTs' duties that arose under the Emergency Medical Services Systems Act, 210 ILCS 50/1 et seq., once the 911 call indicated that a person was unresponsive. Specifically, the family alleged that because the 911 call stated that the patient was unresponsive, the EMTs were automatically required to initiate medical treatment. Therefore, the EMTs failure to follow the procedures in the EMS Act amounted to willful and wanton conduct which would disqualify them from immunity.

The circuit court ruled in favor of the city, stating that the Tort Immunity Act applied, thus barring this action. On appeal, the court was asked to determine the interplay between the Tort Immunity Act and the EMS Act. Specifically, the court examined the relationship between the immunity provisions of the EMS Act and the general immunities of the Tort Immunity Act to determine when each was applicable.

Prior to this case, Illinois courts had not been faced with the question of the interplay between the EMS and Tort Immunity Acts. However, the Illinois Supreme Court, in *American National Bank v. City of Chicago*, 192 Ill. 2d 274, 735 N.E.2d 551 (2000) held that the scope of immunity in the EMS Act is broad, and encompasses more than just where paramedics are rendering life support to a patient. In American National Bank immunity was granted under the EMS Act when paramedics never even saw the patient. Therefore, the appellate court recognized that an overlap in the Tort Immunity Act and EMS Act existed. The court was then faced with the question of which immunity should apply, the limited EMS immunity or the broad absolute Tort Immunity Act immunity.

After analysis, the appeals court held that the Tort Immunity Act would apply in this case. The court turned to the plain language of the Act, which specifically provided immunity for failure to diagnose or to adequately examine a patient. The court held that a diagnosis had not been made in this incident, despite the 911 calls stating that the patient was "unresponsive." To reach this conclusion, the court cited language from *Michigan Avenue National Bank v. County of Cook*, 191 Ill. 2d 493, 732 N.E.2d 528 (2000). There, the court defined "diagnosis" as "the art or act of identifying a disease from its signs and symptoms, and as an investigation of analysis of the cause or nature of a condition situation or a problem."

Using this definition, the court reasoned that "unresponsiveness" was not a diagnosis but rather a symptom of an underlying condition. Therefore, since no diagnosis was made, the Tort Immunity Act provided immunity for these defendants. *Abruzzo v. City of Park Ridge*, ___ Ill. App. 3d ___, 870 N.E.2d 1012 (1st Dist. 2007).

Refusal to issue subpoenas in disciplinary action upheld

Proceedings were initiated by the Illinois Department of Financial and Professional Regulation (Department) to discipline the plaintiff-physician under the Medical Practice Act, 225 ILCS 60/22. The physician sought to depose five potential Department witnesses and asked the Department to issue subpoenas to do so. It refused. The physician then filed suit for a declaration that he had a right to the issuance of the subpoenas under 20 ILCS 2105/2105-105(a), a provision in the statute generally governing the Department. The suit was dismissed and the physician appealed to the First District Appellate Court.

On appeal, the Department argued that, under 20 ILCS 2105/2105-150, in disciplinary actions under the Medical Practice Act, specific provisions of that Act, rather than of 20 ILCS 2105/2105-105(a), apply. As a result,

the Department's position was that it could proceed only in accordance with the provisions of the Medical Practice Act.

Reviewing the language of the relevant statutes, the appellate court agreed with the Department. In doing so the court rejected the plaintiff's arguments based on waiver by the Department and past Department practice in issuing subpoenas. *Rodriguez v. Department of Financial and Professional Regulation*, ___ Ill. App. 3d ___, 870 N.E.2d 1029 (1st Dist. 2007).

Summary suspension of clinical psychologist overturned

In June, the First District Appellate Court overturned the summary suspension of a clinical psychologist for unprofessional and unethical sexual conduct during the treatment of a female patient. While the court upheld the evidentiary and statutory grounds for the Department of Financial and Professional Regulation (Department) taking action, it found that the Department failed to act with the requisite promptness in handling the disciplinary proceedings. Thus the appeals court reversed the trial court's affirmance of the Department's summary suspension.

When a female patient of the plaintiff-psychologist complained to the Department about his inappropriate conduct during a counseling session in November of 2003, the Department filed an administrative complaint. Further, at that time, following an interview with the Department's investigator, the Director of the Department determined that the plaintiff's "certificate of registration" should be summarily suspended under 225 ILCS 15/21.6 which allows for such a suspension where "the continuation in practice by the clinical psychologist would constitute an imminent danger to the public." A hearing on the summary suspension was completed before an administrative law judge (ALJ) on December 15, 2003. The ALJ did not issue her findings and conclusions until March 31, 2004. She recommended a 60-day suspension, a year's probation, and continuing education regarding ethics. Thereafter, in August of 2004, the Clinical Psychologist Licensing and Disciplinary Board (Board) adopted the ALJ's findings and conclusions, but recommended more serious penalties including a 90 day suspension and indefinite probation. Not until January of 2005 did the Director of the Department issue a decision adopting the Board's recommendations. Thereafter, the plaintiff-psychologist filed an action for judicial review. The trial court upheld the Department, and the plaintiff appealed.

On appeal, the court rejected numerous arguments made by the plaintiff including his arguments that the summary suspension provisions in 15/21.6 are unconstitutionally vague and that his summary suspension violated his due process rights. However, the court was concerned about the time it took for the Department to act on the summary suspension. The court noted that under the Illinois Administrative Procedure Act, 5 ILCS 100/10-25(d) in the event of a summary suspension of a license, proceedings must be "promptly instituted and determined." In the court's view and looking to the Illinois Supreme Court's decision in *Lyon v. Department of Children and Family Services*, 209 Ill. 2d 264, 807 N.E.2d 423 (2004), "the Department failed to act with the requisite promptness in waiting until January of 2005 to issue a final decision." Noting that the plaintiff could not practice at all from November of 2003 until June of 2004 when a TRO was issued lifting the suspension, and that in any case, the plaintiff was entitled to a more expeditious resolution of the matter, the court reversed the lower court's judgment. *Morgan v. Department of Financial and Professional Regulation*, ___ Ill. App. 3d ___, 871 N.E.2d 178 (1st Dist. 2007).

Appellate court upholds arbitration award against physician's insurer

Plaintiff, an Illinois physician, was sued in a qui tam action under the federal False Claims Act, 31 U.S.C. §3729 for improper billing of Medicare and Medicaid. Plaintiff thereafter sought representation from defendant-insurance company under his professional liability policy, requiring defense and indemnity for claims arising out of plaintiff's professional practice. Defendant refused to defend pursuant to the professional liability portion of the policy and thereafter, this suit was commenced. Plaintiff alleged that the defendant-insurer owed a duty to him and therefore should reimburse for costs associated with settling the suit, that the defendant was liable for attorney fees, costs, and a statutory penalty under the Illinois Insurance Code, 215 ILCS 5/155, and that the defendant breached its fiduciary duty, and ought to pay punitive damages as a consequence.

The insurer successfully compelled arbitration as agreed to within the terms of the insurance policy. Under a consent order, the parties agreed to resolve the dispute and all associated causes of action by binding arbitration. The arbitrator's findings would be final, and could only be appealed on grounds of corruption, fraud, evident partiality, or a gross error of law or fact associated with the award. The arbitrator found the insurer liable on all three grounds, awarding compensatory damages, attorney fees, costs, a statutory penalty, and punitive damages, for a total sum of close to $6 million. The insurer appealed the arbitrator's decision, asserting that punitive damages were unwarranted and the arbitrators exceeded their powers in awarding those damages. In addition, the insurer asserted that the arbitration award should be vacated on the grounds of several gross errors made by the arbitrators. The circuit court confirmed the arbitration award and the insurer appealed.

The Fifth District Appellate Court affirmed. On the issue of punitive damages, the appeals court found that the parties agreed to binding arbitration on all issues alleged in the complaint, including the prayer for punitive damages. Therefore, the arbitrators were authorized to award punitive damages as they saw fit. Further, the court, noting that judicial review of an arbitration award is more limited than review of a lower court's decision, did not find gross error in the arbitrator's findings. *Beatty v. The Doctors' Co*. ___ Ill. App. 3d ___, 871 N.E.2d 138 (5th Dist. 2007).

Rejecting res judicata claim, court allows husband's suit to proceed

Plaintiff's pregnant wife was rushed to a nearby hospital for complications associated with her pregnancy. She was not rushed to the hospital of her choice or seen by her regular physician, but instead was treated by the defendant obstetrician-gynecologist, an employee of the co-defendant physician association, at a closer hospital. The plaintiff-husband alleged that delays, both in diagnosing his wife's condition and in performing the needed cesarean sec-

tion, proximately caused his daughter's "severe neurological damage."

The first complaint was jointly filed by both spouses, on behalf of their minor child, against the defendant-physician and the treating hospital. The physician was later voluntarily dismissed from the initial suit. Motions for summary judgment were denied as to plaintiff's wife on the issue of apparent agency. No trial ensued, as plaintiff reached a settlement with the hospital. The language of the settlement barred any future claims arising from the incident, including those which were not pursued and those which might arise at a later date. Additionally, the only party to the settlement was the hospital, not the physician or his employer. As a result of the settlement, the suit was dismissed with prejudice by the trial court. Several days later, the plaintiff's wife filed suit against both the physician and the employer alleging negligence, but omitting any allegation of an agency relationship between the hospital and either of these defendants. Plaintiff-husband was later substituted in place of his wife.

Defendants filed a motion to dismiss, asserting that the new claims were barred by the doctrine of res judicata. The trial court agreed, granting summary judgment because "there was an identity of interest between [Defendant physician] and [the hospital] for purposes of res judicata." The trial court also estopped the plaintiff from asserting that the defendant-physician was not an apparent agent of the hospital, since his wife alleged the opposite in the previous suit. Plaintiff appealed.

The Second District Appellate Court reversed and remanded. The court noted that judicial estoppel applies only to "'statements of fact,' not to 'opinions or legal positions.'" Therefore, the plaintiff was justified in making a legal assertion that contradicted his wife's earlier assertion. Further, a factual dispute existed as to whether the consent form was signed by the plaintiff's wife, and therefore, summary judgment was unwarranted. Determining whether an agency relationship existed between the defendant-physician and the hospital was fact-intensive, and should be left to the finder of fact in a trial proceeding. *McNamee v. Sandore*, 373 Ill. App. 3d 636, 869 N.E.2d 1102 (2d Dist. 2007).

Appeals court upholds judgment against nursing home

Plaintiff filed suit on behalf of his mother, who was allegedly injured by the defendant- nursing home. He asserted that negligent care at the nursing home resulted in dehydration, pressure sores, and a urinary tract infection. Further, the plaintiff alleged the negligent acts of the defendant violated the Nursing Home Care Act, 210 ILCS 45/1-101 et seq., and caused "severe and permanent injury" to his mother. In its response, the defendant admitted several instances of negligence, but limited its admissions to the last week of her stay. The defendant denied any causal link between its negligent acts and omissions and the "severe and permanent injury" alleged by plaintiff. Defendant filed a motion in limine seeking to exclude all evidence relating to the negligent acts of the defendant, since those were judicially admitted. The trial court denied this motion, allowed the trial to proceed, and found for plaintiff in the amount of $200,000, including attorney fees and costs of $100,000 under the Nursing Home Care Act. Defendant appealed, and plaintiff cross-appealed.

The Fifth District Appellate Court noted that judicial admissions are "not evidence at all but have the effect of withdrawing a fact from contention." As such, the rule encourages judicial admissions as a measure of judicial efficiency and an incentive to defendants to accelerate trial proceedings. However, the trial court has discretion as to whether a judicially admitted fact is to be excluded from evidence in a particular matter. In this case, the subject matter of the judicial admissions, namely, the negligence of defendant and the injuries suffered by plaintiff's mother, were relevant and essential components of the plaintiff's case. The appeals court noted that a party cannot strategically admit in order to preclude highly relevant information from reaching the finder of fact. Moreover, because the defendant denied a causal link between its negligent acts and the injuries alleged, an accurate description of the care plaintiff's mother received in the nursing home was highly relevant to determining both direct and proximate causation, as well as damages.

The defendant also argued that attorney fees were awarded in error. The Nursing Home Care Act, in its relevant provision, states that "[t]he licensee shall pay the actual damages and costs and attorney fees to a facility resident whose rights . . . are violated," 210 ILCS 45/3-602. Requiring these costs to be paid encourages private enforcement, and encourages nursing homes to comply with the act. In addition, the means of calculating those fees is discretionary, and can be impacted by a number of factors. The trial court was affirmed. *Rath v. Carbondale Nursing and Rehabilitation Center, Inc*. ___ Ill. App. 3d ___, 871 N.E.2d 122 (5th Dist. 2007).

Continuous course of treatment rule applied

An appeal was brought in this medical malpractice case after the circuit court granted summary judgment and dismissed the suit. At issue on appeal was whether the statute of repose prevented the plaintiff from maintaining this action and the application of immunity under the Local Governmental and Governmental Employees Tort Immunity Act. The case involved two public hospital defendants (one associated with a state university and the other a county hospital) as well as multiple individual defendants.

Relevant to the university hospital defendants was 735 ILCS 5/13-212 which states, "no action for medical malpractice shall be brought more than 4 years after the date on which the act or omission or occurrence alleged in such action to have been the cause of such injury." However, a plaintiff can delay the running of this statute of repose if he or she is receiving an ongoing course of negligent medical treatment from the defendants according to the Illinois Supreme Court's ruling in *Cunningham v. Huffman*, 154 Ill.2d 398, 609 N.E.2d 321 (1993). As set forth in *Cunningham*, in order to delay the running of the statute of repose, "the plaintiff must demonstrate: (1) that there was a continuous and unbroken course of negligent treatment; and (2) that treatment was so related and continuous as to constitute one continuous wrong."

In examining the evidence in the instant case, the court held that because the plaintiff's complaint was the same throughout his medical treatment, material facts, which precluded summary judgment, did exist as to whether the treatment was continuous and negligent

with regards to two of the university hospital defendants. The court affirmed summary judgment for the remaining university hospital defendants.

As to the county hospital defendants, the court allowed the application of the Tort Immunity Act, 745 ILCS 10/1-101 et seq., to dismiss the claims against its physicians. The court stated that the plain language of the Tort Immunity Act, coupled with an Illinois Supreme Court decision in *Michigan Avenue National Bank v. County of Cook*, 191 Ill. 2d 493, 732 N.E.2d 528 (2000), made clear that a failure to diagnose, as opposed to a failure to properly treat, is immune from liability.

Further, the county hospital defendants were also protected under the Tort Immunity Act, because the Act specifically grants immunity for "a failure to prescribe treatment" in Section 6-106(a). The scenario in this case is contrasted with a situation where a public employee correctly diagnoses a patient, but then provides negligent treatment. In the later situation, immunity would not be granted to the public entity or public employee.

In conclusion, summary judgment was upheld for all defendants except for two university hospital employees. The case was remanded for further proceedings. *Willis v. Khatkhate*, 373 Ill.App.3d 495, 869 N.E.2d 222 (1st Dist. 2007).

The Federal False Claims Act: A look at qui tam actions aimed at the pharmaceutical manufacturing industry

*By John N. Maher**

I. Cell Therapeutics, Inc.'s Settlement With the United States Stresses The Disastrous Consequences Of Making False Healthcare Claims Against The United States

The qui tam provisions of the False Claims Act ("FCA") have been enormously effective in exposing fraud in the pharmaceutical industry, thereby accomplishing the objectives of protecting the fiscal integrity of Medicare, Medicaid, and Tricare, as well as encouraging those private citizens with insider information to "blow the whistle" and join the United States in addressing fraud, recovering treble damages, securing civil penalties, facilitating compliance with fraud and abuse statutes and regulations, and sending a deterrent message.

For example, on April 17, 2007, the United States Department of Justice made the following announcement in a press release for immediate distribution:

> Cell Therapeutics, Inc. to Pay United States $10.5 Million to Resolve Claims for Illegal Marketing of Cancer Drug.[1]

In an action instituted by a whistleblower, the Complaint alleged that CTI promoted Trisenox to treat various forms of cancer for which the drug was neither approved by the Food & Drug Administration ("FDA"), nor proven to be safe or effective. Because of CTI's actions, the Complaint further alleged, physicians who prescribed Trisenox "off-label" unwittingly submitted false claims for reimbursement to the Medicare program from 2001 until 2005.

Additionally, the Complaint alleged that CTI used illegal kickbacks to induce physicians to prescribe Trisenox. Under sham "consulting agreements," physicians were paid $500 - $1,000 to attend dinners or conferences on the off-label uses of Trisenox. These meetings were held at expensive resorts and restaurants. Physicians who wrote large numbers of prescriptions for Trisenox for off-label uses were asked to speak at various events for additional financial bonuses.

Against this backdrop, this paper presents the latest in a growing series of astronomical settlement agreements between pharmaceutical manufacturers and the United States, in cases brought by qui tam relators for false healthcare claims. The FCA is discussed generally, with the qui tam provisions addressed specifically, in terms of their substance and the procedure involved in advancing a federal whistle-blower claim.

The various incentives and rationales for the growth in qui tam actions in the healthcare industry are examined, with a view of the six pharmaceutical qui tam cases settled prior to CTI, Inc. in April, 2007, involving allegations of "marketing the spread," "concealment of best price," and "off-label" marketing. Finally, recommendations for the general counsel and compliance officer are suggested to avoid altogether a FCA claim, or, in the alternative, to respond prudently and adroitly when the United States calls.

II. Recent Qui Tam Actions Directed At Pharmaceutical Manufacturers

CTI's settlement with the United States once again underscores how the qui tam provisions of the FCA are rightly some of the "most important tools in protecting the integrity of Medicare and other taxpayer-funded healthcare programs."[2] Indeed, "government prosecutors and private parties are frequently turning to the Civil False Claims Act as their weapon of choice in waging the 'war' on health care fraud and abuse."[3]

The Justice Department, the Department of Health and Human Services ("HHS"), and private citizens are all involved in fraud enforcement

at the federal level. The Fraud Section of the Criminal Division of the Justice Department organizes and oversees the national campaign for the prevention and prosecution of health care fraud.[4] Within HHS, the Centers for Medicare and Medicaid Services ("CMS") and the Office of the Inspector General ("OIG") are responsible for fraud enforcement.

And, private citizens may bring an action upon behalf of the United States[5] and often do so for various reasons, the most prominent being: (1) they can share between 15 percent - 25 percent of any settlement or judgment the government obtains, which can be up to three times the amount of damages sustained, plus a civil penalty of $5,500 to $11,000 per claim[6]—these amounts have reached exorbitant amounts of late; (2) should the United States intervene, the Justice Department will normally first-chair and direct the litigation; and (3) settlement is often the most damage-controlling measure available to pharmaceutical companies, given that government officials can leverage their authority to administratively exclude companies from participation in publicly-funded healthcare programs, and, coupled with the large recoveries available, sound a death-knell to companies.

As one commentator noted, the "FCA is a unique statute that deputizes citizens as private attorneys general and incentivizes them as bounty hunters to serve as "relators" and bring lawsuits on behalf of the United States."[7]

Consequently, the FCA provides an economic incentive not only for employees, competitors, and others to report fraudulent activities by pharmaceutical companies to the Justice Department, but also for the government itself to pursue such actions with a view toward forcing manufacturers to resolve matters rather than face the potentially enormous economic exposure brought by an adverse ruling at trial.

Highlighting the effectiveness of the qui tam provisions, not only in terms of encouraging relators to file suit, but also to unearth fraud and thereby serve the public, more than $3.9 billion has been recovered from drug manufacturers over the past six years as a result of just 16 cases brought by qui tam relators.

Of the $1.4 billion obtained in 2005 alone, $1.1 billion was recovered via qui tam suits.[8] Since 2005, pharmaceutical manufacturers have paid a total of $1.6 billion to resolve allegations of Medicare and Medicaid fraud. "Nearly all of the largest settlements and judgments announced against pharmaceutical defendants during the last three years involved a qui tam relator."[9]

The pharmaceutical companies involved are among the largest drug companies in the world: GlaxoSmithKline, Pfizer, AstraZeneca, Shering-Plough, and Bayer.[10] Bristol-Myers Squibb has already announced that it expects to pay $499 million later this year to settle allegations relating to fraudulent pricing and marketing of drugs for the treatment of schizophrenia and bipolor disorder, while the Justice Department has intervened in whistleblower cases against Abbott Laboratories and Dey, Inc.[11]

It should be no surprise then, that the use of the FCA in pharmaceutical fraud and abuse actions has risen, "[g]iven the potential 'prize' that awaits any employee—disgruntled or otherwise—should he or she identify employer wrongdoing that might have resulted in the submission of a false claim to the government."[12]

III. The History and Objectives Of The False Claims Act Qui Tam Provisions

Initially referred to as the "Informer's Act,"[13] the FCA was designed to "protect government funds and property from fraudulent claims"[14] First enacted in 1863, President Lincoln encouraged Congress to pass the first iteration of the law to prevent the fraudulent use of government funds during the Civil War.[15] Thereafter known as "Lincoln's Law," the FCA was aimed at vendors who were selling nonfunctional gunpowder, feeble mules, blind horses, rancid rations, and faulty guns to the Union Army.[16]

The 1863 version of the statute imposed civil liability upon any person who, "inter alia, knowingly presents, or causes to be presented, to an officer or employee of the United States Government … a false or fraudulent claim for payment or approval."[17] Congress and the President intended that the statute, which provided relators one half of the forfeiture as well as one half of the levied fine and costs incurred for bringing the action, would encourage private citizens to reveal instances of fraud against the United States.[18]

Lincoln's law has been amended twice, in 1943 and most recently in 1986. With regard to the former, in perhaps the most significant change, Congress required that the relator provide independent supporting evidence and prohibited suits based on evidence already in the government's possession—a jurisdictional bar.[19] The Justice Department in 1943 apparently disfavored "parasitical actions" that were bootstrapping on the rightful work of the executive branch's law enforcement function.[20] To further this objective, Congress gutted the monetary recovery available to relators, to ten percent if the United States intervened, and 25 percent if the United States declined to intervene,[21] thereby leaving the statute nearly powerless in serving the public.

Congress again amended the FCA in 1986, in large part upon the recognition that the FCA had laid dormant for over 40 years, and in those rare instances wherein relators had brought actions during that time, the results were not in keeping with the objectives of preventing fraud and encouraging those with insider knowledge of it to come forward to assist the United States in enforcing the law. The 1986 amendments have worked. "The percentage of privately initiated FCA actions reflects that an overwhelming majority of the cases brought under the statute in pursuit of public anti-fraud goals are now being brought by private, not public enforcers."[22]

IV. Requirements Of Proof In A False Claims Action

In present form, the elements that must be proved by a preponderance of the evidence to establish a FCA violation are: (1) any person; (2) who presented or caused a third party to present a claim to the government; (3) the claim was false or fraudulent; and (4) the defendant acted knowingly.[23]

A. "Any Person"

Although the FCA prohibits a "person" from presenting or causing to be presented a false claim to the government, the FCA does not define person. Thus, courts have considered whether or not healthcare entities may be considered a "person" for purposes of the FCA. In some instances, courts held that "person" encompasses states, corporations, municipalities, and others, there-

by leaving state and municipal operated healthcare providers vulnerable to FCA actions.[24] But, in 2000, the Supreme Court held that in qui tam suits, the FCA does not impose liability upon a state or a state agency.[25] Still, in 2003, the Supreme Court held that a local government, such as a county, is potentially liable as a "person" subject to a qui tam action.[26]

B. "A Claim To The Government"

The FCA defines a claim as:

> any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provided any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

31 U.S.C. § 3731(c). Even though Medicare claims are submitted to fiscal intermediaries that contract with CMS to process Medicare claims, rather than being submitted directly to the federal government, the term "claim" under the FCA applies. The fiscal intermediaries are usually insurers that are reimbursed by the United States government. Thus, the FCA has been uniformly held to apply to false federal healthcare program claims.[27]

The FCA prohibition extends not only to the submission of a claim to the federal government, but also those who "cause" a claim to be submitted. This type of liability occurs when the person responsible for the falsity is not the one who submits the claim, but instead directs others to submit the claim on their behalf. This type of liability has now been applied to individuals and entities providing billing advice to healthcare providers.[28]

C. "False Or Fraudulent"

A claim may be considered false if any of the items or services claimed on the billing form are not provided as claimed. For example, each answer included by a supplier on a CMS 1500 Form can potentially give rise to a false claim if the services were not rendered exactly as claimed. Similarly, a CMS 1500 Form certifies that the services were "medically indicated and necessary," and if those services were unnecessary, the claim is false.

D. "Acted Knowingly"

"[T]he terms 'knowing' and 'knowingly' mean that a person, with respect to information – (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard for the truth or falsity of the information."[29] Pursuant to this scienter requirement, Congress targeted "persons who ignore 'red flags'" in order to "enable [] the Government not only to effectively prosecute those person who have actual knowledge, but also those who play 'ostrich.'"[30]

E. "Statute of Limitations"

Civil actions must be brought within six years after the date of the violation or within three years after the date when material facts are known or should have been known by the government, but in no event more than ten years after the date on which the violation was committed.[31]

V. The Qui Tam Provisions of the False Claims Act

In keeping with the Congressional intent to encourage participation of the public in preventing and/or addressing fraud, the FCA provides that "[a] person may bring a civil action for a violation of Section 3729 for the person and for the United States Government."[32] Even where a qui tam Plaintiff is a relator, the "action shall be brought in the mane of the Government."[33]

A. "The Qui Tam Relator"

Claims may be brought by the Justice Department or by private parties acting as "whistleblowers."[34] In the latter, the Plaintiff is often a former employee, a competitor, or beneficiary (i.e., a patient), who is the "original source" of the fraudulent information.[35] A private party is authorized to bring suit on behalf of the government and, in exchange for the information and assistance the relator provides, the statute gives the Plaintiff a right to share in the proceeds from any settlements or judgments paid by the Defendant, whether or not the government intervenes. If successful, he may share in the recovery.[36]

Prior to filing a qui tam action, the Plaintiff must supply a copy of the Complaint to the Justice Department together with a written report of "all material evidence and information" the relator possesses.[37] In a departure from standard civil procedure, the relator does not serve a copy of the Complaint upon the defendant, and, is required to file the lawsuit under seal. The confidentiality provided by filing the lawsuit under seal simultaneously facilitates the Justice Department's ability to investigate the claims while protecting the defendant's reputation if the claims are without merit.[38]

B. "Original Source"

One oft-litigated section of the FCA is the "jurisdictional bar" provision, which arose in the 1943 amended, but was also curtailed in the 1986 amendment.[39] This provision states that the "whistleblower" must be the "original source" of the information upon which the FCA claim is based; claims cannot be based on information that has already been publicly disclosed.[40] An "original source" is one who has "direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government…."[41] However, this issue is relatively inconsequential because some courts have been permissive in who they determine to be an "original source."[42]

C. "Government Intervention Or Not?"

The Justice Department then has at least 60 days to evaluate whether to pursue the action.[43] Upon a showing of good cause, the Justice Department may then obtain an extension of time beyond the 60-day period.[44] During this "seal period," the Justice Department may apprise the Defendant of the existence of the case and provide some facts to bring about settlement discussions. The Justice Department may also serve formal investigative subpoenas and less formal inquiries.

Upon conclusion of the Justice Department's investigation, it determines whether to intervene in the relator's lawsuit as an additional Plaintiff. The decision to intervene is a vitally important one to the relator, not only because it determines the percentage share of recovery that the relator may be awarded, but also because the data shows that when the government intervenes and takes over the lead role of pressing the claims, the chances of success and monetary value of those claims increases. Eighty-three percent of the cases in which the Government has

intervened have resulted in settlement or judgment, while only six percent of the cases in which the Government has declined to intervene have had the same result.[45]

Upon intervention, the Justice Department assumes "primary responsibility" for the suit with "wide latitude to assume the conduct of the litigation," although the relator remains as a Plaintiff and is guaranteed a participatory role.[46] As co-Plaintiffs, the division of labor varies: in some instances, the Justice Department handles the entire case, in others, relators and government attorneys work side-by-side, while in still others relators and their attorneys share the bulk of the litigation duties.[47]

Where the Justice Department declines to intervene, the relator may nevertheless press the claim alone. Some have argued that because the relator was not injured by the false claim, he has no standing to bring suit. Ultimately, the Supreme Court held that private relators do have standing as the government has partially assigned its rights under the statute to relators. Thus, the injury to the government is sufficient to confer standing upon the relator.[48]

Even where the government declines to intervene, it still retains authority over the lawsuit in several ways: (1) monitor to potentially join later; (2) settle or dismiss the suit over the relator's objections as long as the relator has been given an opportunity to be heard in court; (3) seek limitations upon the relator's involvement; or (4) choose alternative remedies, such as administrative sanctions in lieu of the relator's lawsuit.[49] The courts also may impose other limitations on qui tam Plaintiffs, including number of witnesses, length of testimony, and cross-examination.[50]

D. "Damages Available"

The amount of damages the government sustains is usually the difference between the amount it paid on the claim and the amount it would have paid had the claim not been false, plus three times that amount. The amount to which a relator may be entitled also varies depending upon the intervention decision. The relator is guaranteed at least 15 percent of any judgment or settlement, and the court may award up to 25 percent, where the government intervenes. Where the government declines to intervene, the relator is guaranteed 25 percent and could receive up to 30 percent.[51] The amounts include attorney fees and costs.[52]

However, these potential recoveries are limited to a maximum of ten percent if the action is based primarily on disclosures of specific information relating to allegations in a criminal, civil, or administrative hearing; in a congressional, administrative, or General Accounting Office ("GAO") report, hearing, audit, or investigation; or from the news media.[53]

These awards encourage "insiders" who know about fraud to come forward. Indeed, government officials confirm the importance of insiders: "Whistleblowers are essential to our operation. Without them, we wouldn't have cases."[54] Healthcare organizations that become the targets of qui tam lawsuits often express frustration that the qui tam relator was the cause of the alleged fraud. But, the framers of the FCA recognized that wrongdoers might be rewarded under the act, acknowledging the qui tam provisions are based upon the idea of "setting a rogue to catch a rogue."[55] Admittedly, that is not always the case.

VI. Why Qui Tam Actions Have Increased In Frequency?

The FCA has become an attractive tool for Plaintiffs to bring suits against health care entities generally and pharmaceutical manufacturers specifically, for several reasons.

First, there is great potential for large recoveries. Anyone found in violation of the FCA may be liable in both treble damages and a "per claim" civil penalty of up to $11,000.[56] The FCA requires courts to impose civil penalties of at least $5,500 and states that "the court may assess not less than 2 times the amount of damages which the government sustains because of the act of the person."[57] And, "per claim" has been interpreted to mean "per line item" and not "per bill." Thus, total recoveries can reach into the millions.[58] Plaintiffs who succeed stand to recover millions of dollars even though they have suffered no harm themselves.[59]

Second, Plaintiffs may sue under statutes that do not themselves create a private right of action. For example, despite the fact that neither the Anti-Self-Referral ("Stark") law nor the Anti-Kickback law, provides a private cause of action, Plaintiffs have been able to use the qui tam provisions of the FCA to press violations of both of these statutes.[60]

Third, the FCA affords evidentiary advantages. Plaintiffs can use the FCA to press fraud claims pursuant to the preponderance of the evidence standard, rather than the higher beyond a reasonable doubt standard found in criminal law. And, the FCA requires no showing that a Defendant's violation of the statute harmed the government.[61]

Fourth, the government's power to exclude companies from Medicare, Medicaid, and Tricare, pursuant to the Social Security Act,[62] offers qui tam relators a measure of security, especially where the United States intervenes, that defendants will seek settlement rather than protracted litigation, further encouraging the exposure of fraud through whistleblowers. Indeed, "[f]or health care providers—including hospitals, doctors, HMOs, and others—who rely extensively on federal programs for reimbursement, exclusion is the equivalent of a corporate death penalty."[63]

Practically speaking, few healthcare organizations and pharmaceutical companies actively litigate violations of the FCA, thus resulting in settlements prominently featured in the headlines. Cases involving drug manufacturers have been the single largest source of FCA recoveries in whistleblower cases involving Medicare, Medicaid, and other programs administered by HHS. Between FY 2001 and FY 2006, there were $5.7 billion in total FCA whistleblower recoveries.[64] Over this same period, over $2.9 billion, or about half of this amount, was attributable to civil settlements in cases initiated by whistleblowers against drug manufacturers. The whistleblowers' shares account for about 13 percent of the civil recoveries.

VII. The Six Qui Tam Settlements Prior to CTI In April, 2007

Over the two-year period from October 1, 2004 through September 30, 2006, there were six settlements in cases brought by whistleblowers against a drug manufacturer: GlaxoSmithKline II; King Pharmaceuticals; Schering-Plough III; Serona; Roxane and Baxter. Each of these involved fraud against Medicaid. The allegations of fraud in these and similar cases fall into three broad categories: "marketing the spread;" "concealment of 'best price;'" and off-label marketing.

A. "Marketing the Spread"

"Marketing the spread" occurs when a manufacturer uses the difference between the price paid for a drug by Medicaid to a pharmacist and the actual cost of the drug to the pharmacist as a tool for selling its product to the pharmacist.[65] The illegality results from the manufacturer's decision to inflate the price of the drug that it provides to an independent price reporting service, knowing that the Medicare and Medicaid programs will use that reported price information to determine how much they will pay the pharmacist.[66] Thereafter, the false claim is made.

In *U.S. ex rel. Ven-A-Care of the Florida Keys, Inc. v. GlaxoSmithKline PLC*,[67] in addition to allegations of marketing the spread, the 2005 settlement involved allegations that the company encouraged customers to "double dip" by billing Medicare for an injection of Kytril, then pooling Kytril leftover from several vials to create a full dose, and then bill Medicare again for administering that dose. Kytril is an anti-emitic drug used to control nausea resulting from oncology and radiology treatments. The relator, Ven-A-Care of the Florida Keys, received $26 million of the $150 million settlement. Also as part of the settlement, a corporate integrity agreement ("CIA") between the company and the Office of the Inspector General required that company to report accurate average sales prices and accurate average manufacturer prices for drugs covered by Medicare, Medicaid, and other federal health care programs.

In *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc., v. Roxane Laboratories Inc.*,[68] Roxane Laboratories settled allegations that it marketed the spread on albuterol drugs by knowingly inflating the prices it reported to the Texas Vendor Drug program. The United States was not a party to the settlement, Roxane did not enter into a CIA, and the relator was Ven-ACare of the Florida Keys.

Baxter Healthcare Corporation settled allegations that it marketed the spread on various intravenous fluids and injectibles by knowingly reporting inflated prices for these products to the Texas Medicaid Program. The settlement amount was $10 million, of which about $3.8 million went to the federal government for its share in the alleged damages to Medicaid. The United States was not a party and Baxter did not enter into a CIA.[69]

B. "Concealment of Best Price"

Concealment of best price is specific to Medicaid. In order for a manufacturer to sell drugs to Medicaid, it must enter into an agreement to provide rebates for drugs purchased by the program.[70] The federal and state governments share in the rebates in the same proportion as they share in the costs of the Medicaid program. In the case of band-name drugs, the rebate amount is the greater of two amounts: (1) 15.1 percent of the average manufacturer price of the drug (the average price paid to the manufacturer by wholesalers for drugs distributed through retail pharmacies), and (2) the difference between the average manufacturer price and the best price, that is, the lowest price at which the manufacturer sells the drug to wholesalers, pharmacists, HMOs, hospital buying groups, or most other private sector customers.

If the manufacturer does not report the actual best price at which it sells the drug, and if the best price is lower than 84.9 percent of the average manufacturer price, then Medicaid overpays for the drug, because the rebate amount paid by the manufacturer is lower than it should be.

King Pharmaceuticals, in *U.S. ex rel. Bogart v. King Pharmaceuticals, Inc.*,[71] settled allegations that, over the period 1994 through 2002, it knowingly submitted inaccurate best price information and average manufacturer price data to the federal government, resulting in Medicaid rebate amounts on its drug products that were lower than they should have been. The products at issue involved King's entire product line, including Altace, an ACE inhibitor that reduces the likelihood of heart attack and stroke.

The total settlement amount was $124.1 million, of which $73.4 million was paid to the federal government and $50.6 million to the states. As part of the settlement, King entered into a CIA with the Office of the Inspector General that, among other things, required the company to engage in Independent Review Organization to test periodically the accuracy of data.

Similarly, Shering-Plough entered into a global settlement totaling $435 million in criminal and civil liability in connection with the marketing of several difference drug products. The allegations claimed that Schering-Plough knowingly and willingly misreported its best price for Claritin Redi-Tabs and K-Dur 20 to the federal government in 1998 and 1999. Allegedly, Schering-Plough failed to report deeply discounted prices for these drugs that it gave to Kaiser Permanente Medical Care Program in order to enable it to retain the HMO as a customer without giving the Medicaid program the same deep discounts.

For example, in the case of the Claritin Redi-Tabs, the HMO was willing to include the drug on its formulary only if the price was reduced to $1.10 per RediTab, which would represent a new best price. Schering-Plough did not report the $1.10 sale price as best price, resulting in a loss to the Medicaid program of $4.4 million in rebate payments.

C. "Off-Label Marketing"

Off-label marketing is prohibited by the Food, Drug and Cosmetic Act ("FDCA"), 21 U.S.C. § 331(d). With the purpose of "prohibit[ing] the movement in interstate commerce of adulterated and misbranded food, drugs, devices, and cosmetics," the Food and Drug Administration ("FDA") was created by the FDCA.[72] As one of its missions, the FDA must approve drugs marketed within the United States.[73] As part of a new drug application, a drug's sponsor, typically the pharmaceutical company that developed the drug, submits detailed clinical evidence demonstrating a drug's safety and effectiveness, along with a proposed label.[74] As long as a drug meets these requirements and there is "substantial evidence" to support these claims, the drug may be approved for distribution in the United States.[75]

Until FDA approval, however, manufacturers may not sell a drug to U.S. consumers. Once the FDA has approved a drug as safe and effective for a specified use, physicians may prescribe it for intended use as well as for FDA-unapproved "off-label" uses.[76] Off-label uses are "uses that are different than those approved by the FDA."[77] This practice, of physician's prescribing drugs for off-label uses "is an accepted and necessary corollary of the FDA's mission to regulate in this area without directly interfering with the practice of medicine."[78] Further, the FDCA does

not "limit or interfere with the authority of a healthcare provider to prescribe or administer any legally marketed device to a patient for any condition or disease with a legitimate healthcare practitioner-patient relationship."[79]

"A physician may prescribe an approved drug for any medical condition, irrespective of whether FDA has determined that the drug is safe and effective with respect to that illness."[80] However, manufacturers may market or promote their products among physicians for approved uses only. The FDCA prohibits a manufacturer from marking or promoting its drug products among physicians for off-label uses.

Medicaid purchases drugs on behalf of its low-income beneficiaries if they are prescribed by a licensed physician as medically necessary, regardless of whether the use is specifically approved by the FDA or off-label. When a manufacturer promotes an off-label use of a drug and physicians respond by prescribing the product for such unapproved uses, the Medicaid program spends more for the drug that it would if its purchase were limited to approved uses. In FCA terms, the manufacturer's violation of the FDCA has caused the presentation of false or fraudulent claims to the Medicaid program because the manufacturer's illegal promotion of off-label uses lead physicians to write prescriptions for these uses that they otherwise would not have written."[81]

Serono S.A., a Swiss firm, agreed to pay $567 million in civil liabilities and $136.0 million in criminal fines as a consequence of off-label marketing of the drug Serostim from 1996 through 2004. Serostim is an injectible recombinant human growth hormone used to treat AIDS wasting, or large involuntary weight loss, especially of lead body mass, in patients with AIDS.

VIII. What Can A Pharmaceutical Company Do To Comply Or Respond?

Given the sheer size of the pharmaceutical industry, the vast number of employees, the host of competitors, as well as beneficiaries, coupled with the comprehensiveness of the statutory and regulatory frameworks addressing healthcare, it appears that the FCA generally, and its qui tam provisions specifically, are areas of the law that must be known by general counsels and compliance officers, observed by corporate officers, and discharged by company employees.

Because compliance is really not an option, but instead, a requirement, it is in the company's best interest to devise and implement, at a minimum, three safeguards. They are: (1) a written regulatory compliance policy and procedure manual; (2) standard and frequent training; and (3) a response plan and team for those instances where the United States, likely by and through a qui tam relator, contacts your company requesting information.

A. "Compliance Policy"

Any corporation, and surely a pharmaceutical manufacturer, is well-counseled to include in its compliance policy those minimum requirements which will likely withstand Justice Department, and perhaps later, court scrutiny. As a floor, a policy should include:

(1) Standards and procedures must be establishes to prevent and detect unlawful activity;
(2) Executive leadership must know the content and operation of the compliance program to prevent and detect violations of the law;
(3) "Extra" due diligence in selecting compliance officers;
(4) Dissemination of standards and procedures to each level of the company;
(5) Oversight plan devised and implemented to monitor and audit;
(6) Systematic promotion and enforcement of the compliance program; and
(7) Respond effectively and responsibly to unlawful conduct that is detected.

These measures are only a start, and must be tailored to the company's specific operational objectives.

B. "Effective Training"

All personnel, especially those with responsibility for the sale and marketing of prescription drugs, must receive vigorous regulatory compliance training about the various fraud and abuse laws applicable to the industry.

C. "Response Plan and Team"

A crisis management plan should be a part of the compliance program, and, be structured to help the company provide the government with any information to which it is entitled, while reducing disruption that any such investigation may cause. Employees should be informed of the company's policy regarding government investigations, the first of which is it is the company's policy to comply with applicable laws governing the provision of healthcare services and to comply with all lawful requests made in a government inquiry or investigation, including any surveys or audits conducted by governmental agencies. The company certainly expects all employees to provide truthful answers to government inquiries, and to safeguard and protect any documents that may relate to the investigation. Counsel should also dispatch a "evidence preservation" letter upon receipt of a government inquiry, if the company does not already have an electronic discovery procedure in place. Employees should be asked to contact the compliance officer if they are contacted by government investigators.

A carefully crafted crisis management plan can reduce the adverse impact of a government investigation while placing the company in the best position to begin a cooperative and collaborative dialogue capable of addressing any issues raised by the government.

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*John N. Maher is a member of Epstein Becker & Green, Chicago, Illinois in the Litigation and Health Care and Life Sciences Practices. He can be contacted at (312) 499-1436 or jmaher@ebglaw.com

1. DOJ Press Release, "Cell Therapeutics, Inc. to Pay United States $10.5 Million to Resolve Claims For Illegal Marketing of Cancer Drug," (April 17, 2007).

2. Memorandum from Deputy Attorney General Eric H. Holder, Jr. to All U.S. Attorneys, First Asst. U.S. Attorneys, Civil Health Care Fraud Coordinators in the Offices of the United States Attorneys, and Trial Attorneys in the Civil Div., Commercial Litigation Section (June 3, 1998) ("Guidance on the Use of the False Claims Act in Civil Health Care Matters).

3. See Lisa Michelle Phelps, Note, Calling Off the Bounty Hunters: Discrediting the Use of Alleged Anti-Kickback Violations to Support Civil False Claims Actions, 51 Vand. L. Rev. 1003, 1004 (1998).

4. Gen. Acct. Office, Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance, GAO-01-506 at 1 (Mar. 30, 2001).

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7. Marc J. Scheineson & Shannon Thyme Klinger, "Lessons From Expanded Government Enforcement Efforts Against Drug Companies," 60 Food & Drug L.J. 1 (2005).

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13. See Joan H. Krause, "Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act," 36 Ga. L.Rev. 121, 129 (2001).

14. *Costner v. URS Consultants, Inc.*, 153 F.3d 667, 676 (8th Cir. 1998).

15. *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968).

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23. 31 U.S.C. § 3729.

24. See e.,g., *United States ex rel. Long v. SCS Busin. & Tech. Inst.*, 999 F.Supp 78 (D.D.C. 1998).

25. *Stevens*, 529 U.S. at 768.

26. *Cook County v. United States ex rel. Chandler*, 538 U.S. 119 (2003).

27. See *United States v. Cabrera-Diaz*, 106 F. Supp. 2d 234 (D. P.R. 2000).

28. See, e.g., *United States v. Kensington Hosp.*, 760 F.Supp. 1120 (E.D. Pa. 1991) (involving physicians who were suspended from participating in the Medicaid program who caused a hospital to submit improper bills on their behalf).

29. 31 U.S.C. § 3729(b)(1)-(3).

30. H.R. Rep. No. 99-660 at 21 (1986); see also S. Rep. No. 99-345 at 7 (1986).

31. 31 U.S.C. § 3731(b).

32. 31 U.S.C. § 3730(b) ("Actions by private persons.").

33. Id.

34. 31 U.S.C. § 3730(a)-(b).

35. See *Cooper v. Blue Cross and Blue Shield of Florida, Inc.*, 19 F.3d 562 (11th Cir. 1994).

36. 31 U.S.C. § 3730(d).

37. 31 U.S.C. § 3730(b)(2).

38. John T. Boese, "Civil False Claims and Qui Tam Actions" (Aspen 2001).

39. 31 U.S.C. § 3130(e)(4).

40. 31 U.S.C. § 3730(e)(4)(A).

41. 31 U.S.C. 3730(e)(4)(B).

42. See, e.g., *United States ex rel. Schumer v. Hughes Aircraft Co.*, 63 F.3d 1512, 1518 (9th Cir. 1995) (holding that disclosure to employees or potential availability to the public through the Freedom of Information Act does not constitute "public disclosure."). For a recent U.S. Supreme Court decision addressing this area, see *Rockwell International Corp v. United States*, 127 S. Ct. 1397 (2007).

43. 31 U.S.C. § 3730(b)(2).

44. 31 U.S.C. § 3730(b)(3).

45. See Robert Fabrikant et. al., "Health Care Fraud: Enforcement and Compliance" § 4.01[3], at 4-53 (Release 19, Law Journal Press 2006).

46. 31 U.S.C. § 3730(b)(2); *United States ex. Rel. Stillwell v. Hughes Helicopters, Inc.*, 714 F. Supp. 1084 (1090 (C.D. Cal. 1989).

47. See *United States ex rel. Merena v. SmithKline Beecham Corp.*, 114 F.Supp2d 1323 (M.D. Fla. 2001) (relator's counsel assumed large measure of responsibility for the litigation).

48. *Stevens*, 529 U.S. at 768.

49. 31 U.S.C. § 3730(c)(3); see also *United States ex rel Garibaldi v. Orleans Parish Sch. Bd.*, 244 F.3d 486, 489 (5th Cir. 2001) (government joined after monitoring); *United States v. Health Possibilities, P.S.C.*, 207 F.3d 335, 340-41 (6th Cir. 2000) (after declining to intervene, government opposed the settlement reached by relator and Defendant).

50. 31 U.S.C. § 3730(c).

51. 31 U.S.C. § 3730(d)(1)-(2).

52. Id.

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54. Justin Gillis, "Whistleblowing: What Price Among Scientists?," Wash. Post, Dec. 28, 1995, at A21 (quoting Lawrence J. Rhoades, a division director at the U.S. Department of Health and Human Services).

55. *Mortgages, Inc. v. United States Dist. Court*, 934 F.2d 209, 213 (9th Cir. 1991) quoting Cong. Globe, 37th Con. 3d Sess. 955-56 (1863)(remarks of Sen. Howard).

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57. Id. In 1999, the original statutory amounts of $5,000 and $10,000 were increased by a Justice Department rule implementing the Debt Collection Improvement Act of 1996, which permits periodic adjustment of penalties imposed under federal law to account for inflation. 64 Fed. Reg. 47,099 (Aug. 30, 1999).

58. "HealthSouth Agrees to Pay $325 Million To Resolve Medicare Billing Allegations," 14 Health L. Rep. 25 (2005).

59. See, e.g., "Tap Pharmaceuticals Settles with DOJ for $875 Million," 55 HealthCare Fin. Mgmt. 10 (2001).

60. See, e.g., *United States ex rel. Pogue v. Am. Healthcorp, Inc.*, 914 F. Supp 1507, 1513 (M.D. Tenn. 1996) (holding that the plaintiff can bring a claim alleging violations of the anti-kickback and anti-self-referral laws under the FCA).

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63. Christopher A. Wray & Robert K. Hur, "Corporate Criminal Prosecution In A Post-Enron Word: The Thompson Memo In Theory and Practice," 43 Am. Crim. L.Rev. 1095 (2006).

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68. No GV3-03079 (District Court Travis County, 201st Judicial Circuit) and No. GV002327 (District Court Traveis County, 53rd Judicial Circuit).

69. Settlement Agreement Release, June 9, 2006, *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Abbott Laboratories Inc., et. al.*, No GV401286 (District Court Travis County, 201st Judicial Circuit).

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74. See id. §§ 355(d) and 355(b)(1)(F).

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77. *See United States ex rel. Franklin v. Parke-Davis*, 147 F. Supp. 2d 39, 44 (D. Mass. 2001).

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