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Health Law

By: Roger R. Clayton, Gregory J. Rastatter and J. Matthew Thompson
Heyl, Royster, Voelker & Allen, P.C., Peoria

The Importance of Clear and Consistent Peer Review Procedures: Appellate Court Clarifies Scope of Medical Studies Act Privilege

The Illinois Medical Studies Act (the "Act") protects from disclosure all information obtained by peer review committees "in the course of internal quality control or medical study…" 735 ILCS 5/8-2101. It does not protect against the disclosure of information generated by individuals who are not members of a qualified committee before a peer-review process begins or after it ends. *Roach v. Springfield Clinic*, 157 Ill. 2d 29, 623 N.E.2d 246 (1993); *Ardisana v. Northwest Community Hosp., Inc.*, 342 Ill. App. 3d 741, 795 N.E.2d 964 (1st Dist. 2003). The Second District of the Appellate Court recently clarified this limitation. In *Kopolovic v. Shah*, 2012 IL App (2d) 110383, the court held that a memorandum of an anesthesiologist, which questioned the ethics of a surgical procedure, yet was written before any peer-review committee was sufficiently involved in the investigation of the surgery, was not created "as a result of" the activities of a qualified committee. *Kopolovic*, 2012 IL App (2d), ¶ 28. Accordingly, no evidentiary privilege applied to protect the document from disclosure in a civil lawsuit for defamation filed by the physician whose actions had been questioned in the memorandum. *Id*.

The Midwest Center for Day Surgery (MCDS) operates a surgery center in Downers Grove. *Id*. ¶ 4. The plaintiff was a plastic surgeon who performed procedures at MCDS and other medical facilities in the area. *Id*. An anesthesiologist was an employee of Anesthesia Services, Ltd., a group of anesthesiologists who had a contract with MCDS to provide services. *Id*. The plastic surgeon had staff privileges at MCDS, and MCDS did the billing for all of the services he performed at the facility. *Id*.

On May 8, 2007, the plastic surgeon performed abdominal surgery to repair an umbilical hernia, and two other unrelated cosmetic procedures on a female patient at the same time. *Id*. ¶ 6. The anesthesiologist participated in the surgery. *Id*. The patient's surgical consent form listed three procedures but did not include the excision of old scars related to a prior Cesarean section and an appendectomy. *Id*. The plastic surgeon's postoperative report listed four surgical procedures, including the "excision of abdominal scars and repair and revision." *Id*. The hernia repair was billed to the patient's insurer, while the patient paid for the cosmetic procedures in advance. *Id*. There was no suggestion that the patient suffered any adverse consequences from the surgery or that she was dissatisfied with any aspect of it. *Id*.

The anesthesiologist, however, became concerned that the surgery was, in reality, an abdominoplasty (a cosmetic procedure commonly referred to as a "tummy tuck") rather than the repair of an umbilical hernia. *Id*. ¶ 7. He voiced those concerns to the chair of an anesthesia department at another hospital in the area. *Id*. The

anesthesiologist was referred to Chair of Anesthesia Services at MCDS and a member of the MCDS Board of Directors. *Id*. The anesthesiologist also spoke with the President of the MCDS board. *Id*. The board president advised the anesthesiologist that he should put his concerns in writing and bring them to the board's attention. *Id*.

The anesthesiologist drafted a memorandum to the MCDS Board of Directors and its "consulting committee," dated May 16, 2007, entitled "Unethical Practices at MCDS." *Id*. ¶ 8. In the memorandum, the anesthesiologist outlined that the patient had minimal or no umbilical hernia, but underwent a full abdominoplasty "disguised" as an umbilical hernia repair. *Id*. The memorandum further advised of the payment setup, and concluded that the procedure was conducted in an unethical manner. *Id*. Despite this strong position, however, the anesthesiologist had not reviewed the patient's medical file, the billing records, or the records relating to the surgery before creating the memorandum. *Id*.

The anesthesiologist distributed the memorandum in sealed envelopes to persons whose names were given to him by the MCDS chair of anesthesiology and the board president. *Id*. ¶ 9. The Medical Director of MCDS investigated the matter. *Id*. ¶ 10. During the course of the investigation, the director spoke with the plastic surgeon on the telephone and met with him in June of 2007. *Id*. The director asked the plastic surgeon to attend the June 25, 2007 board meeting, but he was unable to do so. *Id*. Thereafter, communications broke down, and the plastic surgeon never appeared before the board. *Id*.

The plastic surgeon filed the suit against the anesthesiologist and MCDS, alleging that the anesthesiologist had engaged in defamation *per se* and false light invasion of privacy. *Id.* ¶¶ 10-11. Further, the complaint alleged that MCDS was vicariously liable for the anesthesiologist's actions, and that MCDS was directly liable in negligence, because it breached a duty owed to the plastic surgeon relating to its investigation of the memorandum. *Id*. ¶ 11. According to the director and board president, the board's investigation of the plastic surgeon remained pending at the time of this suit. *Id*. ¶ 10.

Both the anesthesiologist and MCDS filed motions for summary judgment, arguing that the memorandum was protected under the Act, that the memorandum was protected by a common law conditional privilege, and that it was substantially true. *Id*. ¶ 12. MCDS further argued that the anesthesiologist was not an employee, and therefore it could not be vicariously liable for his actions. *Id*. Finally, MCDS argued that it had not been negligent. *Id*. The trial court granted the motions for summary judgment, holding the memorandum was privileged from disclosure under the Act, that it was conditionally privileged, and that it was substantially true. *Id*.

The appellate court reversed, however, holding the memorandum was not privileged under the Act, as the anesthesiologist was not a member of any peer review or quality control committee at MCDS. *Id*. ¶¶ 21, 58-59. The fact that the anesthesiologist was engaged in an attempt to bring to light practices he viewed as unethical and potentially detrimental to patients was not sufficient in the court's eyes to bring the memorandum within the protections of the Act. *Id*. ¶¶ 21-22. Relying on the Illinois Supreme Court's decision in *Roach*, the court held that the Act covered only information generated or created by a committee "already engaged" in peer review or a quality control process with regard to the specific incident. *Id*. ¶ 24 (*citing Roach*, 157 Ill. 2d at 39, 623 N.E.2d at 246). Interpreting the Act broadly to cover any information related to the goal of improving patient care, even if that information was not the "information of" a committee described in the statute, would subvert its purpose. *Id.*

Even the fact that the anesthesiologist had written the memorandum at the behest of two doctors on the MCDS Board of Directors, which may have thus become engaged in a peer review process, did not trigger the privilege. *Id*. ¶¶ 27-32. The information that provided the content for the memorandum had been generated by the anesthesiologist prior to the anesthesiology chair and the board president becoming involved. *Id*. ¶ 40. "Earlier-generated information cannot be cloaked with the privilege through the 'simple act' of furnishing that

information to one of the statutorily described committees." *Id*. ¶ 28 (*citing Roach*, 157 Ill. 2d at 41). Simply put, the memorandum was not generated "as a result of" the board's investigation. *Id.* ¶ 28).

The court continued that despite the further actions of the anesthesiology chair and the board president, the direction of these individual members of a committee are not the same as the actions of the committee itself. *Id*. ¶ 31. This was true even though the hospital's bylaws provided that the chair of the department was accountable for "all professional and administrative activities within his department." *Id*. It was the department itself *as a whole* that was charged with the responsibility for conducting medical reviews, and the bylaws did not grant the department chair the authority to act for the department outside the review process conducted at monthly meetings. *Id*.

The court also rejected the conditional privilege and "substantially true" arguments of the anesthesiologist and MCDS, holding there were issues of facts as to whether any privilege was abused and whether the procedures deviated from the standard of care. *Id.* ¶¶ 41-49. The court declined to rule on MCDS's arguments that it was not negligent or vicariously liable, as the trial court had not reached those issues. *Id*. ¶ 55.

In reviewing this case, it becomes clear to the practitioner and hospital clients that well-outlined quality control/peer-review procedures and a properly functioning committee are essential. The mistake made in this case was the instruction to the anesthesiologist that he commit his thoughts to writing, prior to a proper investigative body being formed. Clear procedures should be set forth in the medical staff bylaws and in policies, rules, and regulations promulgated under the bylaws. Physicians and staff should have a clear understanding of what actions to take when they wish to raise concerns, and the investigation should be conducted in compliance with the procedures set forth in the documents and the Act.

About the Authors

Roger R. Clayton is a partner in the Peoria office of *Heyl, Royster, Voelker and Allen, P.C.* where he chairs the firm's healthcare practice group. He also regularly defends physicians and hospitals in medical malpractice litigation. Mr. Clayton is a frequent national speaker on healthcare issues, medical malpractice and risk prevention. He received his undergraduate degree from Bradley University and law degree from Southern Illinois University in 1978. He is a member of the Illinois Association of Defense Trial Counsel (IDC), the Illinois State Bar Association, past president of the Abraham Lincoln Inn of Court, President and board member of the Illinois Association of Healthcare Attorneys, and past president and board member of the Illinois Society of Healthcare Risk Management and co-authored the Chapter on Trials in the IICLE Medical Malpractice Handbook.

Gregory J. Rastatter is an associate in the Peoria office of *Heyl, Royster, Voelker and Allen, P.C.* where he is a member of the firm's healthcare practice group. Greg's practice involves representing and advising hospitals on compliance issues, including drafting and analysis of hospital and medical staff bylaws, physician and allied health professional contracts, and other aspects health law for compliance state and federal law and Joint Commission standards. He received his undergraduate degree from Bradley University and law degree from the University of Illinois College of Law in 2003. Greg is a member of the Peoria County Bar Association, the Illinois State Bar Association, and the American Bar Association.

J. Matthew Thompson is an associate in the Peoria office of *Heyl, Royster, Voelker & Allen, P.C.*. He practices primarily in the area of general tort defense. He received his B.S. in Accounting from Culver-Stockton College in 2005 and his J.D. *cum laude* from Southern Illinois University School of Law in 2008.

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Illinois Association of Defense Trial Counsel, PO Box 588, Rochester, IL 62563-0588, 800-232-0169, idc@iadtc.org