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ILLINOIS MEDICAL MALPRACTICE REFORM IN LIMBO

By David R. Sinn, Peoria

The medical malpractice tort reform legislation enacted in August of 2005 was celebrated principally for its adoption of damage caps or limits on non-economic damages such as pain and suffering and loss of society and companionship. These intangibles have historically been the "wild cards" in evaluating and litigating medical malpractice cases.

Recently, however, the constitutional challenge to the 2005 malpractice act has produced a ruling from Cook County Circuit Judge Diane Joan Larsen that the new legislation is unconstitutional as special legislation and an invasion of the separation of powers clause of the Illinois Constitution. The ruling will likely be appealed on an expedited basis directly from the Circuit Court of Cook County to the Illinois Supreme Court.

The last attempt at medical malpractice reform in 1995 was declared unconstitutional as special legislation, in part because the Court felt there was no empirical data to suggest that such reforms actually work. This time, however, there is data available from a scientific study published by Ronen Avraham of Northwestern Law School in October 2006. That study evaluated the impact of six different types of tort reform on the frequency, size, and number of total settlements in medical malpractice cases between 1991 and 1998. After analyzing 100,000 malpractice settlement payments reported to the National Practitioner Data Bank from 1991 to 1998, Avraham found that caps on pain and suffering and limitations on joint and several liability reduced the number of annual settlements in malpractice cases. He concluded that the combined effect of all six tort reforms was statistically significant in reducing the number of claims, but not the average amount of settlement. In other words, Avraham's study might suggest that while tort reform legislation including caps may make no measurable difference in any individual case, it is an efficient way to reduce defense costs by reducing the number of total claims.

In addition, recent statistics published by the U.S. Department of Justice on medical malpractice insurance claims in seven states from 2000 to 2004 show that during that interval, physicians in Illinois closed 88 percent of the claims filed against them without any payment by way of settlement or verdict. During that four year interval the average wrongful death settlement in Illinois was $457,000, while the average settlement for cases alleging only emotional damage was $33,000. Significantly, the statistical study showed lower wrongful death settlements in states with tort reform legislation in place, e.g. in Missouri, the average wrongful death settlement was $172,000; in Florida, $216,000; and in Massachusetts, approximately $350,000. This additional data will hopefully dissuade the Illinois Supreme Court from finding as it did in 1997 that there was insufficient proof of public benefit from medical tort reform to exempt it from the ban on special legislation.

The decision of Judge Larsen in the Cook County case is not binding precedent on any other judges sitting in any other court. However, as a practical matter, other judges faced with a motion to adjudicate the constitutionality of the 2005 Tort Reform Act will most likely postpone any decision until the Illinois Supreme Court rules on Judge Larsen's decision.

While the Cook County case is on appeal, it may well be that the trial of any case where the treatment complained of occurred after August 25, 2005 (the effective date of the tort reform legislation) will be stayed. By its terms, the tort reform statute did not apply to any pending malpractice case where the treatment complained of occurred prior to enactment of the legislation. That will cover most of the medical malpractice cases currently pending in Illinois. In other words, we may see a brief hiatus in the trial of more recently filed cases, but it will be business as usual for any claim based on treatment rendered prior to August 25, 2005.

If we look at how medical malpractice trials have been adjudicated in downstate Illinois in the 5 years immediately prior to tort reform, defendant physicians have won no-liability verdicts in roughly 90 percent of the cases tried to verdict during that time period. That is not a vast departure from the norm in downstate Illinois, where physicians have

won roughly 85 percent of all medical malpractice cases taken to trial in the last 30 years.

For the most part, the additional protections of the 2005 legislation have not been needed by downstate Illinois medical providers. Consequently our lawyers believe that the same degree of success can be achieved in any cases which are not stayed for those physicians who go to verdict in 2008 without the benefit of the 2005 legislation. It is more important to tap into the knowledge and experience of lawyers who have been instrumental in producing the 90 percent success rate rather than to hope that more favorable rules will produce a just result. There is no substitute for selecting experienced and proven trial counsel to represent your interests.

Dave Sinn is chair of Heyl Royster's Professional Liability Practice Group. Dave has defended hundreds of medical malpractice cases throughout Central Illinois. He has authored several works on the defense of professional liability cases and speaks frequently before both legal and medical audiences on issues of medical malpractice.

How Do Juries Decide Whether a Doctor Is Liable?

By Adrian E. Harless, Springfield

Introduction

A jury trial is the formal process by which parties involved in a legal dispute resolve their differences. There are several steps involved in a jury trial: the selection of the jury, opening statements, the presentation of the evidence, closing arguments, the court's instructions regarding the law, and jury deliberations to reach a verdict. After the jury has reached a verdict, the court enters judgment in favor the party who prevailed according to the jury's verdict. How do juries decide who prevails? This article addresses the legal requirements to establish whether a doctor is liable.

Elements of a Medical Negligence Case

In a medical negligence lawsuit, there are three questions a jury must answer: (1) Was the defendant negligent?; (2) Did the defendant's negligence injure the plaintiff?; (3) What damages did the plaintiff suffer as a result of these injuries? The plaintiff, the party who files the lawsuit, has the burden of proving each of these elements by a preponderance of the evidence, i.e. that each proposition is more probably true than not true.

The Jury Trial Process

To meet the burden of proof, the plaintiff introduces evidence to establish each element. To establish the defendant's negligence, the plaintiff must establish the standard of care applicable to the defendant and that the defendant failed to meet that standard. The legal definition of the standard of care is: "Professional negligence by a physician is the failure to do something that a reasonably careful physician practicing in the same or similar localities would do, or the doing of something that a reasonably careful physician would not do, under the circumstances similar to those shown by the evidence." Illinois Pattern Jury Instructions (Civil) 105.01. Evidence to establish negligence consists of the testimony from expert witnesses, or evidence of professional standards, policies and procedures. Once the plaintiff has established the defendant was negligent, the plaintiff must then establish that the negligence was the cause of the plaintiff's injuries. This element, known as "proximate cause," is the link between the negligence and the injuries. It is not sufficient to establish that a doctor was negligent and that the plaintiff has incurred a bad result. Rather, plaintiff must show that the negligence, not some other cause, resulted in the plaintiff's injuries. Finally, the plaintiff must establish that injuries resulting from the negligence caused the damages alleged.

Because the plaintiff has the burden of proof, the plaintiff's case is presented first. If the court determines the plaintiff has presented minimally sufficient evidence to meet the burden of proof, the defendant then presents evidence to rebut the plaintiff's evidence. In most instances, the defendant calls expert witnesses to challenge the plaintiff's interpretation of the standard of care, the causal connection between the defendant's treatment and the plaintiff's injuries, and the nature and extent of the damages the plaintiff is claiming.

After the evidence is concluded, the court instructs the jury on the issues and the law. The court provides the jury with verbal and written instructions which list the plaintiff's allegations of negligence, defines the plaintiff's burden of proof, defines negligence (the definition noted previously) and instructs them to deliberate and return a verdict based on the evidence. If the jury determines the defendant was not negligent or that the conduct of the defendant did not cause the plaintiff's injuries, the jury is instructed to return a verdict in favor of the defendant. On the other hand, if the plaintiff proves these elements, the jury is instructed to

determine the amount of damages the plaintiff has suffered for non-economic injuries (pain and suffering, disability and disfigurement) and economic losses (medical expenses, lost wages, caretaking expenses). Unless agreed otherwise by the parties, the jury's verdict must be unanimous: assuming the case is brought in state court, all 12 jurors must agree.

Once the jury reaches a decision, they sign a verdict form indicating the result and return it to the court. The court then reads the verdict and enters judgment for the prevailing party.

Adrian Harless has been defending physicians in Heyl Royster's Springfield office since 1982 and has earned the respect of his clients and peers statewide. He served by appointment for eight years on the Illinois Supreme Court Committee on Pattern Jury Instructions in Civil Cases.

What Every Physician Needs to Know About the Stark Law

By Roger R. Clayton, Peoria

When do physician referrals create ethical concerns? The Stark Law prohibits a physician from referring Medicare or Medicaid patients to an entity for certain designated health services ("DHS") if the physician (or an immediate family member of the physician) has a direct or indirect financial relationship with such entity, unless an exception applies. While this article will provide a general overview of the Stark Law, each referral situation should be specifically reviewed with your attorney to determine whether Stark Law is applicable.

Stark Law has five components:

(1) A physician, defined as a doctor of medicine, must be involved.

(2) The physician (or family member) must have a financial relationship with the entity to which the referral was made. The financial relationships that trigger the prohibition on referrals include any ownership or investment interest in the entity, as well as any compensation arrangement with the entity, unless an exception applies.

(3) The service or item being provided is a DHS. The following are considered DHS:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and speech language pathology services;
- Radiology and certain other imaging services;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment and supplies;
- Prosthetics, orthotics, prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

(4) Payment must be made under either Medicare or Medicaid.

(5) A physician referral is required.

A referral occurs any time a physician orders or certifies the need for a patient to receive an item or service that will not be provided by the referring physician. Under the Stark Law, a referral includes not only an actual referral, but also the ordering of any type of product or service provided by another that is included within the list of DHS. Referrals can be written, oral or electronic depending upon the particular service.

The Stark Law's broad ban on physician self-referral is subject to numerous exceptions. General exceptions include:

- Physician services;
- In office ancillary services;
- Prepaid plan;
- Intra family rural referral; and
- Academic medical centers.

Other exceptions include various types of compensation arrangements and two extremely narrow circumstances for lack of knowledge or intent, otherwise known as "innocent entity" exceptions. Two additional exceptions were added in 2006: electronic prescribing and health records technology.

Stark Law in the News . . .

A hospital and two physician-owned entities have agreed to pay a total of $6.9 million to resolve allegations that they violated the False Claims Act and the Stark Law. Of that amount, the two "whistleblowers" in the case will jointly receive $1.2 million as a share of the recovery under the settlement. According to the complaint, the hospital provided the services of its employees free of charge to one of the entities and purchased platelet products from the other at an inflated

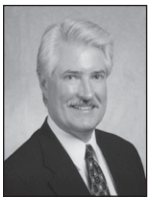
price. The government also alleged that the fees paid by the hospital exceeded fair market value.

In August of last year, the Centers for Medicare and Medicaid Services and the Office of Inspector General published final rules to accelerate the adoption of electronic health record and electronic prescribing technology. These rules provide that donations of such technology will not violate the physician self-referral law (Stark Law).

The Centers for Medicare and Medicaid Services posted an advisory opinion concluding that stock held by physician-shareholders in a charitable, multi-specialty group medical practice did not constitute ownership or investment interest for purposes of the Stark Law. The stock held by the physician-shareholders does not exhibit the benefits of typical stock ownership because it is "restricted in such a way that a physician-shareholder's financial interests cannot be affected by his or her ownership," and the physician-shareholders "do not receive any of the purchase and ownership rights or financial risks and benefits typically associated with stock ownership".

Two South Florida pulmonologists agreed to pay $65,066 and $57,030, respectively, and enter into a three-year Integrity Agreement to resolve their liability under the Anti-Kickback Statute provision of the Civil Monetary Penalties Law ("CMP") and the Stark Law. The OIG alleged that the doctors violated those laws by accepting gifts, including Miami Dolphins tickets and meals, from a durable medical supplier in exchange for patient referrals.

The interpretation of the Stark Law is an evolving process. If you are engaged in a referral relationship with an individual or organization in which you have a financial interest of any kind, we urge you to discuss the fact specific situation with your attorney. Failure to do so can have serious consequences.



Roger Clayton is Chair of Heyl Royster's statewide Healthcare Practice Group, and also regularly represents healthcare providers in medical malpractice and IDPR matters. He is President-Elect of the Illinois Association of Healthcare Attorneys and Past President of the Illinois Society of Healthcare Risk Management.

Roger Clayton, Adrian Harless and Dave Sinn, along with most of the lawyers listed in the column to the right, have been designated "Leading Lawyers" in Illinois as a result of a statewide survey of Illinois attorneys and judges conducted by the Chicago Daily Law Record.

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