A MIDWESTERN LAW FIRM

MEDICOLEGAL MONITOR

A REVIEW OF MEDICAL LIABILITY AND HEALTHCARE ISSUES

HEYL ROYSTER

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A Word From the Practice Chair

The IDFPR giveth your license to practice and can taketh that license away. It's pretty rare that they do, but between a letter of reprimand and revocation of your license, there is a lot of misery they can visit upon you. Fortunately, you have friends at Heyl Royster who can and have worked with the Department for decades and it has been our great good fortune to turn some nightmarish scenes into mere aggravation rather than termination. The trick, in many cases, is to show IDFPR that you recognize the error, that you genuinely regret the error, and that you have concrete plans that make repetition of the error highly unlikely. In other cases, if you dig in your heels and fight them, you may find that this "giant" called "The State" has feet of clay.

In the article by Ann Barron, she discusses two recent Appellate Court decisions involving a rule of law that has been honored more in the breach than the observance over the last 24 years. It has long been the law of Illinois that no aspect of an investigation into a bad outcome is privileged from discovery until a member of the formal peer review committee requests such an investigation. All interviews and reports generated before that request is made are fully discoverable in litigation. Ann does your profession a great service by reminding you of that fact. Hopefully her warning will accomplish what 24 years of Appellate Court decisions have not.

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Recent Trends in Illinois Department of Financial and Professional Regulation Actions

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The Illinois Department of Financial and Professional Regulation (IDFPR) regulates the practice of over 100 professions and occupations in Illinois, including those licensed to render healthcare to patients. The Department has the authority to obtain information, investigate and discipline the license of an individual upon proof of a violation of the applicable licensing act under which the license was issued. Typically, this would be either the Illinois Medical Practice Act or the Illinois Nursing Practice Act.

Overview of the Process

Case Initiation

When an allegation is received against a person licensed by IDFPR, the allegation is forwarded to IDFPR's Complaint Intake Unit. Typically, these allegations come from patients, hospital reports, medical malpractice settlement reports, or government agencies.

Investigation

Once an allegation has been reviewed, it is assigned to an investigator who is responsible for determining if there has been a potential violation of a licensing law or Department rules and regulations. 225 ILCS 60/22(A)(1)-(43) sets forth the grounds upon which the IDFPR may seek disciplinary action against a physician. 68 Ill. Admin. Code Section 1285.240 sets forth the standards for three of the most frequently plead allegations: dishonorable, unethical or unprofessional conduct; immoral conduct; and gross negligence. An action must be brought pursuant to Section 60/22 in most actions against a physician within five years after receipt of a complaint or not more than two years after the receipt of the notification of a medical malpractice settlement or verdict. The five year limitation does not apply to alleged violations relating from

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practicing under a false name, fraud or misrepresentation in applying for or procuring a license or for cheating on the licensing examination.

After the investigator reviews relevant documents and talks to the personnel involved, the investigator refers the case to a prosecuting attorney.

Prosecutions

Once a case is referred to the Prosecutions Unit, the Chief of Prosecutions reviews the case to determine whether additional investigation is necessary, whether the case can be closed subject to approval by the Medical Disciplinary Board, or assigns the case to a unit prosecutor for further action. The IDFPR attorney handling the case can then either file a formal complaint or schedule the matter for a disciplinary conference/informal hearing. Even when a formal complaint has been filed, IDFPR attorneys are generally willing to schedule an informal conference/disciplinary hearing to attempt to resolve the matter prior to a formal hearing.

Informal Conference/Disciplinary Hearing

An informal conference is an informal meeting (typically in Chicago) with the IDFPR attorney assigned to the case and a member or members of the Licensing Board of the licensee's profession. During the conference, the IDFPR attorney and any board member in attendance generally inquire about the licensee's background, experience, and specific care of the patient involved. The licensee and the attorney representing the licensee are then excused from the room while the IDFPR attorney and board member discuss the matter and formulate their recommendation to the Medical Disciplinary Board. The licensee and attorney are then called back into the room and are informed as to the recommendation which will be made to the Medical Disciplinary Board. The licensee is typically given one to two weeks to consider IDFPR's recommendation and determine whether or not to accept that recommendation.

Consent Orders

If the licensee agrees to accept the recommendation, the IDFPR attorney will prepare a proposed Consent Order specifying the specifics of the resolution of the matter. A Consent Order must be approved by the licensee, the licensee's attorney, the Chief of IDFPR Prosecutions, the Medical Disciplinary Board, and the Director of IDFPR.

Formal Complaint

If the licensee refuses to accept the recommendation from the informal conference, a formal complaint will be filed specifying the details of the allegations against the licensee and the matter will proceed to a formal hearing.

Formal Hearing

If the matter cannot be resolved via informal conference, the matter will proceed to formal hearing before an administrative law judge and member of the Medical Disciplinary Board. The rules of evidence are applied loosely to what, in essence, is a mini malpractice trial. Each side typically brings in witnesses, including expert witnesses. IDFPR has the burden of proof, and there are opening statements and closing arguments just as in a medical malpractice trial. After the formal hearing, the administrative law judge prepares a report called Findings of Fact, Conclusions of Law, and Recommendations which is forwarded to the members of the Licensing Board for their review. The Board then meets to determine whether it will accept or reject the administrative law judge's recommendations and ultimately makes its own recommendation to the Director of IDFPR.

Ultimately, the Director of IDFPR may accept or reject the Board's recommendation and signs an order for the result that he or she deems appropriate. The order of the Director, if unfavorable to the licensee, may be appealed to the Circuit Court.

Results

The most hoped-for results of an informal conference or formal hearing are dismissal or a letter of concern. Both are considered to be nondisciplinary. A letter of concern is simply an administrative warning letter expressing concern about the care rendered in the particular case. A letter of concern remains in a licensee's file, but has no impact on the ability to practice medicine and does not need to be disclosed in response to credentialing questions inquiring about disciplinary actions.

A reprimand is the lowest form of discipline, but is still considered discipline. A reprimand must be reported in response to questions asking whether there has been discipline against the licensee's license but does not impact the licensee's ability to practice. Probation is much the same as a reprimand, although it is considered slightly more severe. Like a reprimand, it does have to be reported when asked about disciplinary action and does not affect the individual's ability to practice.

Suspension is a form of discipline whereby the licensee's license is suspended for a period of time or indefinitely. Revocation is a loss of the license.

Often, the various forms of discipline, other than revocation, are coupled with a fine and requirements for continuing medical education approved by IDFPR's Medical Director.

Current Trends

More Enforcement

Several years ago, the *Chicago Tribune* ran an exposé on discipline of Illinois doctors. At the time, Illinois ranked 48th of the 50 states in terms of effective enforcement against physicians. This prompted the state to beef up enforcement by hiring more prosecutors and requiring more licensees to travel to Chicago for informal conferences. In the past, IDFPR was focused on what most would consider "bad docs." Those included physicians who moved from state to state leaving a path of patient destruction, as well as those who participated in billing fraud and abuse. Today, this has changed and even "good docs" are being brought before IDFPR. Typically, this is the result of National Practitioner Data Bank reports from hospitals concerning privilege actions and/or from insurance carriers or self-insureds regarding medical malpractice lawsuit payments. All of this results in an increased emphasis on the quality of care delivered.

Rural Disparity

In a rural healthcare setting, there is often a tremendous disparity in availability of specialists and Medicaid providers which significantly impacts the timing and quality of care provided. Although IDFPR pays lip service to the fact that it recognizes this disparity, the majority of physicians asked to review cases for IDFPR are from major metropolitan areas where they practice at major teaching institutions which have no lack of availability of specialists. Despite this, these physicians are asked to establish the standard of care that should have been given in a rural setting.

More Reprimands

More and more cases which would have simply received a letter of concern (nondisciplinary) in the past are now receiving reprimands (discipline). This allows IDFPR to increase its discipline rates. As a result, not only are more physicians being summoned to Chicago for informal conferences, but more and more are receiving reprimands which IDFPR suggests to physicians should be welcomed as "the least form of discipline."

Focus on Opioids and Other Narcotics

Several IDFPR attorneys have focused their primary interest on addressing the opioid epidemic in our country. Frequently, well-intentioned physicians who truly believe they are helping their patients relieve significant pain issues with opioids get lulled into this trap. Often, they have not attempted alternative treatment, sought psychiatric counseling, or checked the website for narcotic drug administration on their patients. IDFPR is working much more closely and sharing information with other governmental agencies, including the Drug Enforcement Agency (DEA). In fact, DEA recently honored two IDFPR attorneys for their efforts in fighting the opioid epidemic.

Other States

When an individual is disciplined in one state, the discipline often follows to other states where the individual is licensed. In effect, the various state licenses of the individual fall like dominoes. Often, this can be aggravated by an individual not reporting discipline in other states to IDFPR.

More CME

IDFPR has significantly increased continuing medical education requirements (CME) in its Consent Orders. Typically, CME must be approved by the Medical Director of IDFPR and completion of CME requirements must be reported to IDFPR as part of a Consent Order.

More Fines

In the last five years, IDFPR has dramatically increased both the number and amount of fines upon licensees. In some cases, licensees have been fined even though the case against them was recommended for dismissal. It is not unusual to see fines of $5,000 to $10,000 or more.

More Turnover

There has been a great deal of turnover of IDFPR attorneys. Many career IDFPR attorneys have decided to leave the Department due to state funding uncertainty. As a result, many experienced attorneys with institutional history of how various situations were to be dealt with are no longer present.

Less Predictability

For many of the reasons discussed above, there is far less predictability in the outcome of similar cases before IDFPR.

Conclusion

Navigating one's course through the Illinois Department of Financial and Professional Regulation can be challenging, and often, frustrating. The best chance to obtain a favorable result is at the informal conference stage. Unfortunately, that stage can also be highly unpredictable since it is dependent upon the "luck of the draw" as to the particular Medical Disciplinary Board member who will be in attendance. Rarely are Disciplinary Board members at informal conferences of the same specialty in question. Although there can certainly be no guarantees of a favorable outcome, experienced representation

can greatly increase the probability of a good result. This is done primarily through preparation of the licensee so that that individual will have a realistic understanding of the system and will be well prepared to address the issues in the case in a professional manner.

Roger Clayton has extensive litigation experience includes defending more than 700 medical and hospital cases, taking a significant number to verdict. In recent years, he has developed a special focus on brain-injured infant cases and other catastrophic loss cases. Many of his cases are against leading Chicago and national counsel where damages sought against his target defendants often reach tens of millions of dollars. Although always prepared to try these cases when necessary, Roger is a skilled negotiator and has had great success mediating many of these cases. Roger has taught master's-level courses in healthcare law and is a frequent national speaker on healthcare issues, medical malpractice, and risk prevention to insurers, medical associations, professional groups, and healthcare institutions. He co-authored the chapter on trials in the *Medical Malpractice Handbook* published by the Illinois Institute of Continuing Legal Education. Roger also co-authored a chapter for *The Law of Medical Practice in Illinois* published by West Publishing. He also authors the "Health Law" column in the *Illinois Association of Defense Trial Counsel Quarterly*.

The Illinois Medical Studies Act Privilege After *Grosshuesch* and *Eid*

By: Ann Barron, abarron@heylroyster.com

Illinois hospitals and other medical facilities routinely conduct peer review and quality committee investigations and meetings relating to the care and treatment received by patients. These proceedings are conducted under the auspices of the Illinois Medical Studies Act (Act). In certain circumstances the Act may provide a privilege against the discovery of information generated by facility committees in a later lawsuit relating to the patient's care and treatment.

The Act specifically provides:

> all information . . . reference or other third party confidential assessments of a health care practitioners professional competence or other data of . . . committees of licensed or accredited hospitals or their medical staffs, or their designees, used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care . . . *shall be privileged, strictly confidential* and shall be used only for . . . the evaluation and improvement of quality care.

735 ILCS 5/8-2101 (emphasis added). Section 8-2102 of the Act provides that "the information, records, reports, statements, notes, memoranda or other data, *shall not be admissible as evidence, nor discoverable* in any action of any kind any court or before any tribunal, board, agency or person." 735 ILCS 5/8-2102 (emphasis added).

Ensuring that the Act's privilege applies requires that the documents not have been created until the facility's committee is engaged in a peer review or quality process and authorizes an investigation into a ***specific*** patient or incident and meticulous record keeping. Two recent Illinois cases emphasize these points.

In *Grosshuesch v. Edward Hospital*, 2017 IL App (2d) 160972, the plaintiff had contacted the hospital's patient advocate regarding concerns the plaintiff had about her care and treatment. The plaintiff's concerns resulted in a referral to the medical staff quality committee (MSQC). The MSQC liaison consulted with two hospital staff physicians who performed a peer review before any member of the medical staff quality committee requested an investigation of the incident. The MSQC liaison entered her notes into an electronic database which the MSQC considered at its later meetings.

The plaintiff sought the liaison's notes in discovery. The hospital objected arguing that the Act protected the documents. The hospital submitted affidavits from its claims counsel which explained the hospital's peer review policy. The hospital argued that the information and conclusions in the liaison's notes resulting from the peer review investigation were consistent with the hospital's peer review policy, were completed for internal quality control, and were privileged. The hospital further argued that the MSQC, via its own policy, instructed the liaison to assist the committee by coordinating an investigation into the plaintiff's concerns for the purpose of quality control and that the notes served an integral function of the peer review process.

In considering the Act's privilege from discovery, the trial court found that the hospital did not establish when the investigation into this *specific* plaintiff's concerns began or which member of the committee directed the investigation to begin. The trial court further found that the committee was not engaged in the peer review process for this specific occurrence at the time the notes were created, and thus, the notes were not privileged under the Act. The appellate court agreed. The appellate court noted that documents generated specifically for the use of a peer review committee are protected under the Act. However, since the hospital's committee had not yet met and its designee had not been authorized to conduct an investigation into this "*specific incident*," the liaison's notes were not privileged under the Act. The court found no merit in the hospital's argument that the committee's policies, enacted years earlier and which directed the liaison to coordinate an investigation, were sufficient to shield the notes from discovery. The court concluded that the notes in question "were generated before any peer review committee or its designee authorized an investigation into a specific incident" and thus, the notes were not privileged. The decision in *Grosshuesch* follows an earlier 2017 decision in *Eid v. Loyola Univ. Med. Ctr.*, 2017 IL App (1st) 143967. There the Illinois Appellate Court considered whether information generated by a designee of the peer review committee for the use of the peer review committee in the course of internal quality control was subject to the provisions of the Act. In *Eid*, the hospital had a medical care evaluation and analysis committee (MCEAC) which conducted peer reviews of hospital deaths for the purpose of reducing morbidity and mortality. The chairperson of the MCEAC was tasked with determining if an investigation of patient care was warranted and could direct an individual to assemble information for the MCEAC's use.

On the morning after the death of a patient, the risk manager contacted the chairperson of the MCEAC, who was also the hospital's chief medical officer, to inform him of the patient's death. The chairperson instructed the risk manager to investigate the death on the MCEAC's behalf from a quality perspective. The risk manager created 13 pages of documents during her investigation which the hospital claimed were privileged under the Act as they were created as part of an MCEAC investigation after the go ahead was given for the specific investigation.

Plaintiff sought production of the documents in discovery. In support of the Act's privilege, the hospital submitted affidavits from the committee chairperson/chief of staff and the risk manager, discussing in detail the steps which lead to the creation of the documents. The trial court found that the documents were privileged under the Act and the appellate court affirmed.

The appellate court first found that the affidavits showed that under the hospital bylaws the chairperson and the risk manager were designees of the MCEAC. The court noted that the trial judge found that the hospital's bylaws specifically authorized the chief medical officer to begin a peer review investigation. In addition, the affidavits of the chairperson and risk manager established that the risk manager reported the information to another member of the MCEAC and that the matter was presented to the full board of the MCEAC. Since the documents were generated by the risk manager at the chairperson's directive pursuant to the chairperson's authority under the bylaws as a designee of the MCEAC, contributed to the MCEAC's deliberations, and were considered prior to the conclusion of the MCEAC's review, the documents were privileged under the Act.

The recent decisions in *Eid* and *Grosshuesch* stand for the principle that where a member of a peer review committee has the authority to authorize an investigation by a designee of the committee into a potential quality issue, any documents generated after an investigation of the specific incident has been ordered can be privileged. Establishing the Act's privilege, however, can be challenging; in court, the facility bears the burden of establishing the privilege. Thus, we recommend that each facility review its bylaws to ensure:

1. The bylaws permit the committee, a member of the committee or the committee's designee, to conduct an investigation for purposes of internal quality control, medical study for the purpose of reducing morbidity or mortality, or improving patient care.
2. The bylaws contain a procedure for the committee or a member thereof such as the chair of the committee to authorize an investigation into a specific matter via procedures set forth in the bylaws.

We also recommend good record keeping by the facility regarding the quality committee. The following steps should be taken as part of the record keeping associated with quality investigations and committee meetings:

1. The date and time that the committee authorized the investigation should be recorded. A facility should record the name and position of the individual who authorized the investigation in accordance with the bylaws and the name of the person ordered to conduct the investigation. If directives are provided at a committee meeting, the facility should record the date and time of the meeting, who is in attendance at the meeting and who has been authorized to undertake what steps as part of the investigation.

2. The facility or the individual conducting the investigation should record the date and time on all documents created as part of the investigation to easily establish that the documents were created after authorization occurred.
3. The information collected and documents created should be provided to the committee for the committee's use and/or discussion at a subsequent meeting, noting in any minutes the work undertaken.
4. Committee minutes should clearly designate between the committee's results, ultimate decisions, recommendations and internal conclusions. Results of a committee which take the form of ultimate decisions made or actions taken are not privileged. Recommendations and internal conclusions of a committee should be privileged regardless of whether they are implemented.
5. Realize at the outset that documents created as part of the facility's ordinary course of medical business will not be privileged. Documents used for dual purposes such as quality assurance and risk management, such as incident or situation reports, which are not commenced after a directive from a hospital committee will not be privileged. In addition, materials later given to a peer review or quality committee will not become cloaked in the privilege.

These steps will assist in ensuring that the information necessary to establish the Act's privilege has been created and maintained.

Ann Barron has extensive litigation experience in medical malpractice, personal injury, environmental, class action, employment and commercial litigation. She has handled all aspects in defending a case from responsive pleadings to trial and has appeared before numerous appellate courts. Ann previously worked for a Fortune 500 company which gives her a unique insight into an entity's risk benefit analysis and internal processes. Ann currently serves as a Board Member of the Illinois Society of Healthcare Risk Management and spends time lecturing on issues facing hospitals and other medical providers in litigation.

Heyl Royster serves clients in every county in Illinois. We have offices in six major population centers in Illinois - Peoria, Champaign, Chicago, Edwardsville, Rockford, and Springfield - which allows us to appear in any Illinois state or federal court quickly, effectively, and cost-efficiently for our clients. Our offices collaborate with each other and with our clients to achieve client goals. Our statewide practice has earned Heyl Royster a reputation for innovation, excellence, and professionalism and brings our clients a specialized knowledge of the courts and adversaries we face.

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