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The Illinois Medical Studies Act: Scope of the Peer Review Privilege

In the 1980s — in response to a perceived medical malpractice crisis and concerns about the effectiveness of self-regulation in the medical profession — legislatures in various states, including Illinois, enacted statutes that provide for a medical peer review privilege that protects the work product of peer review committees from disclosure in discovery in medical malpractice litigation. Medical peer review is the process by which physicians evaluate the quality of work performed by their colleagues to determine compliance with appropriate standards of care. The underlying rationale of the peer review process is that only a physician's colleagues or peers have the expertise to effectively evaluate that physician's work. The privilege is intended to encourage frank and effective evaluation and criticism by a physician's peers to ultimately improve health care.

In medical malpractice litigation, there is a tension between the public policy interest in full disclosure of relevant facts through discovery and the improvement of health care through the peer review process. The statutory peer review privilege is seen as striking a balance between these competing public policy interests. Within this framework, Illinois courts have strictly construed the peer review privilege codified in the Medical Studies Act, 735 ILCS 5/8-2101 *et seq*.

The Statute

The Medical Studies Act (Act) provides, in pertinent part, as follows:

> "All information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third-party confidential assessments of a health care practitioner's professional competence, or other data of . . . committees of licensed or accredited hospitals or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees, and Executive Committees, 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 . . ." (735 ILCS 5/8-2101)

The Act further provides that such privileged material "shall not be admissible as evidence . . . in any court or before any tribunal, board, agency or person." 735 ILCS 5/8-2102.

The Act's purpose is to encourage and facilitate professional self-evaluation by members of the medical profession to advance the quality of health care. *Frigo v. Silver Cross Hospital & Medical Center,* 377 Ill. App. 3d 43, 876 N.E.2d 697 (1st Dist. 2007); Roach v. Springfield Clinic, 157 Ill. 2d 29, 623 N.E.2d 246 (1993). The Illinois Supreme Court in Roach acknowledged that the statute is premised on the belief that, absent the statutory peer-review privilege, physicians would be reluctant to sit on peer-review committees and engage in frank evaluations of their colleagues. Illinois courts have identified this reluctance as stemming from, among other things, loss of referrals, respect and friends; possible retaliations; vulnerability to tort actions; and fear of malpractice actions in which the records of peer-review proceedings might be used. While the often-stated purpose of the Act is to encourage self-evaluation by medical professionals, courts emphasize that the statute was never intended to shield hospitals from liability.

It is well established that the Act is to be strictly construed, and the party seeking to invoke the privilege has the burden of establishing its applicability. This burden may be met by submitting the materials claimed to be privileged for an *in camera* inspection or by submitting affidavits setting forth the facts sufficient to establish the applicability of the privilege to the particular documents being withheld. Whether the privilege applies is a question of law, which is reviewed *de novo* on appeal. The question as to whether specific materials are part of a peer review or medical study within the scope of the Act, however, is a factual question within that legal determination.

The Act does not protect all information used for internal quality control or peer review, only the "information of" the committees described in the Act. "Information of" has been given a specific meaning by Illinois courts: it encompasses only information "initiated, created, prepared or generated by" a peer-review or quality-control

committee.

Peer Review Committee

The first question is whether the information was of a peer review or medical review committee covered by the statute. Unlike investigations performed by hospital committees, internal investigations performed by the hospital administration are not privileged. Similarly, a hospital administrator's conversations with a nurse and defendant physician following an adverse event did not belong to a peer-review committee, and therefore were not privileged from disclosure under the Act. The Illinois Supreme Court has held that a hospital's chief of the anesthesia department was not a hospital peer review committee so as to protect from disclosure the information that he obtained from the nursing supervisor. *Roach,* 629 N.E.2d 246. The *Roach* Court noted that the information obtained during the course of the conversation was not transformed into "information of" the anesthesia department merely because the chief of the department reported the incident to that body at some later time. Further, the Court noted that the ordinary meaning of the word "committee" is a body or group of persons, not just a single individual.

"Information of"

The next question is when the information claimed to be privileged was gathered. Illinois courts have long held that information regarding an incident that was generated prior to the committee's decision to review the incident is not protected by the Act. Information generated or created before the time that the relevant committee met to address the incident is not "information of" the committee, and cannot be made privileged by its later submission to the committee. As the *Roach* Court stated, "if the simple act of furnishing a committee with earlier-acquired information were sufficient to cloak that information with the statutory privilege, a hospital could effectively insulate from disclosure virtually all adverse facts known to its medical staff . . ." Further, the court emphasized that such a broad interpretation of the privilege would make it very difficult for patients to hold hospitals responsible for medical malpractice, and in turn decrease the incentive of those institutions to pursue the goal of improved patient care, thereby subverting the purpose of the Act. Moreover, merely stamping a document "confidential" is insufficient to invoke the protection of the Act.

Similarly, documents generated after the peer review process are not protected from disclosure under the Act. Moreover, the results or ultimate decisions made or actions taken as a result of the peer review process are not protected from disclosure under the Act. Any actual changes, such as modifications to hospital policy or procedure, that were adopted as a direct result of the recommendations and internal conclusions of a peer review committee are discoverable. Importantly, however, the act expressly prohibits from disclosure "[a]ll . . . recommendations of a peer review committee." (735 ILCS 5/8-2101; *Anderson v. Rush-Copley Medical Center, Inc.,* 385 Ill.App.3d 167, 894 N.E.2d 827 (2d Dist. 2008). This includes both implemented and nonimplemented recommendations of peer review committees.

Conclusion

As noted by Illinois courts in applying the peer review privilege, the Act was not intended to protect from disclosure all information used for internal quality control or peer review. It was intended to protect only "information of" the committees described in the Act. That is, only information "initiated, created, prepared or generated by" a peer review or quality control committee. Defense counsel representing a hospital or other party seeking to invoke the privilege in medical malpractice litigation, must take care to draft affidavits in support of their position. The courts examine each document and look for facts, not conclusions. The affidavits must state who made the request for the information, and when and where it was made. Further, the affidavits should include facts establishing that the information was "initiated, created, prepared, or generated" by the peer review committee. To further the laudatory goal of the statute, the confidentiality of the peer review process must be safeguarded.

Federal Court Holds That Hospitals Providing HMO Services to Federal Employees Are Federal Contractors at the Same Time the OFCCP Appears to Increase Its Focus on Auditing Health Care Providers

UPMC Braddock v. Solis, No. 2009-1210 (D.D.C. Mar. 30, 2013)

Several years ago, the Federal Office of Contract Compliance Programs (OFCCP) requested that three Pennsylvania hospitals provide copies of affirmative action plans and other materials required of Federal Contractors. Each hospital had a Health Maintenance Organization (HMO) contract with the UPMC Health Plan to provide medical products and services to United States Government employees pursuant to a contract between the Health Plan and the United States Office of Personnel Management (OPM). The hospitals resisted the audits by the OFCCP arguing that their provision of medical care through the HMO plans did not render the hospitals government contractors or subcontractors and that their contracts specifically stated that the hospitals were not to be considered subcontractors. The Department of Labor's Administrative Review Board ruled in favor of the OFCCP. On March 30, 2013, the District Court of the District of Columbia affirmed the decision of the ARB. The Court ruled that because the Plan agreed to provide direct medical services to federal employees through an HMO, as opposed to simply insurance reimbursement, the hospitals were government subcontractors who provided services necessary for the Plan to meet its obligations under its Federal Contract. The Court further held that the language of the contract stating that the hospitals were not subcontractors was not enforceable and could not overcome the applicable Executive Order. The Court's decision could have far-reaching effects on health care providers who do not otherwise hold federal contracts. Not only can the OFCCP require compliance and conduct audits of providers contracting with HMO Plans serving federal employees, but the health care provider's contract does not have to address such obligations and the parties do not have to explicitly consent to the OFCCP's jurisdiction.

In addition to this decision, it appears as if the OFCCP may be increasing its focus on audits of health care providers by sending warning letters to health care systems. In light of these developments, all health care providers should consider identifying and reevaluating their contracts with HMO Plans that provide services to federal employees. Health care employers who receive either a warning notice from the OFCCP in Washington DC or a desk audit notification letter from their local OFCCP office should immediately contact their legal counsel to

organize a response in the limited time frame provided.

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Antitrust Update: Federal Trade Commission Continues to Challenge Hospital Mergers

As mergers amongst health care providers gain popularity, scrutiny of them — and, in some cases, injunctions against the mergers — by the federal government has risen as well. This is highlighted by a recent case in Georgia. In Dougherty County, Georgia there are only two hospitals — Phoebe Putney Memorial Hospital (Memorial) and Palmyra Park Hospital (Palmyra) — both located in the city of Albany. The Hospital Authority of Albany-Dougherty County (Authority), a government agency, owns Memorial and formed two private not-for-profit corporations to manage it — Phoebe Putney Health System, Inc. (PPHS) and Phoebe Putney Memorial Hospital, Inc. (PPMH). The Authority decided to purchase Palmyra and planned to lease it to PPHS. Before the transaction was completed, in April 2011 the Federal Trade Commission (FTC) filed an administrative complaint against PPHS, PPMH and the Authority and sought a temporary restraining order (TRO) and preliminary injunction to prevent the consummation of the transaction.

In defending against the FTC's initial request for a TRO and preliminary injunction, PPHS, PPMH and the Authority invoked the state action doctrine defense, which exempts conduct from federal antitrust laws if the conduct essentially is compelled by state law. The trial and appellate courts upheld the defense and the transaction was consummated in December 2011. On appeal, the U.S. Supreme Court rejected the state action defense based on the facts, reversed the prior rulings and ordered the matter back to the trial court.

The FTC renewed its quest for a TRO and preliminary injunction to prevent the parties from further consolidation of their operations. The trial court granted the TRO on May 15, 2013. In its order, the court prohibited the hospitals from taking any additional steps to consolidate their operations and from making any price changes to existing contracts (although not from entering into new contracts).

The TRO will remain in effect until the trial court decides the FTC's pending motion for a preliminary injunction, which is scheduled to be heard on June 14, 2013. The court likely will enter a preliminary injunction and continue the existing prohibitions pending a ruling on the merits at the trial, which is scheduled to begin before an administrative law judge on August 5, 2013.

Health care providers should be aware that the FTC is reviewing all mergers and other types of consolidation. Transactions that will result in decreasing the number of providers in the same city or in a small geographic area are subject to even closer scrutiny. The FTC generally has not challenged transactions when the acquiring provider previously was not operating in the acquired provider's geographic market.

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Hinshaw Representative Matters

Jennifer L. Johnson and Gregory T. Snyder, Partners in Hinshaw's Rockford, Illinois, office, represented defendant plastic surgeon in a case in which plaintiff patient alleged that certain post operative care following breast-reduction surgery was deficient. After having delayed approximately seven months before filing a Section 2-622 report, the patient filed a deficient report, which did not clearly identify any reason that a reasonable and meritorious cause for filing an action existed. Although the attorney affidavit accompanying the report recited the language of Section 2-622 — for instance by indicating that the reviewer had reviewed the "medical record and other relevant material involved" in the action — the actual written report stated that the reviewer had not reviewed all of the medical records concerning the surgery and management of post-surgical complication The Circuit Court of Winnebago County (Illinois) characterized the Section 2-622 report and affidavit as a "non-starter." In light of the facts and circumstances, the court exercised its discretion and dismissed the matter with prejudice.

Ms. Johnson and Mr. Snyder also represented a general surgeon and his practice in a medical malpractice case in the Circuit Court for McHenry County (Illinois). Plaintiff patient filed the wrongful death medical malpractice action on the eve of the statute of limitations and named the surgeon and his practice as respondents, essentially extending the statute of limitations. The patient's counsel deposed the surgeon, obtained a supporting 735 ILCS 5/2-622 written report, and then, on the date of the deadline to convert, faxed a motion to convert and for leave to file an amended complaint to counsel of record. However, the patient failed to actually file the motion with the circuit clerk. In the face of Hinshaw's written objection to the conversion, which pointed out the jurisdictional nature of the conversion period and the requirement that the motion be timely received by the circuit clerk, the patient withdraw his motion to convert. The matter proceeded as to the originally named defendants, but the status of the surgeon and his practice as respondents was terminated.

Patrick P. Devine, a Partner in Hinshaw's Northwest Indiana, office represented a family practice physician in a case in which plaintiff patient alleged negligence due to a bowel perforation during a colonoscopy. The patient complained of pain following the physician's procedure, but was sent home by hospital staff. The patient remained at home for approximately 12 hours before contacting the physician, who suggested that she return to the hospital where the perforation was discovered. The patient required a colostomy and reversal. Pursuant to Indiana law, the matter proceeded to a medical review panel consisting of three physicians, who reviewed the parties' written submissions and rendered a unanimous, favorable opinion for the physician. As legally permitted, the patient re-filed her case in state court. Hinshaw moved for summary judgment on the physician's behalf based upon the panel opinion and the requirement that the patient prove her case through expert testimony. Two days before the hearing on summary judgment, the patient filed a response, including an expert affidavit from a gastroenterologist implicating negligence on the part of the physician. Hinshaw requested and obtained leave to depose the patient's expert prior to filing a summary judgment reply. At the expert's deposition, Hinshaw exposed the fact that the expert's opinions of negligence were based solely upon speculation. Thereafter, Hinshaw filed a reply on the physician's behalf and argued that the opinions of the patient's expert were unreliable and could not create an issue of material fact. The court agreed and granted summary judgment in favor of the physician.

Terese A. Drew, a Partner in Hinshaw's St. Louis office, represented a emergency department physician in a case in which plaintiff patient alleged that the doctor was negligent in that he failed to communicate to the receiving hospital a differential diagnosis of an incarcerated inquinal hernia and bladder outlet obstruction. The physician had done a complete chemistry and CBC. A CT of the abdomen was also done to check for bladder obstruction. It was read as normal. The paperwork sent with the patient was not complete, in that the portion the physician would note for transfer and differential diagnosis was blank. However, the EMS sheet clearly stated "hernia" and the physician stated that he had a conversation with the receiving hospital emergency department physician as to his diagnosis. The receiving hospital emergency department physician had the paperwork and examined the patient. He found the inguinal hernia but thought he reduced it. The patient was placed on the floor to address the bladder outlet obstruction. He became progressively more ill and ultimately was diagnosed with a small bowel obstruction. He had complications and had a prolonged hospital stay and a subsequent re-admission for DVT that developed. The codefendants (the receiving hospital and its emergency department physician) settled. The jury returned a unanimous defense verdict after deliberating for less than 30 minutes.

Patrick F. Koenen, a attorney in Hinshaw's Appleton, Wisconsin, office, represented a surgeon and an on-call physician in a medical malpractice case in which plaintiff patient sought to recover for the loss of his eye. The patient had a long history of diabetes, which affected his vision. He ultimately had surgery on one eye. The surgery went smoothly. Post-operatively, the patient was examined by the surgeon, who thought his presentation was typical for a post-operative patient and scheduled another routine check-up for a few weeks later. A few days later, the patient's wife called to report that the condition of her husband's eye was getting worse. The clinic staff then called the patient to discuss his condition. The patient stated that he was doing "OK." All of this information was reported to the on-call physician, who made a diagnosis over the phone and recommended that the patient return to the clinic as originally planned. Within a few days, the patient's condition became unbearable and he called the clinic to report on the situation. He was seen immediately and diagnosed with a severe eye infection known as endopthalmitis. Ultimately, the patient lost his eye. This case was particularly difficult to defend in that the surgeon who performed the procedure and the on-call physician had been, but were no longer, business partners when the case was tried. Mr. Koenen helped the doctors realize that a united defense would be the best defense. After a four-day jury trial before Judge William Atkinson in Green Bay, Wisconsin, a defense verdict was rendered for defendant physicians.

Chad D. Kasdin, a Partner in Hinshaw's Chicago office, represented a large Chicago hospital in a case filed by plaintiff, a long-suffering mental health patient. The patient had been admitted to the hospital for psychiatric care and treatment, and was placed on the drug Lithium to treat her schizoaffective disorder. While in the hospital, the patient's Lithium level spiked to a dangerously toxic level, causing renal impairment. A few weeks later she was noted to have a softball-sized mass in her kidney, which turned out to be a rare infection — xanthogranulomatous pyelonephritis. The infection required the removal of the patient's right kidney, a portion of her liver, and other organs. The patient claimed that the toxic Lithium level started a chain of events that caused the infection. Following a 10-day trial involving complex medical issues and eight experts witnesses, the jury returned a not guilty verdict for all defendants.

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