

June 1, 2005

Illinois General Assembly passes historic medical malpractice reform bill

Effective Date

The legislation is effective on becoming law, which will be the date the Governor signs it - expected to be shortly.

However, many of the more-publicized provisions (e.g. caps) will apply to "causes of action accruing on or after [the law's] effective date." This phrase has usually been interpreted as the date an *injury* happened, which would mean any injury or incident occurring *before* the Governor signs the bill into law will be handled under the old rules, even if a lawsuit is not filed for some time.

Caps on Non-Economic Damages

A "cap" (the limit on the maximum amount recoverable) has been placed on "non-economic damages" in any medical malpractice action or wrongful death action based on medical malpractice. The cap appears to apply on a *per defendant* basis, rather than a single limit for the plaintiff or injury (regardless of the number of defendants). The cap will vary depending whether the defendant is a *hospital* or *physician* –

Hospital: "...the total amount of non-economic damages shall not exceed \$1,000,000 awarded to all plaintiffs in any civil action arising out of the care."

Physician: "an award against a physician and the physician's business or corporate entity...shall not exceed \$500,000 ...as to all plaintiffs..."

In awarding damages, the jury is to render a specific award for economic loss and one for non-economic loss. However, the jury is not to be informed about the caps.

These provisions apply only to "causes of action accruing" after the effective date.

735 ILCS 5/2-1706.5 (a)

Pages 50-51 of the Bill

Comments:

1. Limitation of the jury's award to 'economic' and 'non-economic' should eliminate some of the separate lines currently filled in on verdict forms by jurors (i.e. 'disability', 'disfigurement', 'pain and suffering', etc.) and the effect these extra lines have had on increasing total awards.
2. As worded ("a hospital and its personnel or hospital affiliates"), the single limit of \$1,000,000 arguably is intended to cover everyone in the hospital's risk-family. However, "personnel" is not defined, and it's likely that when hospital-employed *physicians* are individually named as defendants, plaintiffs may argue they are entitled to the separate, *additional* amount allocated in physician caps. On the other hand, plaintiffs at times may seek to come under the "hospital" limit for physician-based negligence (as 'agent' or 'employee', but no other hospital negligence alleged) because of the greater amount available from a hospital.

3. While “medical malpractice” may have a widely-accepted street meaning, there have been courts in other states holding that “negligent credentialing” or even “negligent supervision” claims against hospitals are *not* “medical malpractice” for statutory purposes, and therefore legislative protections have been denied under these very narrow rulings. The term is not defined in the Bill, but 735 ILCS 5/2-1704 defines “medical malpractice action” to mean “any action, whether in tort, contract or otherwise, in which the plaintiff seeks damages for injuries or death by reason of medical, hospital or other healing art malpractice.” At the time this statutory definition was made, the concept of ‘negligent credentialing’ was virtually unknown.
4. The cap tie-in to the *defendant’s status* as hospital or physician (rather than tied to plaintiff’s injury or the entire case) may be an incentive to name additional defendants to increase the total of capped damages available.
5. The Bill does not provide within its sections a definition of “non-economic” (or “economic”) damages. There already exists in 735 ILCS 5/2-1115.2 a definition of these terms; *however*, that entire legislation was declared unconstitutional by the Illinois Supreme Court in *Best v. Taylor* in 1997. 735 ILCS 5/2-1115.2, defines “non-economic” loss or damages as: “*damages which are intangible, including but not limited to damages for pain and suffering, disability, disfigurement, loss of consortium and loss of society*”.
6. There are no caps or qualifications of any kind on “economic damage”, which is defined in 735 ILCS 5/2-1115.2 as: “*all damages which are tangible, such as damages for past and future medical expenses, loss of income or earnings and other property loss*”. It’s likely some plaintiffs will attempt to expand this category by more cleverly *quantifying* certain elements. In this respect, note that the Bill provides [in 735 ILCS 5/2-1706.5(b); page 51 of the Bill] “where an individual plaintiff earns less than the annual average weekly wage, as determined by the Illinois Workers’ Compensation Commission ... any award may include an amount equal to the wage the individual plaintiff earns or the annual average weekly wage” [emphasis added]. In other words, even a plaintiff who was not employed, will be entitled to recover something under this element of economic damages.

2-622 Report

Several changes have been made to the existing 2-622 statute [735 ILCS 5/2-622] governing a review of plaintiff’s case by a health professional in order to file/proceed with the case. These include:

- The name, address, current license number and state of licensure of the reviewing health care professional [reviewer] must be stated in writing in plaintiff’s attorney’s affidavit.
- The reviewer must meet expert witness standards which have been added and which apply to all aspects of witness involvement, not just 2-622. [See section below on “Expert Witness Standards” for discussion of these.]
- The reviewer must have practiced or taught in the same area of health care at issue within the preceding 5 years (shortened from 6).
- A “single written report must be filed to cover each defendant in the action”. As to defendants who are *individuals*, the report must be from a health professional licensed in the same “profession”. As to defendants who are *not individuals*, the report need only be from a licensed physician “who is qualified by experience with the standard of care, methods, procedures and

treatments relevant to the allegations at issue.”

- Plaintiff is limited to *one* 90-day extension to obtain the reviewer’s report, except where there has been a withdrawal of plaintiff’s counsel. (The only-one extension is in contrast to the current practice in several localities of multiple extensions).
- A statement has been added that a reviewer is not to be discriminated against by medical liability insurers, or by professional organizations, on the basis that a report has been prepared.
- These provisions apply only to “causes of action accruing” after the effective date.

735 ILCS 5/2-622

Pages 44-48 of the Bill

Comments:

When a hospital is a defendant, the new law appears to permit a physician to be the reviewer regardless of the position at the hospital of those being criticized. However, this is somewhat contradicted by both the new expert witness standards and current case law decisions (that a physician cannot testify about nursing standards of care).

Expert Witness Standards

Additions to the existing statute on expert witness standards (to be applied by the court in determining if someone qualifies as an expert) include:

- Whether the witness is board certified, board eligible or completed a residency in “the same or substantially similar” specialty as the defendant “and” is otherwise qualified by “significant experience” with the standard of care, methods, procedures, and treatments relevant to the allegations against that defendant.
- Whether the witness has devoted a “majority” of “work” time to the practice of medicine, teaching or university-based research regarding the care and treatment at issue (prior statute used “substantial portion” of time, and didn’t specify “work” time).
- Whether the witness has the “same class of license” as to *individual* defendants – in addition to the “same profession” requirement of the existing statute.
- An expert “shall” provide evidence of active practice, teaching or engaging in university-based research.
- A *retired* expert “shall” provide evidence of “attendance and completion of medical education courses for 3 years previous to giving testimony.”
- An individual who has not “actively practiced, taught, or been engaged in university-based research, or any combination thereof during the preceding 5 years may not be qualified as an expert.”
- These provisions apply only to “causes of action accruing” after the effective date.

735 ILCS 5/8-2501

Pages 52-53 of the Bill

Comments:

1. The witness does not have to be board certified, but the board eligible or residency statement indicate a need for formal training in the same specialty. ["Board eligible" is not defined in the Bill, and is no longer an officially recognized term by most medical organizations.]
2. "Whether" the witness has met certain qualifications [the first three items above] infers these are not absolutely required – in contrast to the "shall" language used in other subsections.
3. The "significant experience" qualification is separate, but in addition to, board certification/formal training.
4. The term "*class* of license" is not defined, and it's unclear what this phrase adds to the requirement of being in the "same profession".
5. The *form* of evidence to be provided by the expert is not specified, including whether oral statements by the witness would be sufficient.
6. The type of "medical education courses" a *retired* expert must establish is not restricted to those in the specialty at issue.
7. The practice/teach/research for the "preceding 5 years" does not clarify whether it's for *each and every year of*, or just *some time during*, that period.

'72 Hour Statements' by Health Care Provider

"Any expression of grief, apology or explanation" by a health care provider to the patient, family or legal representative "about an inadequate or unanticipated treatment or outcome" provided within 72 hours of when the provider "knew or should have known of the potential cause of such outcome" is not admissible in "any action of any kind in any court or before any tribunal, board, agency or person." Even an improper disclosure of such information shall not waive or have any effect on its confidentiality or inadmissibility.

735 ILCS 5/8-1901 (b)

Pages 51-52 of the Bill

Comments:

1. Statements of grief or apology can be somewhat limited in scope, but an "explanation" is wide-open. While well-intended from a defense perspective, the inability to waive inadmissibility could be turned against a defendant who might like to make certain communications and explanations with the patient known.
2. The 72 hour window relates to the time knowledge of cause of outcome was, or should have been, known. As the timing of this could be days or weeks after an 'incident', statements or apologies made before (or after) that point may be admissible.
3. Statements by anyone who is not a "provider" (e.g. an administrator) may not qualify for this protection.

4. This provision applies only to “causes of action accruing” after the effective date.

Periodic Payment of Judgments

The new law replaces the former provisions of periodic payment of future damages in medical liability cases with a system calling for periodic payment only of *future medical expenses* and *life care needs*. Either party or the court may elect the periodic payment of judgments within 5 days after a verdict in a medical malpractice case. In each case in which a jury awards future medical expenses, the jury will be required to make the following findings:

- The present cash value of the plaintiff’s future medical expenses and costs of life care.
- The current year annual cost of the plaintiff’s future medical expenses and costs of life care.
- The annual composite rate of inflation that should be applied to future medical expenses.

The jury may also indicate any year-to-year variances in the amount of future costs based on the evidence presented at trial.

If an election is made to use the periodic payment statute, the defendant is required to pay 20% of the present cash value assessed by the jury (along with the other elements of damage) immediately. The defendant will then have to purchase a qualified annuity that will guarantee payment of 80% of the annual cost of care found by the jury, inflating at the rate determined by the jury. These payments will continue only for the remaining life of the plaintiff.

Significantly, if an election is made for periodic payments and the annuity company becomes unable to pay the amounts required by the judgment, the defendant will obtain another annuity to make payments for the remainder of the plaintiff’s life.

735 ILCS 5/2-1704.5

Pages 49-50 of the Bill

Physician Profile – Patients’ ‘Right to Know’ Law

The IDFPR (Illinois Department of Financial & Professional Regulation) shall provide to the public (by website, and in writing if requested) information about a physician – restricted to that occurring within the most recent 5 years. There are 17 separate items (3 of which are optional) including:

- Criminal convictions for felonies and Class A misdemeanors.
- Final disciplinary action – in Illinois and from other states.
- A description of: revocation or involuntary restriction of privileges, resignation from or nonrenewal of membership, or restriction of privileges in lieu or settlement of a pending disciplinary case. All of the foregoing are limited to actions related to competence or character.
- All medical malpractice judgments, arbitration awards and settlements involving payment to a complainant. A cautionary note will be attached regarding appeals and settlements. *Pending* malpractice claims shall not be disclosed, but IDFPR is not prohibited from

investigating and disciplining in regard to *pending* claims.

- Specialty board certification.
- Number of years in practice and locations.
- Names of hospitals where have privileges.

The IDFPR shall provide the physician with a copy of the profile before releasing it, and the physician has 60 days to correct inaccuracies.

225 ILCS 60/24.1

Pages 39-42 of the Bill

Medical Disciplinary Board

As stated in the preamble of the Bill, to enhance the oversight and disciplining of physicians, a number of changes have been made to the existing Medical Disciplinary Board, including:

- The Board's membership has been increased from 9 to 11, with a "goal" that at least one member practice neurosurgery, one practice ob-gyn, and one practice cardiology. In addition, one member of the Board "shall" have an osteopathic degree and one "shall" have a chiropractic degree.

225 ILCS 60/7

Page 15 of the Bill

- The number of investigators for the Board is doubled.

225 ILCS 60/7

Page 18 of the Bill

- The time within which the IDFPR can take action against a licensee has been extended:

(1) Up to 5 years (instead of 3) for most of the 43 grounds specified – but no more than 10 years (instead of 5) after date of incident or violation.

(2) For actions involving a "pattern of practice or other behavior which demonstrates incapacity or incompetence to practice", all of the actions must have occurred within 10 years preceding filing of the IDFPR's complaint.

(3) In the case of a settlement or final judgment based on negligence, IDFPR has an additional 2 years (instead of 1) after notification to the IDFPR.

[Not a change, but note that apparently there is no end limit for 3 violations: practicing under a false name, fraud or misrepresentation in application, and cheating on exam – subsections (8), (9) and (29) respectively.]

225 ILCS 60/22(A)

Pages 19-26 of the Bill

- Fines for disciplinary action have been increased to (not to exceed) \$10,000 (instead of the current \$5,000 limit).

225 ILCS 60/22(A)

Page 29 of the Bill

- When a hospital, professional society or insurer is required to report action involving a licensee (e.g. loss or restriction of privileges, adverse malpractice judgment or settlement, etc.), the reporting party must now include the *date of birth of the patient* or some other means of identifying the patient (beyond name), and identification of the hospital or facility where the care at issue took place.
225 ILCS 60/23(B)(3) Page 33 of the Bill
- The Board or IDFPR may subpoena copies of hospital or medical records in cases reported to it, and this power is not restricted to when consent of the patient has not been provided.
225 ILCS 60/(B) Page 33 of the Bill
- Adds “a peer review committee” to the immunity section that previously mentioned only the Board. When participating in proceedings for, or serving as a member of, such body, a person shall not be subject to criminal prosecution or civil damages. This also protects someone voluntarily reporting alleged errors or negligence to the Board or a peer review committee.
225 ILCS 60/23(C) Page 34 of the Bill
- A licensee will now have 30 days (instead of 60) to respond to a Board notification of a report, and the licensee within that time shall submit any medical records related to the report.
225 ILCS 60/23(E) Page 36 of the Bill
- On request of the IDFPR, a plaintiff’s attorney shall, within 30 days, provide patient records related to the licensee. This will not be deemed a waiver of the attorney-client privilege, and the patient’s consent is *not* required for this.
225 ILCS 60/24 Page 39 of the Bill
- No deferral in the effective date is specified for these provisions, which means they will take effect immediately.

Comments:

Note that by virtue of a “sunset” provision, 225 ILCS 60 (the Medical Practice Act of 1987), is scheduled to be repealed January 1, 2007 – though the General Assembly may provide for its continuation.

Liability Insurance Issues

The Insurance Code has been amended to increase regulation of insurers providing malpractice coverage to physicians and other health care providers. The significant changes include:

- The Insurance Code already provides that insurers providing medical malpractice coverage may not charge either excessive, inadequate or unfairly discriminatory rates. Current law includes a safe harbor providing that no rate would be considered excessive unless the rate was “unreasonably high for the insurance provided, and a reasonable degree of competition does not exist in the area” for the type of insurance. It also provided that a rate would not be inadequate unless it was unreasonably low for the insurance provided and the use of the rate would endanger the company’s solvency. Both of these safe harbors have been eliminated.
- The Director of Insurance will be called the Secretary of Financial and Professional Regulation.
- The Secretary must call a public hearing on any rate increase if: (1) 1% of the company’s insureds within a single specialty or 25% of all insureds request a hearing; or (2) the rate

increase exceeds 6%. After a hearing, the Secretary may adjust the rate or take other action.

- A company must file its rates when it starts business in Illinois or whenever rates change.
- The Secretary may request statistical information necessary to determine the manner in which rates are set and the reasonableness of the rates, and the information must be made available to the public on a company-by-company basis.
- The Secretary is empowered to impose a \$1,000/day fine on a company that violates the provisions of the statute with respect to rates if the violation is willful or if the company has violated it repeatedly. This is an additional remedy to the Secretary's power to suspend or revoke the company's certificate of authority.
- The insurance company will have the burden of justifying the rate.
- Insurance companies must offer their insureds the option to make payments on a quarterly basis.
- Companies are encouraged, but not required, to offer the opportunity to use deductibles and to provide premium discounts for participation in risk management activities.
- A company must give 180 days notice before it discontinues writing medical liability insurance in Illinois.
- All medical liability insurers must report to the Secretary all claims and suits filed in Illinois after December 31, 2005 alleging liability of a physician, hospital or health care provider for medically related injuries. These records will be publicly available, but will not disclose the parties' identities. Failure to comply can result in a fine of \$1,000.
- Medical liability insurers must provide reports giving statistical information regarding paid and incurred losses, broken down by county, for the last 10 years. This information will also be publicly available.
- A Professional Liability Insurance Resource Center website is to be established containing the name and base rates of each licensed medical liability insurer, plus the name of each producer selling medical liability insurance and the name of each company for which the producer sells. Publication of this info shall commence on January 1, 2006.

215 ILCS 5/155.18; 5/155.18a; 5/155.19

Pages 2-15 of the Bill

Free Medical Clinics – Good Samaritan Act

The Good Samaritan Act [745 ILCS 49/30] has been amended in minor respects as to "free medical clinics," and to add "retired physician" to those receiving exemption from civil liability for services performed without compensation.

745 ILCS 49/30

Pages 54-55 of the Bill

Sorry Works! Pilot Program Act

This provision incorporates elements encouraging admission of fault with financial support to health care

providers, but its availability is severely restricted: to one hospital in a county whose population exceeds 250,000 people and the county is contiguous with the Mississippi River . The hospital is selected by a committee whose membership is set in the statute. In the 2nd year of the program, one additional hospital can be added.

Pages 56-58 of the Bill

Inseverability

"If any provision is held invalid, then this entire Act, including all new and amendatory provisions, is invalid."

Page 58 of the Bill

Comment:

Given the breadth and complexity of the new law, this "inseverability" provision makes the law only as strong as its weakest link, and may increase the odds of the entire legislation being declared invalid. Note that in the final version of the Bill that was passed, language was *deleted* that specifically stated if any section was declared invalid, the other provisions would not be affected.

Items Not Addressed in the Bill

Among the items not addressed in the new law are:

- The doctrine of apparent (or ostensible) agency
- Elimination of 'joint and several liability'
- Shortening or other change in the statute of limitations
- Protection of physician personal assets
- Restriction or elimination of plaintiff's right, after a voluntary dismissal [735 ILCS 5/2-1009], to re-file [735 ILCS 5/13-217]