SmithAmundsen Health Care QUARTERLY

SUMMER 2008

NEWS AND EVENTS OF INTEREST
to SmithAmundsen clients.

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QUARTERLY CONTRIBUTORS:

- Donna Fernandez, Editor
- Carmel Cosgrave
- Bill Dury
- Fleming Ford
- Rita Gitchell
- Linda Newman
- Jennifer Stuart
- Alana Zusis

In the Alternative: Nursing Home Neglect and Contractual Arbitration Clauses

By Linda F. Newman

Is $83 million too much for a jury to award for the death of a 90 year old woman with infected bedsores? What if it was reduced to $56 million? For nursing homes stung by some of the big verdicts of the 1990s, that is not a difficult question to answer. Many view such verdicts as outrageous and not reality based.

The highly litigious climate for nursing home claims has resulted in efforts to secure legislative reform and assistance. In instances where the legislature has lagged behind, one approach has been to limit access by aggrieved residents and their survivors to overly sympathetic juries with no knowledge of the challenges faced by facilities balancing care needs and budgetary constraints. More and more nursing home residents and their families are agreeing to give up their right to sue in exchange for securing a much desired place of residence in nursing home facilities or assisted living communities. As a result, the nursing home and assisted living industry have begun to require new residents to sign contracts agreeing to take any future disputes to arbitration rather than to court. Under these arbitration agreements, nursing home residents and their families agree to settle disputes through a third-party arbiter.

For obvious reasons, the nursing home industry exalts the virtues of arbitration because it is relatively inexpensive for plaintiffs and defendants and permits the nursing home staff to focus on patient care rather than litigation. Moreover, arbitrators are viewed as being less likely than juries to award the large punitive damages.

Not unexpectedly, plaintiffs' attorneys fight arbitration tooth and nail for the very same reasons that the nursing home industry and defense attorneys encourage them. In particular, consumer advocates and plaintiffs' attorneys have criticized arbitration clauses in resident contracts because they are contained in the residency agreement and are mandatory to obtaining residency in the facility. Additionally, the elderly and/or disabled nursing home population is not always of an appropriate state of mind to evaluate an agreement containing an arbitration clause. Such mandatory clauses are viewed by some as depriving the resident of his right to have his day in court and are often viewed as unconscionable. Nevertheless, some courts have upheld arbitration clauses even when they were signed by residents who could not read or who suffered from confusion. Others have agreed they were signed under duress and/or were unconscionable, alluding to the unequal bargaining position between a large corporate entity and someone desperate to find a place for their loved one.

Here in Illinois, arbitration agreements, such as those being utilized in several other states like Florida, appear to be precluded by legislative language for public policy considerations. Notably, the Illinois Nursing Home Care Act specifically states,

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"Any party to an action brought under §3-601 through 3-607 shall be entitled to a trial by jury and any waiver to the right to a trial by a jury, whether oral or in writing, prior to the commencement of an action, shall be null and void, and without legal force or effect."

Most recently, in *Carter v. SSC Odin Operating Company, LLC*, the U.S. Appellate Court considered the interplay between the Federal Arbitration Act, which mandates enforcement of agreements to arbitrate, and the Illinois Nursing Home Care Act, which invalidates the same agreements. In *Carter*, the special administrator had executed two separate health care arbitration agreements on behalf of the resident, one for each of the resident's two admissions to the health care center. Both agreements required that all disputes related to the resident's care be submitted to binding arbitration but that this clause would not apply where the amount in controversy was less than $200,000.00.

The special administrator in *Carter* brought a claim against the health care center after the resident's death and the health care center sought to compel arbitration, which was denied by the trial court. On appeal, the lower court was affirmed. The court held that because §§3-601 and 3-607 of the Illinois Nursing Home Care Act concern the validity, revocability, and enforceability of contracts generally, and did not specifically target arbitration agreements, these agreements present a legitimate state law contract defense as a violation of public policy and they must be void. The court reasoned that §§3-601 and 3-607 applied equally to all contracts attempting to restrict the right of nursing home residents to "commence an action" pursuant to the Nursing Home Care Act or to waive the right to trial by a jury regardless of whether the contract involves arbitration. Accordingly, a contract that never mentions arbitration, but requires a bench trial or some other form of alternative dispute resolution, rather than a trial by jury, would be voided by the same extent as a contract containing an arbitration agreement.

While the public policy concerns are undeniable, the statutory language seems to thwart a nursing home resident's ability to waive certain rights but not others. It simply makes no sense that a resident is deemed competent to designate a power of attorney for health care, execute a DNR, agree to psychotropic drug administration, or designate requested health care professionals, etc. but not to an arbitration clause set forth in separate and bold print in a residency agreement. Arguably, the Illinois legislature has usurped the nursing home resident's right to contract based merely on the resident's choice of residency and health care arrangements rather than on the resident's competency or other considerations.

Nevertheless, the Illinois Nursing Home Care Act language of §3-601 through 3-607 has not precluded other creative attempts for alternative dispute resolution and does not preclude agreement to arbitrate or mediate before trial. Recently, Madison county judges in downstate Illinois approved the Medical Malpractice Mandatory Mediation Program, which calls for each party to a case to sit down with a mediator present to discuss a possible resolution before going to trial in both medical malpractice cases and in nursing home litigation. Circuit Judge David Hylla stated that while nursing home cases fall under a different act, these cases are similar to medical malpractice cases. According to Judge Hylla, after the Medical Malpractice Mandatory Mediation program was initiated, they were approached by attorneys representing nursing homes and by the residents affected. Interestingly, mandatory mediation was considered at the suggestion of an attorney, Bob Gregory, who specializes in personal injury and nursing home litigation. According to Gregory, if both parties approach mediation with good faith effort for resolution, many cases can be resolved sooner rather than later. For the injured elderly or disabled nursing home resident, early resolution is especially desirable so that the resident can benefit from early compensation.

Moreover, the Health Care Council of Illinois, the public policy arm of the Illinois Healthcare Association which represents about 600 licensed and certified long-term care facilities, has endorsed the mandatory mediation idea and recognizes the benefit of having the parties discuss the issues prior to trial. The existing rule requires that mediation take place within ninety days of depositions being taken from the parties in the case. By that time, both sides will likely have a clear understanding of the strengths and weaknesses of their case and should be in position to evaluate it at mediation in a controlled environment with guidance from a knowledgeable mediator familiar with the issues and nuances of the claim.

The Madison county approach appears to comport with the recent *Carter* decision. It does not constrain a resident's right to a trial by jury, but it does require that the parties sit with a mediator ninety days prior to trial to attempt to work out their differences, where possible, without the expense and time of a jury trial. An experienced mediator or a judge, well versed in the issues and realities of nursing home care, can be highly effective in helping the parties evaluate the damages realistically. Perhaps even more importantly, mediation or a pretrial can effectively remove the "runaway jury factor" known to result in $83 million dollar verdicts.

REFERENCES:

210 ILCS 45/3-607 (2008).

Carter v. SSC Odin Operating Co. LLC, 885 N.E.2d 1204 (5th Dist. 2008).

Medical News Today, *Nursing Homes Increasingly Use Arbitration To Avoid Lawsuits, Reduce Costs*, Apr. 14, 2008, http://www.medicalnewstoday.com/articles/103806.php.

County Requires Mediation in Nursing Home Cases: Trying to Resolve Issues Before Trial, http://hefpn.advisen.com/articles/article7527824915792688.

Debra Cassens Weiss, *Some ADR Firms, Plaintiff's Lawyers Shun Nursing Home Arbitration*, www.abajournal.com.

Georgia Rules Caps Unconstitutional; Oregon Upholds Five Year Statute of Limitations for Minors; Lebron Plaintiffs to Respond to Defense Arguments in Illinois

As the 2005 tort reform measures remain pending before the Illinois Supreme Court in the consolidated case of *Lebron v. Gottlieb Memorial Hospital*, two other states have recently issued rulings on their own tort reform provisions, providing additional fodder for the constitutionality debate here in Illinois.

In Georgia, a trial court judge ruled that the state's cap on pain and suffering awards in medical liability cases violated Georgia's constitution because it discriminates against poor and middle-class plaintiffs. The judge found that the caps on non-economic damages favored those earning high incomes over other plaintiffs, as the high-income plaintiffs could win substantially higher awards for economic losses as opposed to the capped non-economic damage awards. The judge also said that the caps discriminate against the more seriously injured, who are compensated for only a small percentage of their actual non-economic injury. Notably, these are two of the arguments set forth by plaintiff's counsel in the *Lebron* case.

In a showing that tort reforms do survive challenges, the Oregon Supreme Court recently upheld a five-year statute of limitations on medical malpractice lawsuits involving minors. The court ruled against a claim that laws in effect when Oregon was a territory blocked the statute of limitations that the Legislature approved after Oregon became a state.

Oregon's statute of limitation in this regard is much more limiting than the statute of limitation that currently exists in Illinois. Illinois provides a minor with eight years in which to file a medical malpractice claim, although in no event can a claim be brought after an individual's 22nd birthday. The 2005 Illinois reforms do not set forth any changes in the existing statutes of limitations, and as such, these limitations are not in danger of being affected by the outcome of the *Lebron* case.

In *Lebron*, the defendants and their amici have submitted the initial round of briefs and memoranda to the Supreme Court in support of the 2005 tort reform measures. The plaintiffs will now be given an opportunity to respond with their arguments against the reforms. SmithAmundsen attorneys Carmel Cosgrave, Michael Resis, Ellen Green, and Jennifer Stuart were involved in the preparation and submission of an *amicus brief* in support of the tort reform measures on behalf of Advocate Health and Hospitals Corporation. Advocate's brief was one of only a handful of *amici briefs* accepted by the Supreme Court.

A copy of the amicus brief submitted by SmithAmundsen on behalf of Advocate Health and Hospitals Corporation can be viewed here. We look forward to seeing plaintiffs' responses to the strong arguments set forth by all of the defendants in this matter, and will continue to keep you updated as this case proceeds.

REFERENCES:

735 ILCS 5/13-212 (2008).
Park v. Wellstar, No. 07 CV 135208 (Georgia Sup. Ct. Apr. 28, 2008).
Christiansen v. Providence Health Sys., No. CA A122603, 2008 Ore. LEXIS 276 (Or. May 8, 2008).

New Federal Law Prohibits Discrimination Based on Genetic Information

On May 21, 2008, the Genetic Information Nondiscrimination Act of 2008 (GINA) was signed into law. GINA, which will take effect in 18 months, prohibits discrimination on the basis of genetic information, and makes changes to numerous laws. Essentially, this new law is designed to prohibit the improper use of genetic information in health insurance and employment. It prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions.

With limited exceptions, GINA also makes it unlawful for an employer to request, require, or purchase an employee's genetic information, except in limited circumstances. Employers who do possess genetic information about employees must keep the information confidential and maintain it in separate files. In addition, GINA prohibits group health insurance plans from adjusting premiums based on genetic information. GINA does not, however, prohibit group health plans from using the results of genetic information in making payment determinations.

GINA's provisions also amend several federal laws, including the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), the Health Insurance Portability and Accountability Act (HIPAA), the Internal Revenue Code, and the Social Security Act. Importantly, GINA requires that genetic information be treated as health information under HIPAA, subjecting it to the same requirements as health information, and prohibits the use or disclosure of genetic information for health insurance or Medicare underwriting purposes.

The health insurance provisions of GINA generally will be enforced through the various laws that it amends. For example, GINA's privacy provisions will be enforced through HIPAA, which imposes civil penalties of $100 per violation and criminal penalties of up to $250,000 and 10 years in prison for commercial and malicious violations. GINA's discrimination provisions will be enforced primarily through ERISA and the PHSA, which will be amended to authorize penalties of $100 per day per person, with minimum penalties of $2,500 (for de minimis violations) or $15,000 (for more serious violations), and a maximum of $500,000 for unintentional violations. GINA's employment discrimination provisions will be enforced through Title VII of the Civil Rights Act of 1964 and the Government Employee Rights Act of 1991. Notably, however, GINA explicitly precludes any cause of action based on a disparate impact theory of genetic discrimination.

CMS Proposal Increases Number of Non-Reimbursable Hospital-Acquired Conditions

The Centers for Medicare & Medicaid Services (CMS) recently proposed an increase in hospital quality measures, including a greater number of hospital-acquired conditions that will not be reimbursable under Medicare. The impact of this proposal would almost double the amount of data that hospitals generally collect. The final rule will be issued on or before August 1, 2008.

The proposed additions to the existing eight-item list of hospital-acquired conditions will include nine new categories that must be reported when a patient is first admitted. These additions are:

- Surgical site infections following certain elective procedures
- Legionnaires' disease
- Extreme blood sugar derangement
- Latrogenic pneumothorax or collapsed lung
- Delirium
- Ventilator-associated pneumonia
- Deep vein thrombosis or pulmonary embolism
- Staphylococcus aureus septicemia (blood infection)
- Clostridium difficile associated disease (intestinal bacterium)

CMS has also indicated that it wants to increase the number of hospital quality measures from 30 to 72 over the next fiscal year, including fifteen cardiac surgery measures alone. In order to reduce the amount of data collected by a hospital, they may stagger the start date for the specific measures.

Spotlight

Jennifer Stuart

As the daughter of a high school biology teacher, Jennifer Stuart's father would let her dissect any left over specimens while he taught his students on "Bring Your Daughter to Work" days. This opportunity lead Jennifer to her love of science and an undergraduate degree in biology from the University of North Carolina at Chapel Hill and a master's degree in pathology from Duke University School of Medicine. Jennifer was working at a tissue bank at Brigham & Women's Hospital in Boston, when she first encountered HIPAA. "It shut down our work for a week! I just couldn't understand it. Here we were banking tissue for research on lung cancer and mesothelioma, and the federal law was making it more difficult for us to do our job!"

This early encounter, with the direct effect that one piece of legislation had on health care, led Jennifer to Loyola University School of Law. "My dream was to eventually help develop policy and legislation that made sense for the health care industry," Jennifer explains. While at Loyola, Jennifer had many opportunities to explore the effect that the law had on the delivery of health care as a member of the Health Law Society and Senior Editor for the *Annals of Health Law*. Jennifer also received a CALI Award for appellate advocacy, and was a Katten Muchin Zavis Rosenman Health Law Fellow. Jennifer graduated *cum laude*, with a J.D. and a certificate in Health Law in 2006. "I never really considered litigation until I took Professor James Carey's Trial Advocacy Course in Law School. Then it dawned on me that litigation would allow me to advocate for the health care industry and still help develop more workable and realistic policies for the health care industry."

Jennifer's passion for health care and trial advocacy made her a natural fit for the Health Care Group at SmithAmundsen. "With our experience representing hospitals, long term care facilities and other health care organizations, we have seen first hand, the good, the bad and the ugly effects that regulation has had on the health care industry," said Carmel Cosgrave, Chair of the Health Care Practice Group. "At SA, we have built a team of lawyers who not only try complicated cases, but who also serve as advisors to the health care industry."

"I cannot believe how many opportunities I already have been given to indulge my passion for health care policy and litigation," Jennifer adds. "In the two years or so that I have been at SA, I have written several successful motions for directed verdicts on apparent agency and institutional negligence. I have had an opportunity to second chair a wrongful death case, collaborated on several post trial motions, and assisted in the appeals of two medical negligence cases. I am also very excited to have worked on an *amicus brief* in support of the 2005 Tort Reform legislation."

From laboratory to law school to court room, Jennifer has always looked forward to a challenge and new opportunities. Her meticulous attention to detail, efficient researching skills, and outstanding communication skills have made her an asset to SA's Health Care Group. "Everyone on the team loves working with Jen," said Carmel. "Not only is she a great writer, with wonderful research skills, but she has a great sense of humor and is a real team player. She really impressed me while we were on trial in January. Jennifer's knowledge of neuropathology was invaluable in a case where images of the brain and the cause of a stroke were the central issues. Jennifer became incensed when the plaintiff's expert neuroradiologist tried to mislead the jury. Jennifer had several useful insights that I was able to incorporate into the cross examination. It was no accident that the jury came back with a finding in favor of the defendants in less than two hours."

When asked what other opportunities she would like to develop in her career, Jennifer commented, "I am always asking to be involved in any case where I can use my pathology skills, like cancer cases and birth injury cases. But I have already seen that by following my curiosity, I have discovered new career paths. I am fascinated by biotechnology, and I have already learned that as medicine and technology advance, the law will have to try keep pace. I am open to the changes that will come!"

Feature Article

HEALTH CARE LAW

Challenging the Boundaries of the Wrongful Death Act – Can a Mother Recover for an Aborted Fetus?

By Rita L. Gitchell

Under the Wrongful Death Act, recovery is permitted for the death of an individual by wrongful act, neglect, or default. This cause of action may be brought for the exclusive benefit of the surviving spouse and next of kin with no distinction made between whole and half blood kindred. Adopted parent and child are treated as natural parent and child. A posthumous child born after the death of his or her parent may recover. Illegitimate children are likewise characterized as next of kin. On the other hand, foster parents are not entitled to recover for the death of a foster child not withstanding full support and care. Similarly, neither parents nor siblings are next of kin when the decedent leaves surviving children. But, how would an Illinois court decide a scenario where a parent is seeking to recover under the Wrongful Death Act for the injuries sustained by her aborted fetus?

Recently, in *Williams v. Manchester*, the Illinois Supreme Court was faced with this very question. The underlying facts set the stage for consideration of this issue: On October 15, 2002, Michelle Williams, then 10 ½ weeks pregnant, was a passenger in a car involved in a serious automobile accident. Suffering serious injuries to her head and hips, she was taken to the hospital for evaluation. While physicians informed her that she did not suffer a spontaneous abortion and the fetus was not injured, Williams suffered from a broken hip and pelvis.

At Williams' request, Dr. Keller, a high-risk obstetrician gynecologist was consulted to determine the future potential risks to the fetus and her in treating the broken hip and pelvis. According to Dr. Keller, there were definite risks involved, for both Williams and the fetus, should she continue with the pregnancy and have surgery on her pelvis. Essentially, Dr. Keller discerned four potential options for Williams: (1) immediate pelvis surgery without termination of pregnancy; (2) immediate termination of pregnancy and post-recovery pelvis surgery; (3) delayed pelvis surgery until the second trimester of pregnancy; or (4) delayed pelvis surgery until after giving birth. The first option would place the fetus at risk for loss and could also potentially result in long term negative effects from the radiation exposure that would necessarily occur with surgery. The third and fourth options, could still potentially have a negative effect on the fetus because of the radiation exposure, however, this risk would be decreased. With both of these options, the delay in undergoing the surgery would decrease the likelihood

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Practice Group Highlight

ENTERTAINMENT, MEDIA & PRIVACY

Privacy is a cornerstone of the patient-physician relationship. Privacy issues in health care stem from three bases of law: litigation, federal law, and state law. Conflicts amongst these laws emerge when more stringent state privacy laws preempt the requirements of federal laws, such as HIPAA. For example, Illinois law often prohibits the use or sharing of health information in situations where HIPAA allows the release of this data. The preemption analysis necessary to interpret compliance requirements can be difficult and federal agencies do not often give adequate guidance to health care organizations as to the specific state laws.

In addition to the HIPAA compliance requirements imposed by state laws, federal laws shape the way health organizations obtain and use personal health information. The Federal Electronic Communications Privacy Act (ECPA) adds to the requirements of HIPAA as well as creates a private right of action which allows consumers to bring suit against health care providers over privacy violations. The ECPA's private right of action furthers the need for health care organizations to effectively comprehend and navigate the law when establishing their privacy policies and procedures.

The issues often facing those in the health care industry create the need for a proactive and workable legal approach that will not only protect your patients, but also protect your organization. At SmithAmundsen, our attorneys in the Media and Privacy Practice Group have experience in counseling clients on diverse privacy law issues. As consultants, we guide your development of compliance procedures and ensure your organization takes the necessary steps necessary to prevent inadvertent disclosure violations. As your legal advisor, we will minimize unnecessary litigation, address your unique privacy claims, and ensure legal compliance with the applicable state and federal laws. For more information on any media and privacy issues as they relate to the health care arena, contact Ryan Jacobson at 312-894-3252, or Carmel Cosgrave at 312-894-3228, or visit our Web site at www.salawus.com.

of a good result to Williams. On the other hand, the second option provided Williams with the "best chance" of a positive long term outcome. In effect, the longer Williams delayed the surgery on her pelvis, the more likely she was to have a negative long term outcome.

One week after the accident, Williams made the decision to terminate the pregnancy and the pelvis surgery was performed one week thereafter. She then brought a claim against the other driver involved in the car accident and included allegations of negligence under the Wrongful Death Act asserting that the defendant driver's negligent actions caused the accident and ultimately, the death of the fetus. Following discovery, the defendant moved for summary judgment as to this particular claim arguing that the accident, radiation exposure, and any other potential risk to the fetus was not the proximate cause of the fetus' death. Instead, the defendant asserted that the fetus' death was the result of William's voluntary decision to terminate the pregnancy, particularly when considering that there were surgical options available which would have allowed her to forego termination of the pregnancy.

In response, Williams contended that the defendant's negligence was the "cause in fact" of the fetus' wrongful death since "but for" the defendant's negligence, the termination of the pregnancy would not have occurred. She further maintained that her decision to terminate the pregnancy was a foreseeable result of defendant's negligence. Finding in favor of the defendant on its motion for summary judgment, the trial court asserted that the Wrongful Death Act did not take into consideration the reasonable foreseeability of an injury or death. Rather, the focus is whether a defendant's conduct actually caused the alleged injury or death. The evidence presented during discovery showed that the fetus was uninjured and viable following the accident, and thus Williams could have continued with the pregnancy and waited until later to address her own injuries. The court held that Williams was the actual cause of the fetus' death and therefore, she could not recover under the Wrongful Death Act.

The Appellate Court was divided on this issue on appeal. The majority reversed the lower court's decision, emphasizing that, aside from the occurrence of a death, a wrongful death claim is identical to any common law negligence claim. The majority held that, as a matter of law, it would be unforeseeable for a pregnant woman injured by another party's negligence to agree to endure medical consequences to herself or her fetus for the sake of maintaining a pregnancy. It was the majority's contention that the foreseeability of a woman's choice under these circumstances must be determined by a jury. The dissent strongly disagreed with this analysis asserting that the plain language of the Wrongful Death Act did not allow Williams' claim to stand because, had the fetus not been aborted, there is no way to ascertain whether the fetus suffered an actionable injury before death.

In taking up this issue for itself, the Illinois Supreme Court sided with the dissent and was sharply critical of the majority's analysis. It contended that the majority failed to properly consider the plain language of the Wrongful Death Act, which has remained unchanged since 1853. The pertinent language provides:

"Whenever the death of a person shall be caused by wrongful act, neglect or default, and the act, neglect or default is such as would, if death had not ensued, have entitled the party injured to maintain an action and recover damages in respect thereof, then and in every such case the person who or company or corporation which would have been liable if death had not ensued, shall be liable to an action for damages, notwithstanding the death of the person injured, and although the death shall have been caused under such circumstances as amount in law to felony."

Based upon this plain language, an injury resulting from a wrongful act, neglect, or default of another gives the victim, if the victim survives the injury, a right of action. If the victim does not survive, the Wrongful Death Act allows the right of action to be transferred to the victim's personal representative. Case law interpreting this principle has consistently required that, as a condition for maintaining a wrongful death action, the decedent must have been able to bring, at the time of his death, an action for damages resulting from the occurrence. Put more simply, a wrongful death action is barred if the decedent, at the time of death, would not have been able to pursue an action for personal injuries.

In the case of Williams' fetus, the evidence demonstrates that the fetus could not have maintained a claim for personal injury against the defendant driver based upon the car accident itself. Williams' physicians testified that the fetus was not injured in the accident and that the pregnancy could have gone to term. Moreover, Williams conceded that there was not sufficient evidence to show that the fetus suffered a present, actionable injury as a result of the radiation exposure from Williams' initial treatment following the accident. Accordingly, the Illinois Supreme Court reversed holding that Williams was unable to establish that her fetus, prior to death, had a present injury such that the fetus could have maintained an action against defendant.

REFERENCE:

Williams v. Manchester, 2008 Ill. LEXIS 306 (2008).
740 ILCS 180/1 (2008).

Disparate Hospital Billing Practices Found Not to Violate Consumer Fraud Act

In *Galvan v. Northwestern Memorial Hospital*, the First District found that a hospital's practice of charging insured patients more than an uninsured for services rendered did not violate the Consumer Fraud Act. The court also held that the imposition of a lien on the plaintiff's settlement did not constitute unjust enrichment. In *Galvan*, an uninsured plaintiff was taken to the hospital emergency room following an accident and was hospitalized for fifteen days, incurring over $87,000 in medical bills. Plaintiff then brought a claim against the hospital under the Consumer Fraud Act alleging that, because he was uninsured, he was unfairly charged fifty percent more in hospital fees than his insured counterpart would be charged. Plaintiff further alleged that the hospital was unjustly enriched by recovering from plaintiff's personal injury settlement. The hospital's motion to dismiss plaintiff's claims was granted and plaintiff now appeals.

Under the Consumer Fraud Act, plaintiff must plead the following elements to survive a motion to dismiss:

- An unfair or deceptive act or practice by the defendant;
- The defendant's intent that the plaintiff rely on the unfair or deceptive practice;
- The unfair or deceptive practice occurred in the course of conduct involving trade or commerce; and
- The unfair or deceptive practice proximately caused plaintiff's injury.

In *Galvan*, plaintiff argued that the hospital's practices were unfair due to their oppressive nature and his lack of a meaningful choice "but to pay." The First District disagreed, noting that insured and uninsured patients are not similarly situated so as to qualify for similar prices. When an insurance company contracts with a hospital payment is guaranteed on behalf of those insured but "there is no such guarantee from uninsured patients."

The court also found that while the hospital may have concealed information about its rates and billing practices from plaintiff, he did not plead any damages that were proximately caused by the concealment. The hospital did not institute any form of collection other than asserting a lien and plaintiff never alleged that he would have sought care elsewhere had the rate information been provided. Addressing the unjust enrichment claim, the court held that the unadjudicated lien did not confer a benefit on the hospital so as to qualify as an "unjustly retained benefit."

Because the hospital's billing practices do not violate the Consumer Fraud Act and because there was no unjust enrichment conferred on the hospital, the decision of the trial court to dismiss plaintiff's claims was affirmed.

REFERENCE:

Galvan v. N.W. Mem. Hosp., 2008 Ill. App. LEXIS 349 (1st Dist. 2008).

Seventh Circuit Reverses $7 Million Loss of Consortium Award

In *Arpin v. U.S.*, the Seventh Circuit recently affirmed a district court decision holding two defendant hospitals jointly and severally liable for the death of a patient after the defendant hospitals' physicians failed to diagnose and treat an infection of the hip muscle. In *Arpin*, the decedent was seen by a second year resident following an accident at work in which the decedent landed on his hip. The resident diagnosed the decedent with a muscle strain even though he was experiencing worsening pain three days after the accident and the supervising physician did not perform an examination. Within two weeks, the decedent died of multi-organ failure from an infection to the hip muscle. The Seventh Circuit agreed that both physicians were liable, however, it reversed and remanded the district court's determination that $7,000,000 in damages ought to be awarded for the loss of consortium of the decedent's wife and four children.

The Court considered whether the $7,000,000 award for loss of consortium was "so excessive as to shock the conscience." The Court noted that while it may be difficult for a court to justify any specific damage amount on a loss of consortium claim, a judge must indicate the reasoning process that connects the evidence to the conclusion, and thereby satisfy Rule 52(a) of the Federal Rules of Civil Procedure. It may be useful for a judge to consider awards in similar cases, both in Illinois and elsewhere, even when the Illinois rule on comparison evidence may not bind federal courts. In addition, judges may seek guidance from the Supreme Court's ratio approach to assessing the constitutionally of punitive damages. In *Arpin*, the Seventh Circuit found that the loss of consortium award was excessive and that portion of the judgment was vacated and remanded back to the district court for further proceedings.

REFERENCE:

Arpin v. U.S., 521 F.3d 769 (7th Cir. 2008).

Dental Malpractice Claim Barred by Statute of Limitations Despite Claim of a "Continuing Course of Negligent Treatment"

The First District recently affirmed the trial court's dismissal of a dental malpractice action in *Caywood v. Gossett* because the plaintiff filed her claim more than two years after she should have known of the alleged injury caused by the defendant dentist. Plaintiff began seeing the defendant dentist in January 1988 and began experiencing severe pain and swelling in her mouth and face in March 2001. Over the course of the next year, the defendant dentist continued to prescribe pain medication and antibiotics, but did not refer plaintiff to a specialist even though the pain and symptoms appeared to be worsening. Eventually, in August 2001, plaintiff sought treatment from a new physician following the extraction of a tooth by the defendant dentist which she believed resulted in an improperly treated infection. Plaintiff last saw the defendant dentist on December 11, 2001 and filed her claim against him on December 11, 2003. Defendant's motion to dismiss based upon expiration of the statute of limitations period was granted and plaintiff now appeals.

Pursuant to Section 13-212 of the Illinois Code of Civil Procedure, the two year statute of limitations started running once the plaintiff knew or reasonably should have known that an injury was wrongfully caused. The knowledge requirement is satisfied once a plaintiff possesses sufficient information concerning an injury and its cause to put him or her on inquiry to determine whether actionable conduct is involved. The Court focused on plaintiff's deposition, stating that her testimony revealed that she was on inquiry prior to November 19, 2001 that actionable conduct occurred. Accordingly, the burden was on her to determine whether a cause of action was proper within the statute of limitations period.

Plaintiff also argued that the defendant's treatment constituted a "continuing course of negligent treatment" and thus, the limitations period did not begin to run until she last saw the defendant on December 11, 2001. In order to prevail under this theory, plaintiff had to show:

- That there was a continuous and unbroken course of negligent treatment, and
- That the treatment was so related as to constitute one continuing wrong.

The court held that plaintiff did not satisfy these requirements because she testified at deposition that she could not recall any negligent treatment provided by the defendant dentist at the last visit and there are no similar negligent allegations in the complaint. Accordingly, the judgment of the trial court to dismiss plaintiff's claim was affirmed.

REFERENCE:
Caywood v. Gossett, 2008 Ill. App. LEXIS 345 (1st Dist. 2008).

Defense Verdict Upheld Where Defendants Failed to Produce Expert Witness

The First District recently upheld a defense jury verdict, rejecting a plaintiff's claims that a new trial should have been granted due to the court's refusal to give the "missing witness" jury instruction, I.P.I. 5.01, after the defendants failed to produce their expert witness at trial. In *Lisowski v. MacNeal Memorial Hospital*, the defendants' controlled expert witness opinion disclosures stated that their pulmonologist expert would testify that the defendant physician's conduct complied with the standard of care. Plaintiff maintained, however, that the expert testified at his deposition that the defendant physician deviated from the standard of care in his treatment of the decedent.

Shortly before trial, counsel for plaintiff contacted defense counsel and indicated her desire to call defendants' expert as his own witness if the defendants intended to abandon him. The defense responded that they had no such intention. At trial, plaintiff's counsel made numerous references to the defense expert's anticipated testimony, including cross-examining the defendant physician regarding his prior training under defendant's expert and asking if the defendant "had any problem" with his former instructor testifying that the defendant physician had violated the standard of care. After the defendants objected to this questioning, the court informed plaintiff that he now had the burden of producing the expert to back up his questioning.

On the final day of trial, defense counsel informed the court that their expert was unavailable to testify because of his surgical schedule, and as such, the defense would proceed to closing arguments without him. The expert testimony was not technically necessary because the defendant physician had offered expert testimony on his own behalf that he had not violated the

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standard of care. In response to defendants' failure to call their expert, plaintiff asked that the "missing witness" instruction be given to the jury. This instruction allows the jury to infer that any evidence not offered but within the control of a party is adverse to that party. The trial court noted that both parties had an obligation to produce this expert, and neither party did so. As such, an instruction allowing an adverse inference against the defendants was not proper when plaintiff never subpoenaed the witness himself. Plaintiff asked to reopen his case-in-chief and call the expert as his own witness, but could not force him into court due to the absence of a subpoena.

The jury came back with a defense verdict, and the plaintiff appealed. The Appellate Court noted that although the expert was under the defendants' control to the extent that they had named him as a controlled expert witness, plaintiff, with reasonable diligence, could have obtained his appearance by subpoena under Supreme Court Rule 237. Given plaintiff's failure to take reasonable steps to secure the expert's testimony at trial, the court's refusal to offer the "missing witness" instruction was not error, and the jury verdict in favor of defendants was upheld.

REFERENCE:

Lisowski v. MacNeal Mem. Hosp. Ass'n, 885 N.E.2d 1120 (1st Dist. 2008).

Court Upholds Plain Language Meaning of "Fee Sharing"

In *Center for Athletic Medicine, Ltd. v. Independent Medical Billers of Illinois, Inc.*, the First District upheld the granting of a motion for summary judgment in defendant's favor finding that the percentage based fee agreement between the parties violated the broad prohibition against fee sharing. Plaintiff and defendant had entered into a contract where defendant would receive a percentage of the insurance reimbursements from plaintiff's sports medicine practice in exchange for work on billing, accounts receivable, and collection services. Plaintiff's initial complaint alleged that defendant breached the contract and should be forced to pay damages because it failed to maximize plaintiff's reimbursements, handle plaintiff's debts in a timely manner, and properly encode charged documents. Alternatively, plaintiff alleges that the defendant benefited from unjust enrichment. Defendant successfully moved for summary judgment on the grounds that their agreement was void under the fee-splitting provision of Section 22(A)(14) of the Medical Practice Act, and plaintiff now appeals.

The fee-splitting provision of the Medical Practice Act explicitly bans "dividing with anyone other than physicians with whom the licensee practices . . . any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered." Plaintiff contended that they did not violate the public policy behind the provision, and thus the agreement should be enforced.

Citing *Lieberman & Kraff M.D., S.C. v. Desnick*, the Appellate Court noted that, "where an agreement results in fee splitting, the purpose behind the agreement is irrelevant; the agreement is void." Despite plaintiff's protestations that the defendant did not affect patient decisions, the court found that the act of fee sharing was present because the defendant's fee was based on a percentage of the plaintiff's revenue. The Court did make the distinction that if the defendant's payment had been a flat fee, the case's outcome could have been different. Additionally, the court rejected plaintiff's assertion of unjust enrichment. The fact that there was a contract between the parties, void or not, makes the plaintiff unable to sue in equity for unjust enrichment.

REFERENCES:

Ctr. for Athletic Med., Ltd. v. Indep. Med. Billers of Ill., Inc., 2008 Ill. App. LEXIS 494 (1st Dist. 2008).
Lieberman & Kraff, M.D., S.C. v. Desnick, 244 Ill. App. 3d 341 (1st Dist. 1993).
225 ILCS 60/22(A)(14) (2008).

SmithAmundsen Health Care Team Members

Carmel Cosgrave
Chair, SA Health Care Team

Attorneys
Cynthia Besecker
Donna Fernandez
Rita Gitchell
Patrick Lubenow
Linda Newman
Ruth Robinson
Jennifer Stuart

Nurse Medical Analysts
Betsy Ballek
Lori Butler

Paralegal
William Dury

Assistants
Sharon Blaszak
Ann Finney
Kristina Shera

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OFFICE LOCATIONS

150 North Michigan Avenue
Suite 3300
Chicago, Illinois 60601-7524
(312) 894-3200

2460 Lake Shore Drive
Woodstock, Illinois 60098-2664
(815) 337-4900

Stewart Square
308 West State Street
Suite 320
Rockford, Illinois 61101-1140
(815) 987-0441

415 West Washington Street
Suite 204
Waukegan, Illinois 60085-5564
(847) 599-9503

3815 East Main Street
Suite A-1
St. Charles, Illinois 60174-2488
(630) 587-7910

4811 South 76th Street
Suite 306
Milwaukee, Wisconsin 53220
(414) 282-7103

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