

SURVEY OF ILLINOIS LAW: HEALTH CARE

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I. INTRODUCTION

Health Care remains among the most active and varied legal fields. This year's Survey reviews significant state health care law developments with respect to the tax-exempt status of not-for-profit health care providers, physician restrictive employment covenants, the tort litigation collateral source rule, hospital negligent medical staff credentialing, physician fee splitting and health care professional licensure and discipline. The various articles have been written by a diverse group of Illinois health care lawyers, almost all of whom are current or former members of the Illinois State Bar Association's Health Care Section Council, to inform Illinois lawyers of significant developments in this dynamic practice area.

II. RECENT DEVELOPMENTS—ILLINOIS NOT-FOR-PROFIT HOSPITALS AND THE PROPERTY TAX EXEMPTION¹

The tax-exempt status of not-for-profit health care providers has been the subject of considerable dispute and litigation recently, both nationwide and in Illinois.² In a 2006 decision from the Third District Appellate Court,

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1. This section of the Survey article is by W. Eugene Basanta, the Southern Illinois Healthcare Professor of Law, Southern Illinois University School of Law; Professor, Southern Illinois University School of Medicine, Department of Medical Humanities and Co-Director, Southern Illinois University Center for Health Law and Policy.
 2. See, e.g., David A. Hyman & William M. Sage, *Subsidizing Health Care Providers Through the Tax Code: Status Or Conduct?* 25 HEALTH AFF. (Web Exclusives) w312 (2006); CONGRESSIONAL BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (Dec. 2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf> (last visited Apr. 15, 2008). For a recent state court decision denying a tax exemption for a charitable entity (not a hospital) see *Under the Rainbow Child Care Ctr. v. County of Goodhue*, 741 N.W.2d 880 (Minn. 2007). At the federal level, the Internal Revenue Service has recently revised Form 990, the reporting form filed annually by charities and other tax-exempt organizations. IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief, IR-2007-204, Dec. 20, 2007, available at <http://www.irs.gov/newsroom/article/0,,id=176722,00.html> (last visited Aug. 22, 2008).

In part, this recent controversy regarding hospitals traces its roots to high-profile media coverage of particular cases. See, e.g., Lucette Lagnado, *Hospitals Try Extreme Measures to Collect Their Overdue Debts*, WALL ST. J., Oct. 30, 2003, available at

Community Health Care v. Illinois Department of Revenue,³ a not-for-profit, community-based primary care clinic, offering care to underserved patients, was denied a property tax exemption. The clinic applied for the tax exemption for its Rock Island, Illinois location based upon its claim that it used this property for charitable purposes.⁴ The Illinois Department of Revenue (IDOR) denied the request, and the clinic appealed to an administrative law judge (ALJ). The ALJ upheld IDOR's decision, finding that the clinic had not demonstrated that it qualified as a charitable organization under the Property Tax Code⁵ or that the property was used exclusively for charitable purposes.⁶ The clinic appealed to the circuit court, which reversed the ALJ's order. The appellate court overturned the circuit court's holding and reaffirmed the ALJ's order.

The clinic presented evidence that it provided a "sliding scale" of fee discounts, especially for those patients below 200% of the poverty level, and that 27% of the its patients had received some level of discounted services in 2003, most of whom received a 100% discount. Further, the clinic's evidence showed that it advertised this program in various media resources. The evidence indicated that, while the clinic received 65% of its revenue from patient fees, 17% of the fees were discounted. However, much of the clinic's

<http://webreprints.djreprints.com/858821310103.html> (last visited Apr. 15, 2008); Lucette Lagnado, *Anatomy of a Hospital Bill*, WALL ST. J., Sept. 21, 2004, available at <http://webreprints.djreprints.com/1073641266651.html> (last visited Apr. 15, 2008).

While the recent controversy has been intense, it is in fact not new. In the late 1980s and early 1990s there were a variety of legal challenges to state tax exemptions for hospitals. John D. Columbo & Mark A. Hall, *The Future of Tax-Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1 (1992); GENERAL ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION, HRD-90-84 (May 1990), available at <http://archive.gao.gov/d24t8/141681.pdf> (last visited Apr. 15, 2008). For relevant cases see *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985); *Medical Ctr. Hosp. of Vermont, Inc. v. City of Burlington*, 152 Vt. 611, 566 A.2d 1352 (1989); *Allentown Hosp.-Lehigh Valley Hosp. Ctr. v. Bd. of Assessment Appeals*, 148 Pa.Cmwlth., 422, 611 A.2d 793 (1992). In 1991, Congress considered but did not enact the Charity Care and Hospital Tax-Exempt Status Reform Act, H.R. 790, 102d Cong., 1st Sess. (1991). This bill would have established charity care criteria for a hospital to meet in order to qualify for a federal tax exemption.

3. 369 Ill. App. 3d 353, 859 N.E.2d 1196 (3d Dist. 2006). The Illinois Supreme Court declined to review this decision. *Cnty. Health Care, Inc. v. Illinois Dept. of Revenue*, 223 Ill.2d 632, 865 N.E.2d 967 (2007).
4. The clinic also had other facilities in the Quad Cities area.
5. *Community Health Care*, 369 Ill. App. 3d at 354, 859 N.E.2d at 1197. 35 ILL. COMP. STAT. 200/15-65 (2007) permits a tax exemption for property, "actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit." ILL. CONST. of 1970, art. IX, § 6 states: "The General Assembly by law may exempt from taxation only . . . property used exclusively for . . . charitable purposes."
6. *Community Health Care*, 369 Ill. App. 3d at 354, 859 N.E.2d at 1197.

evidence relative to the Rock Island facility was based on extrapolations from data from all of its area facilities, rather than on location-specific data.

In its analysis, the appellate court followed the six-part test established in *Methodist Old Peoples Home v. Korzen*⁷ to determine whether the clinic was eligible for a property tax exemption. Under *Methodist Old Peoples Home*, in order to be eligible for a property tax exemption, the alleged charity must show that: (1) it is set up for the benefit of an indeterminate number of persons; (2) it has no capital, capital stock, or shareholders and earns no profits or dividends; (3) it derives its funds primarily from public and private charity and holds those funds in trust for the objectives and purposes expressed in its charter; (4) it dispenses charity to all who need and apply for it, does not provide gain or profit in a private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need and would avail themselves of the charitable benefits it dispenses; (5) the property is actually and factually used exclusively for the charitable purpose, regardless of any intent expressed in the organization's charter or bylaws; and (6) charity use is the primary purpose for which the property is used and not a secondary or incidental purpose.⁸

The appellate court noted that findings of fact made by an ALJ “are considered prima facie true and correct,” that an ALJ’s decision should stand unless “clearly erroneous,” and that the burden of proof falls on the party seeking the tax exemption.⁹ Focusing on the sixth factor in the *Methodist Old Peoples Home* test, the appellate court found that the clinic’s property was not primarily used for charitable purposes.¹⁰ Besides showing that 27 % of its patients received subsidized care, the clinic “had little concrete data to support its conclusion.”¹¹ As the court noted, based upon the clinic’s own evidence, 73 % of the time the subject property was used to treat patients who receive no fee discount. Further, the court stated that, “[b]ecause [the clinic] admits that its application is based on data from other facilities and an assumption that the facility in question will serve the same number and type of patients . . . [the clinic] has not carried its burden of proving a right to an exemption.”¹² As such, the appellate court upheld IDOR’s denial of a property tax exemption for the clinic’s Rock Island facility.¹³

7. *Methodist Old Peoples Home v. Korzen*, 39 Ill.2d 149, 233 N.E.2d 537 (1968).

8. *Id.* at 157, 233 N.E.2d at 541-42.

9. *Community Health Care*, 369 Ill. App. 3d at 356, 859 N.E.2d at 1199.

10. *Id.* at 357, 859 N.E.2d at 1199–200.

11. *Id.*

12. *Id.* at 357, 859 N.E.2d at 1200.

13. *Id.*

In addition to the *Community Health Care* case, a critical legislative proposal was put forth by Illinois Attorney General Lisa Madigan in 2006, the Tax-Exempt Hospital Responsibility Act.¹⁴ As introduced, this proposal, which received tremendous media attention,¹⁵ would have required that Illinois hospitals, in order to maintain their tax-exempt status, among other things, demonstrate that they provide “aggregate annual charity care in an amount equal to at least 8% of the hospital's total operating costs as reported each year in the most recently settled Medicare Cost Report.”¹⁶ The bill defined “charity care” as,

medically necessary services provided without charge or at a reduced charge to patients who meet eligibility criteria no more restrictive than those set forth in . . . this Act. Charity care must not be recorded by a hospital or community medical center as revenue, as an account receivable, or as bad debt, and the care must be rendered with no expectation of payment.¹⁷

Illinois hospitals vigorously opposed the Tax-Exempt Hospital Responsibility Act as introduced. According to the Illinois Hospital Association (IHA),

[T]he charity care mandates proposed in House Bill 5000 would cause 28 hospitals, which are already losing money, to lose an additional \$158 million a year, as well as push an additional 45 hospitals into deficits. Collectively, the 133 hospitals that would be affected by HB5000 would face additional financial burdens and costs of \$739 million a year, wiping out their bottom lines. That is, their collective expenses would be greater than their collective revenues.¹⁸

There are several areas of concern about proposals such as H.B. 5000. To the extent that such proposals establish a minimum level of charity care as the sole determinant of entitlement to a tax exemption and adopt a restrictive definition of charity care, not-for-profit hospitals have argued that they ignore

14. H.B. 5000, 94th Ill. Gen. Assembly (2006).

15. See, e.g., Editorial, *Squeezing Hospitals*, CHI. TRIB., Feb. 5, 2006, available at <http://www.ihatoday.org/issues/payment/charity/trib2-5.pdf> (last visited Apr. 15, 2008); Editorial, *House Bill 5000 Shouldn't Pass*, NAPERVILLE SUN, Mar. 8, 2006, available at <http://www.ihatoday.org/issues/payment/charity/napsun.pdf> (last visited Apr. 15, 2008).

16. H.B. 5000, 94th Ill. Gen. Assembly, § 25(a) (2006).

17. *Id.* at § 10.

18. Press Release, Illinois Hosp. Ass'n, Hospital Leaders Urge General Assembly to Reject Damaging Proposals on Charity Care and Billing (Feb. 7, 2006), available at <http://www.ihatoday.org/issues/payment/charity/pressconfrelease.pdf> (last visited Apr. 15, 2008).

the other “community benefits” hospitals provide, as well as the substantial financial burden of a higher volume of uninsured or underinsured (e.g. Medicaid) patients and the related problem of bad debt.

Active discussion occurred between IHA and the Attorney General’s office regarding H.B. 5000. Several amendments were made to the bill as originally proposed.¹⁹ Still, H.B. 5000 was not enacted.²⁰

In addition to the *Community Health Care* case and H.B. 5000, IDOR has actively pursued revocation of tax exemptions for not-for-profit hospitals in two high-profile cases.

In September of 2006, IDOR overturned a 2005 finding by an ALJ rejecting a 2003 decision by the Champaign County Board of Review recommending denial of a tax exemption for Provena Covenant Medical Center in Urbana.²¹ In part, the Board’s denial was based on the well-publicized debt collection practices used by Provena. In his 2006 decision, Brian A. Hamer, the Director of IDOR found that Provena had failed to establish that it was entitled to an exemption “because the evidence is clear that this property is not used exclusively for charitable purposes.”²² In his decision, Director Hamer stated:

The primary basis of my conclusion is simple: Covenant admitted that its 2002 revenues exceeded \$113 million and that its charitable activities cost it only \$831,724, or about .7% of total revenue. The property tax exemption it requested was worth over \$1,100,000 [T]o obtain the exemption Covenant was required to prove that its primary purpose was charitable care.

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19. Among the amendments to H.B. 5000 that were adopted was a provision calling for the Attorney General to provide, by rule, a process for exempting from the charity care requirements for a year, any tax-exempt hospital, if it could demonstrate that compliance with those provisions would jeopardize the continued operation of the hospital. House Amendment 001, H.B. 5000, 94th Ill. Gen. Assembly (2006). Another amendment to H.B. 5000 would have codified the *Methodist Old Peoples Home* tax exemption criteria for hospitals. House Amendment 002, H.B. 5000, 94th Ill. Gen. Assembly (2006).
 20. No such legislation is currently pending in the Illinois General Assembly although it seems likely similar legislation will be introduced in the future. A companion bill to H.B. 5000, H.B. 4999, 94th Ill. Gen. Assembly (2006), the Fair Patient Billing Act, was enacted. See P.A. 94–885, 94th Ill. Gen. Assembly (2006) (codified at 210 ILL. COMP. STAT. 88/1 *et seq.* (2007)). There has also been litigation in Illinois regarding hospital billing practices. *Compare*, Hill v. St. Francis Health Services, Inc., 2006 WL 3783415 (N.D. Ill. 2006) with *Rockford Memorial Hosp. v. Havrilesko*, 368 Ill. App. 3d 115, 858 N.E.2d 56 (2d Dist. 2006).
 21. Dep’t of Revenue of Ill. v. Provena Covenant Med. Ctr., No. 04–PT–0014 (Ill. Dept. Rev., Sept. 29, 2006), available at <http://www.ihatoday.org/issues/payment/charity/dordecision.pdf> (last visited Apr. 15, 2008). The Champaign County Board of Review’s recommendation regarding Provena Covenant is available at <http://www.co.champaign.il.us/BOR/Provena.pdf> (last visited Apr. 15, 2008).
 22. Provena Covenant Med. Ctr., No. 04–PT–0014 (Ill. Dept. Rev., Sept. 29, 2006) at 2.

These financial figures fall far short of meeting the primary purpose standard.²³

Provena sought judicial review of the IDOR ruling.²⁴ Among other things, Provena argued that it clearly met the established criteria for a tax exemption in Illinois. IDOR's decision, Provena reasoned, improperly ignored this established test and focused only on one factor, the amount of free care provided.²⁵ Provena asserted that, while such an approach was inconsistent with Illinois law, using this approach, it still was entitled to an exemption.²⁶ Finally, Provena claimed that IDOR's decision failed to recognize that Provena "makes other charitable contributions that are substantial, in purely financial terms, and of great value to the . . . community" including, for example a "crisis nursery."²⁷ In response, IDOR emphasized that Provena functioned as a profit making institution billing in excess of its costs regardless of its stated charitable purposes.²⁸

In July of 2007, in a ruling from the bench without a written opinion, the Circuit Court for Sangamon County reversed the IDOR decision.²⁹ In September of 2007, the Illinois Attorney General filed notice that it was appealing the circuit court's decision to the Fourth District Appellate Court.³⁰ This appeal is currently pending.³¹

In addition to the *Provena* case, IDOR has also been engaged in litigation with the Carle Foundation regarding property used by Carle Foundation Hospital and other Carle entities in Champaign County. In a February, 2007

23. *Id.* at 2–3.

24. The Provena press release at the time of the appeal is available at <http://www.ihatoday.org/issues/payment/charity/provenarel.pdf> (last visited Apr. 15, 2008).

25. Brief of Plaintiffs in Support of Complaint, *Provena Covenant Med. Ctr. v. Dep't of Revenue of Ill.*, No. 2006–MR–597 (Ill. Cir. Ct., March 7, 2007) at 20, available at [http://op.bna.com/hl.nsf/id/psts-6z8rlx/\\$File/provena_brief.pdf](http://op.bna.com/hl.nsf/id/psts-6z8rlx/$File/provena_brief.pdf) (last visited Apr. 15, 2008).

26. *Id.* at 21.

27. *Id.*

28. Ill. Hosp. Ass'n, Trial Court Reverses Department of Revenue's Decision to Deny Hospital's Tax Exempt Status, July 23, 2007, available at <http://www.ihatoday.org/issues/legal/provenasummary.html> (last visited Apr. 15, 2008).

29. *Provena Covenant Med. Ctr. v. The Dep't of Revenue of Illinois*, No. 2006–MR–597 (Ill. Cir. Ct. July 20, 2007). On August 8, 2007 the trial court issued its written order and judgment. See 2007 WL 4913149 (Ill. Cir. 2007).

30. Illinois AG Files Appeal Notice Seeking Reversal of Provena Decision, 16 Health L. Rep. (BNA) 1107 (Sept. 13, 2007). As this article went to press, the Fourth District Appellate Court reversed thereby upholding IDOR's decision. *Provena Covenant Med. Ctr. v. The Dep't of Revenue of Illinois*, No. 4–07–0763 (Ill. App. 4th Dist., Aug. 26, 2008).

31. While the appeal is pending, Provena has filed an action seeking a refund of \$6 million in taxes paid to Champaign County. *Provena Covenant Medical Center Sues County, Seeking Property Tax Refund*, Health L. Rep. (BNA) 1462 (Dec. 6, 2007).

summary decision, IDOR upheld the recommendation of the Champaign County Board of Review to revoke the tax exemption for the majority of Carle's property.³² Apparently, the basis for this decision, like that in the *Provena* case, was the amount of free care provided by Carle Hospital, as well as claims that Carle was overcharging patients and benefiting private physicians (i.e. the Carle Clinic Association) rather than the community.³³ Pending further administrative review, in December of 2007, Carle filed suit in the Cook County Circuit Court challenging IDOR's decision.³⁴ Carle filed the suit based upon provisions of the Property Tax Code which Carle asserts specify that once a tax exemption is granted. That exemption is not subject to revocation unless it is shown that the current use of the property is not "comparable" to the use at the time the exemption was initially granted.³⁵

III. ILLINOIS SUPREME COURT UPHOLDS PHYSICIAN RESTRICTIVE COVENANTS³⁶

In its December 21, 2006, decision in *Mohanty v St. John Heart Clinic*,³⁷ the Illinois Supreme Court held that restrictive covenants in the employment agreements of two physicians are enforceable and that the medical corporation which formerly employed the physicians was entitled to a preliminary injunction to enforce the restrictive covenants. In the years leading up to this decision a minority of Illinois courts held that physician restrictive covenants violate public policy by interfering with patient choice and are therefore void.³⁸ The Illinois Supreme Court has now rejected this theory, focusing on the traditional analysis of whether the restrictions are reasonable considering the employer's interests, the hardship caused by the covenant, and any injury to the public.

32. Another Nonprofit Hospital in Illinois Denied Exemption by State Tax Officials, Health L. Rep. (BNA) 263 (Mar. 1, 2007). Board of Review decision in the Carle Foundation matter available at <http://www.co.champaign.il.us/BOR/CARLE2004.pdf> (last visited Apr. 15, 2008).

33. Another Nonprofit Hospital in Illinois Denied Exemption by State Tax Officials, Health L. Rep. (BNA) 263 (Mar. 1, 2007).

34. Nonprofit Hospital in Illinois Files Appeal of Decision Denying Property Tax Exemption, Health L. Rep. (BNA), 1527 (Dec. 20, 2007).

35. *Id.* See 35 ILL. COMP. STAT. 200/23-25(e) (2007).

36. This section of the Survey article is by Rick L. Hindmand, a member of McDonald Hopkins LLC, practicing in its Chicago office, where he represents physicians and other health care providers in connection with corporate, transactional, and compliance matters. He is a member of the ISBA Health Care Section Council and a past Chair of the Chicago Bar Association Health Law Committee.

37. *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill.2d 52, 866 N.E.2d 85 (2006).

38. See *Carter-Shields v. Alton Health Inst.*, 317 Ill. App. 3d 260, 739 N.E.2d 569 (5th Dist. 2000), *aff'd in part and vacated in part*, 201 Ill.2d 441, 777 N.E.2d 948 (2002).

A. Background

This case arose out of employment agreements, which a medical corporation (referred to in the opinion as the "clinic") entered into with Dr. Raghu Ramadurai and with Dr. Jyoti Mohanty.³⁹ The agreement with Dr. Ramadurai contained a restrictive covenant prohibiting Dr. Ramadurai from practicing medicine within a two-mile radius of any clinic office or any of four hospitals during the three year period after terminating employment.⁴⁰ The restrictive covenant in Dr. Mohanty's employment agreement contained a similar restrictive covenant, except the geographic area was five miles and the restricted period was five years.⁴¹

Drs. Ramadurai and Mohanty resigned in 2003 and filed complaints in the Circuit Court of Cook County for declaratory relief, alleging that the covenants were void as against public policy, unenforceable due to the clinic's breach of their employment agreements, and invalid because the restrictions were not necessary to protect the interests of the clinic.⁴² The clinic filed a counter-complaint for relief including preliminary and permanent injunctions to enforce the restrictive covenants.⁴³

The trial court rejected the physicians' claim that the clinic materially breached the employment agreements but denied the clinic's request for a preliminary injunction, holding that in light of the clinic's specialty in cardiology the prohibition on the practice of medicine was broader than necessary to protect the clinic's interests.⁴⁴ The appellate court reversed, holding that the restrictive covenants would not cause undue hardship to the physicians and were not broader than necessary to protect the clinic's interests.⁴⁵ In addition, the appellate court rejected the physicians' argument that restrictive covenants in physician employment agreements are void as against public policy and held that the physicians' claim of material breach of contract was premature.⁴⁶

On appeal to the Illinois Supreme Court the physicians asserted that the restrictive covenants were unenforceable based on three separate theories: (i) that all restrictive covenants in physician employment contracts violate Illinois public policy and are therefore void, (ii) that the clinic materially breached the

39. *Mohanty*, 225 Ill.2d at 57, 866 N.E.2d at 88.

40. *Id.*

41. *Id.*

42. *Id.* at 58, 866 N.E.2d at 88-89.

43. *Id.* at 59, 866 N.E.2d at 89.

44. *Id.* at 61, 866 N.E.2d at 90.

45. *Id.* at 61-62, 866 N.E.2d at 91.

46. *Id.* at 62, 866 N.E.2d at 91.

employment contracts (which entitled them to compensation based on a percentage of their gross receipts) by excluding the technical component of diagnostic tests from the calculation of their compensation, and (iii) that the restrictive covenants were unreasonable because the restrictions were broader than necessary to protect the clinic's interests.⁴⁷

B. Public Policy

With respect to the first theory (that physician restrictive covenants are void *per se*), the Illinois Supreme Court observed that it has a long tradition of upholding the right of parties to freely contract and that the physicians had a heavy burden of showing that physician restrictive covenants are either clearly contrary to the constitution, statutes, or case law which have been declared to be Illinois public policy, or that the restrictive covenant is “manifestly injurious to the public welfare.”⁴⁸

The physicians cited the 1998 holding of the Illinois Supreme Court in *Dowd & Dowd, Ltd. v. Gleason*⁴⁹ and the 2000 decision of the Appellate Court for the Fifth District in *Carter-Shields v. Alton Health Institute*⁵⁰ for the general proposition that covenants restricting skilled professionals from practicing their trade are contrary to public policy.⁵¹ The physicians argued that the public policy reasons for invalidating restrictive covenants are more compelling for physicians than for attorneys, noting that physician restrictive covenants “interfere with the doctor-patient relationship, deny patients the freedom to choose their” physicians, “create barriers to the delivery of” care, “hinder competition,” require duplicative testing, and limit physician autonomy and freedom of movement.⁵²

The Illinois Supreme Court rejected this argument, noting that the appellate court decision in *Carter-Shields* was vacated by the Illinois Supreme Court and “stands alone in its rejection of long-standing Illinois precedent on the validity of restrictive covenants in physician employment contracts.”⁵³ The court distinguished *Dowd & Dowd* because that decision was based on the

47. *Id.* at 64, 866 N.E.2d at 92.

48. *Id.* at 65, 866 N.E.2d at 93.

49. *Dowd & Dowd, Ltd. v. Gleason*, 181 Ill.2d 460, 693 N.E.2d 358 (1998) (holding that restrictive covenants in attorney employment contracts are void as a matter of public policy).

50. *Carter-Shields v. Alton Health Institute*, 317 Ill. App. 3d 260, 739 N.E.2d 569 (5th Dist 2000), *aff'd in part and vacated in part*, 201 Ill.2d 441, 777 N.E.2d 948 (2002) (holding that physician restrictive covenants violate public policy by interfering with patient choice and are therefore void).

51. *Mohanty*, 225 Ill.2d at 65, 866 N.E.2d at 93.

52. *Id.* at 65–66, 866 N.E.2d at 93.

53. *Id.* at 66, 866 N.E.2d at 93.

conflict between the restrictive covenants and Rule 5.6 of the Illinois Rules of Professional Conduct governing attorneys.⁵⁴ In contrast, the court found no similar expressions of public policy with regard to physician employment contracts.⁵⁵ The court also rejected the physicians' argument that an opinion of the American Medical Association (AMA) expresses public policy in Illinois.⁵⁶

While acknowledging that some states prohibit restrictive covenants in physician employment agreements, the Illinois Supreme Court stated that it was unable to find any case in which a court prohibited physician restrictive covenants in the absence of legislation.⁵⁷ Furthermore, the court noted that most states follow standards similar to the Illinois approach, which focuses on whether the restrictions are reasonable.⁵⁸

Continuing its public policy analysis, the court determined that the physicians failed to show that physician restrictive covenants are “manifestly injurious to the public welfare.”⁵⁹ The court pointed out that restrictive covenants protect the business interests of established physicians and encourage them to hire less experienced physicians, and that this positive impact needs to be weighed against the negative effects referenced by the physicians.⁶⁰ The court concluded that the decision of whether to prohibit physician restrictive covenants should be left to the legislature, which can weigh the competing interests.⁶¹

C. No Material Breach

The Illinois Supreme Court observed that a breach of the employment agreements by the clinic could relieve the physicians of their restrictive covenant obligations, but affirmed the holding of the trial court that the physicians did not establish such a breach.⁶² The Illinois Supreme Court noted the testimony from the clinic's expert witness that the technical component of the diagnostic tests at issue does not encompass physician work, and held that

54. *Id.*

55. *Id.*

56. *Id.* at 67–68, 866 N.E.2d at 94.

57. *Id.* at 68, 866 N.E.2d at 94.

58. *Id.* at 68, 866 N.E.2d at 94–95.

59. *Id.* at 69, 866 N.E.2d at 95.

60. *Id.*

61. *Id.* at 70, 866 N.E.2d at 95.

62. *Id.* at 75, 866 N.E.2d at 98.

the physicians did not carry their burden of showing that the trial court's determination was against the manifest weight of the evidence.⁶³

D. Reasonable Restrictions

The court then examined the scope of the activity restriction (the practice of medicine), the duration (three years with respect to Dr. Ramadurai and five years with respect to Dr. Mohanty) and the impact of these restrictions on the availability of cardiologists to provide patient care, and determined that these restrictions were not unreasonably broad.⁶⁴

The Illinois Supreme Court agreed with the appellate court that the restriction on the practice of medicine was not greater than necessary to protect the clinic's interests.⁶⁵ The court reasoned that "[c]ardiology, like other specialties, is inextricably intertwined with the practice of medicine" and that the restriction applied only within a "narrowly circumscribed area of a large metropolitan area."⁶⁶

The Illinois Supreme Court applied an objective standard for determining whether the duration is reasonable, and noted that the subjective motivations for imposing the particular time period⁶⁷ were irrelevant.⁶⁸ The court determined that the three and five year restrictions were reasonable in light of testimony that it took a minimum of three to five years for the clinic's shareholder to develop a referral base, that nearly all of the physicians' referrals came from the clinic, and evidence that it took more than 10 years for the clinic to establish a successful cardiology practice.⁶⁹

With regard to whether the restrictions harm the public, the court determined that the covenants would not seriously diminish the number of cardiologists available to care for patients.⁷⁰ The physicians argued that the clinic would be unable to handle its patient load, but the court characterized this argument as "unresponsive to the issue" of whether the restriction is greater than necessary.⁷¹ The court noted that potential harm to the public is

63. *Id.*

64. *Id.* at 76–77, 866 N.E.2d at 98–99.

65. *Id.* at 77, 866 N.E.2d at 99.

66. *Id.*

67. The trial court found the three and five year time limits problematic because the clinic's owner testified that the three year time period "just came into his mind" and that the five year limitation was imposed on the other physician because the owner did not trust him. *Id.* at 61, 866 N.E.2d at 90.

68. *Id.* at 78, 866 N.E.2d at 100.

69. *Id.*

70. *Id.* at 79, 866 N.E.2d at 100.

71. *Id.*

determined based on whether there will be a sufficient number of cardiologists in the area to meet patient needs.⁷²

E. Dissenting and Concurring Opinion of Justice Freeman

Justice Freeman concurred in part and dissented in part.⁷³ His opinion focused on the effects on patient care, which he asserted were given “short shrift” by the majority.⁷⁴ In particular, he argued that the enforcement of restrictive covenants disrupts continuity of care to the potential detriment of patients.⁷⁵ He agreed with the majority that any general prohibition on physician restrictive covenants should be left to the legislature, but stated that “[a] strong case exists for a blanket abolition of all physician restrictive covenants in Illinois as being void against public policy” and recommended that the legislature enact such legislation.⁷⁶

Justice Freeman dissented with respect to the holding that the restrictive covenants were reasonable and criticized the failure to consider the impact on the physician-patient relationship and continuity of care.⁷⁷ He would have reversed and remanded the case to the trial court because the record did not contain sufficient evidence of the hardships on the physicians’ existing patients.⁷⁸

* * *

It is now clear that physician restrictive covenants are not void *per se* in Illinois and that the enforceability of physician restrictive covenants will continue to be determined on a case-by-case basis focusing primarily on whether the restrictions are reasonable in temporal and geographic scope.

72. *Id.*

73. *Id.* at 82–103, 866 N.E.2d at 102–14.

74. *Id.* at 82, 866 N.E.2d at 102.

75. *Id.* at 86–87, 866 N.E.2d at 104–05.

76. *Id.* at 93, 866 N.E.2d at 108.

77. *Id.* at 86–87, 866 N.E.2d at 104–05.

78. *Id.* at 97–103, 866 N.E.2d at 110–14.

IV. THE COLLATERAL SOURCE RULE: RECENT DEVELOPMENTS AND APPLICATIONS⁷⁹

Illinois law follows the collateral source rule in personal injury litigation. Under this rule, “benefits received by the injured party from a source wholly independent of, and collateral to, the tortfeasor will not diminish damages otherwise recoverable from the tortfeasor.”⁸⁰ The collateral source rule is often applied where a defendant seeks a reduction of damages because a plaintiff has received insurance benefits that partly or wholly indemnify the plaintiff for the loss.⁸¹ The collateral source rule operates as both a rule of damages and a rule of evidence.⁸² As to damages, “the rule prevents any reduction of a plaintiff’s recovery due to amounts received from third parties, which are collateral from the tortfeasor.”⁸³ As a rule of evidence, “it prevents juries from learning anything about collateral income that could affect their assessment of damages.”⁸⁴

It is well established in Illinois that damages recovered by the plaintiff are not decreased by the amount the plaintiff received from insurance proceeds, where the defendant did not contribute to the payment of the insurance premiums.⁸⁵ The purpose of allowing recovery despite indemnification from a collateral source is founded in public policy. The wrongdoer should not benefit from the expenditures made by the injured party or take advantage of contracts or other relations that may exist between the injured party and third persons.⁸⁶ In essence, the defendant should not be allowed to benefit from the plaintiff’s foresight in acquiring insurance.⁸⁷

Throughout the years, Illinois courts have defined what constitutes a collateral source and when the rule will or will not apply. In the 1979 case of *Peterson v. Lou Bachrodt Chevrolet Co.*, the Illinois Supreme Court held the collateral source rule does not apply when the injured plaintiff has “incurred

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80. *Arthur v. Catour*, 216 Ill.2d 72, 78, 833 N.E.2d 847, 851 (2005).

81. *Id.* at 79, 833 N.E.2d at 852.

82. 15 Illinois Law and Practice §40 at 416–17 (2000).

83. *Id.*

84. *Id.*

85. *Arthur*, 216 Ill.2d at 79, 833 N.E.2d at 852.

86. *Id.*

87. *Id.*

no expense, obligation, or liability in obtaining the services for which he seeks compensation.”⁸⁸

In *Peterson*, the issue was whether the plaintiff could recover the value of medical services that were rendered at no charge and with no expectation of payment. The case held that one is not entitled to recover for the value of services that he or she has obtained without expense, obligation or liability.⁸⁹ In its holding, the court noted that, in tort claims, the purpose of compensatory damages is to compensate; it is not to punish defendants or bestow a windfall upon the plaintiffs. “The view that a windfall, if any is to be enjoyed, should go to the plaintiff borders too closely on approval of unwarranted punitive damages, and it is not a view espoused by our cases.”⁹⁰ Recovery of medical expenses when paid for by a collateral source is acceptable under the rule only if the plaintiff has some sort of expense, obligation or liability in gaining the benefit of the collateral source.⁹¹

In the more recent case of *Arthur v. Catour*, the plaintiff fractured her leg as the result of stepping in a hole on a farm owned by the defendant. The plaintiff’s medical bills as a result of the occurrence totaled \$19,355.25, and Blue Cross/Blue Shield, her health insurer, paid only \$13,577.97 toward the medical bills. The defendant sought to limit the plaintiff’s medical expense claim to the amount that was actually paid to satisfy the medical bills, rather than the total amount billed. The Illinois Supreme Court held that a plaintiff may recover the entire amount billed (assuming the billed amount is reasonable), including those medical expenses contractually adjusted or written off by the medical providers, when the collateral source is an insurance company or HMO.⁹² The court emphasized that but for the plaintiff’s contract with her insurance company and the coverage inuring therefrom, the plaintiff was liable for the full amounts billed for her medical treatment. Furthermore, the collateral source was the insurance company and not the so-called “discount,” and the plaintiff did not receive a discount from the provider.⁹³ Furthermore, the court noted that any lower charges negotiated by the plaintiff’s insurance company are as much a benefit of the insurance contract as the payments themselves, which should inure to the plaintiff as opposed to the defendant under the goal of the collateral source rule.⁹⁴

88. *Peterson v. Lou Bachrodt Chevrolet*, 76 Ill.2d 353, 362, 392 N.E.2d 1, 5 (1979).

89. *Id.* at 363, 392 N.E.2d at 5.

90. *Id.*

91. *Id.*

92. Theodore R. LeBlang, *Survey of Illinois Law: The Collateral Source Rule*, 29 S. Ill. U. L.J. 695–700 (2005) (thoroughly discussing the collateral source rule and its application in *Arthur*).

93. *Arthur*, 216 Ill.2d at 81, 833 N.E.2d at 853.

94. *Id.*

Although *Arthur* and *Peterson* addressed the issue of the collateral source rule in the context of insurance coverage and charitable services, respectfully, the gray area in Illinois until very recently pertained to government benefits and how they are categorized with regard to the collateral source rule. In 2007, two Illinois cases addressed the situation where a portion of a plaintiff's medical bill was paid and a portion was written off by the medical provider as a result of a Medicare or Medicaid exclusion or reduction. In *Wills v. Foster*, the Fourth District Appellate Court held that only the portion actually paid may be admitted into evidence. Subsequently, in *Nickon v. City of Princeton*, the Third District Appellate Court held the full amount billed may be allowed into evidence. To clarify this gray area, the Illinois Supreme Court granted a petition for leave to appeal in *Wills*. Its highly anticipated decision was filed on June 19, 2008.

As background, the *Wills* plaintiff was involved in a motor vehicle accident, which aggravated a pre-existing condition and proximately caused the need to undergo spinal cord fusion.⁹⁵ The amount billed for the plaintiff's medical expenses was greater than the amount ultimately paid by Medicare and the medical assistance program of the Illinois Department of Healthcare and Family Services (DHFS) (i.e. Medicaid). The plaintiff sought review of the trial court's order reducing the jury's personal injury award for compensatory damages from \$80,163.47 (amount billed) to \$19,005.50 (amount paid). The plaintiff claimed that under the collateral source rule, she was entitled to recovery of the expenses billed, not the amount of medical expenses actually paid at a discounted rate. The defendant argued that the collateral source rule does not apply when expenses are paid through Medicare or Medicaid, because the plaintiff did not incur liability for her medical expenses, did not bargain for her coverage, and did not pay premiums as part of any contractual relationship. Thus, the governmental medical benefits should not qualify as a collateral source.⁹⁶

Considering the *Arthur* opinion and its applicability in light of a situation in which the plaintiff did not bargain for her benefits but received them free of charge from the government based on her status, the appellate court in *Wills* held that the policy behind the collateral source rule did not apply.⁹⁷ It noted that *Arthur* dealt with pre-discounted bills in the context of a contractual arrangement between a private insurance company and the plaintiff. The *Wills* appellate court opined the primary reason for the *Arthur* holding was the

95. *Wills v. Foster*, 372 Ill. App. 3d 670, 671, 867 N.E.2d 1223, 1224 (4th Dist. 2007) (a substantive dissent by Justice Cook merits review), *rev'd*, 229 Ill.2d 892 N.E.2d 1018 (2008).

96. *Id.* at 670–71, 867 N.E.2d at 1224.

97. *Id.* at 673, 867 N.E.2d at 1226.

existence of the insurance contract, which would explain the justification for the apparent windfall to the plaintiff. Prior to *Arthur*, the latter notion was rejected in *Peterson*. The *Wills* appellate court further speculated that the *Arthur* court anticipated the insurance company would enforce a subrogation lien.⁹⁸

In a matter of first impression in Illinois, the *Wills* appellate court likened its situation to the plaintiff in *Peterson*, stating that individuals covered by Medicare or Medicaid do not make expenditures and have not bargained for their coverage.⁹⁹ The appellate court further stated that in this type of situation, a “covered plaintiff’s liability is non-existent as well, because by accepting payments from DHFS, Medicare or Medicaid, health care providers have agreed such payments constitute full satisfaction of their fees.”¹⁰⁰

In *Nickon v. City of Princeton*, the plaintiff filed a negligence action against the City of Princeton for injuries sustained when he tripped and fell on a sidewalk. During trial, the plaintiff introduced evidence of medical bills for his injuries totaling \$119,723.11.¹⁰¹ The defendant attempted to produce evidence that the medical providers accepted a discounted amount of \$34,888.61 from Medicare as payment in full. The trial court, however, prohibited the defendant from introducing any evidence to the jury that demonstrated Medicare paid the reduced amount. The jury proceeded to return a verdict in favor of the plaintiff in the amount of \$170,800, which included initially billed medical charges of \$119,000. The court subsequently denied the defendant’s post-trial request for set-off or reduction of the verdict to reflect the amount actually paid by Medicare.¹⁰²

On appeal, the plaintiff asserted the trial court correctly applied the collateral source rule by prohibiting introduction of the evidence, and the defendant argued the Medicare payment did not constitute a collateral source under Illinois law.¹⁰³ In affirming the trial court, the Third District Appellate Court recognized the existence of a single exception to the collateral source rule—that collateral sources should not include services rendered by charitable providers without charge, *i.e.* without generating an initial bill.¹⁰⁴ It emphasized, however, that this exception is inapplicable if the medical provider clearly billed for the services in expectation of payment. The *Nickon* court held the exception developed by the court in *Peterson* did not apply

98. *Id.* at 674, 867 N.E.2d at 1226–27.

99. *Id.* at 674, 867 N.E.2d at 1227.

100. *Id.* at 675, 867 N.E.2d at 1228.

101. *Nickon v. City of Princeton*, 376 Ill. App. 3d 1095, 1097, 877 N.E.2d 776, 778 (3d Dist. 2007).

102. *Id.* at 1098, 877 N.E.2d at 779.

103. *Id.* at 1098–99, 877 N.E.2d at 779.

104. *Id.* at 1099, 877 N.E.2d at 780.

because the medical provider in *Nickon* clearly billed for the services in expectation of payment, unlike the charitable Shriner hospital in *Peterson*.¹⁰⁵

In a related discussion regarding the *Arthur* decision, the *Nickon* court noted that “significant to the court’s analysis in *Arthur* was the amount the medical provider ‘expected’ as payment when initially billing for the services, not the amount the medical provider ‘accepted’ from a third party in payment as full.”¹⁰⁶ In utilizing that analysis, the *Arthur* court held the jury was entitled to evidence of the amount actually billed by the medical providers for services rendered.

The *Nickon* court emphasized, “we refrain from applying the decision in *Arthur* to expand the reach of *Peterson* to services initially billed but subsequently discounted for a third party payor.”¹⁰⁷ Further, the court observed the collateral source rule does not allow a “wrongdoer to take advantage of contracts or *other relations* that may exist between the injured party and third persons.”¹⁰⁸ In stating this, the court acknowledged that courts have foreseen the possibility that relationships “other than” those arising from an insurance contract may be considered collateral sources of payment, which was the situation in *Nickon*. The plaintiff’s relationship with Medicare was “other than” a contract with a collateral source and arose because of his previous employment, his past contributions, and his current age.

The *Nickon* court proposed a practical solution to the collateral source question: “[S]imply give the jury the initial bill and move on with the evidence. After a verdict is rendered, the trial court may consider a motion to reduce the award,”¹⁰⁹ which was the situation in *Nickon*.

In a footnote, the *Nickon* court acknowledged its awareness of the Fourth District’s decision in *Wills*, adding Medicare and Medicaid as exceptions to the collateral source rule. It chose not to follow the majority’s rationale in that opinion, and anticipated that the Illinois Supreme Court would provide further guidance on the issue.¹¹⁰

Additionally, the *Nickon* court addressed whether the denial of the defendant’s post-trial motion for set-off or reduction was proper. In this regard, the court examined whether the medical service provider intended to grant the patient gratuitous services regardless of the source of payment. If,

105. *Id.* at 1099–1100, 877 N.E.2d at 780.

106. *Id.* at 1099, 877 N.E.2d at 780.

107. *Id.* at 1100, 877 N.E.2d at 780.

108. *Id.* (emphasis in original).

109. *Id.* at 1100–01, 877 N.E.2d at 781.

110. *Wills*, 372 Ill. App. 3d at 676–77, 867 N.E.2d at 1228–29 (Cook, J., dissenting). The dissenting opinion disagrees that *Peterson* should be expanded to prohibit application of the collateral source rule when the plaintiff’s medical expenses were paid through Medicare or Medicaid.

as in *Peterson*, the provider did not intend to charge the patient for all or part of the patient's services, then such payments would not be deemed collateral sources. However, if the medical provider accepted a reduced payment from a third party, which the medical provider otherwise would not have granted to the patient without the involvement of the third party, then such payments would be collateral source payments.

The court reasoned that to interpret *Peterson* in any other way "lends itself to endless analysis of the minute differences in each case related to the relationship between payor and patient, depending on whether Medicare or Medicaid paid for the services, and whether the insurance company was paid by the injured person or someone else."¹¹¹ The court further stated, "these considerations create a plethora of possibilities to tantalize the most skillful advocates and curious legal scholars, but this type of complexity is not necessary."¹¹² In denying the post-trial motion for the reduction in charges, the court noted the plaintiff would have been responsible for all charges had a private insurer or Medicare not been the payor.

As mentioned above, the Illinois Supreme Court filed its highly anticipated opinion in *Wills* on June 19, 2008, unanimously reversing the appellate court decision and holding that the trial court erred in reducing the plaintiff's award to the amounts actually paid by Medicare and Medicaid.¹¹³ In its holding, the Supreme Court noted that courts across the country have adopted one of three approaches to determine whether a plaintiff is entitled to recover the entire amount of billed medical expenses when the billed amount was later settled by a third party for a lesser amount. These three approaches are as follows: 1) "actual amount paid" (*i.e.* recovery is limited to the amount actually paid in full settlement of the bill); 2) "benefit of the bargain" (*i.e.* recovery is allowed for the full value of medical expenses where the plaintiff has paid some consideration for the benefit of the write-off); and 3) "reasonable value" (*i.e.* recovery is based upon the reasonable value of medical services regardless of whether the plaintiff has private insurance or is covered by a government program).¹¹⁴

In *Wills*, the Supreme Court followed the "reasonable value" approach as opposed to the "benefit of the bargain" or the minority "actual amount paid" approaches. Its rationale was that a plaintiff is entitled to recover the reasonable value of medical expenses, and the "benefit of the bargain" approach discriminates amongst plaintiffs and "undermines the spirit of the

111. *Nickon*, 376 Ill. App. 3d at 1101, 877 N.E.2d at 781.

112. *Id.*

113. *Wills v. Foster*, 229 Ill.2d 393 at 407, 892 N.E.2d 1018 at 1032 (2008).

114. *Id.* at 398, 892 N.E.2d at 1023.

collateral source rule" by allowing a defendant's liability to be determined by the nature of the injured party's relationship with a source collateral to the tortfeasor.¹¹⁵

Importantly, the Supreme Court specifically overruled its decision in *Peterson*, holding that *Peterson* is incompatible with the "reasonable value" approach by focusing solely on the compensatory nature of tort damages and explicitly rejecting the reasoning that any windfall should be awarded to the plaintiff rather than the defendant.¹¹⁶ The Supreme Court preliminarily noted that it had been criticized for its failure to discuss *Peterson* in the *Arthur* case, which was decided twenty-six years later.¹¹⁷ The court proceeded with a thorough analysis of *Peterson* and *Arthur*, recognizing that its holding in *Peterson* was contrary to the positions adopted by most states, as well as contrary to section 920A of the Restatement (Second) of Torts (which supports a "reasonable value" approach).¹¹⁸

The Supreme Court further acknowledged that although its language in *Arthur* did not specifically adopt a "reasonable value" approach or a "benefit of the bargain" approach, *Arthur* represented a move toward the former, which is incompatible with *Peterson*. Thus, *Peterson* was overruled and the Supreme Court unambiguously stated that Illinois is now aligned with the "reasonable value" approach.¹¹⁹

Additionally, the Supreme Court noted that although a plaintiff may place the entire amount of medical services billed into evidence, the plaintiff must first establish the proper foundational requirements to show the reasonableness of the medical bills.¹²⁰ It recognized that defendants are free to cross-examine any witnesses that a plaintiff calls to establish reasonableness, and the defense is free to call its own witnesses to testify that the billed amounts do not reflect the reasonable value of services. Defendants may not, however, introduce evidence that the plaintiff's bills were settled for a lesser amount, because this would undermine the collateral source rule.¹²¹

The Illinois Supreme Court holding in *Wills* represents the most recent analysis of the collateral source rule in Illinois, shedding bright light on this significant and evolving issue in Illinois personal injury litigation. It has eliminated existing confusion caused by recent conflicting appellate court

115. *Id.* at 404, 892 N.E.2d at 1029.

116. *Id.*

117. *Id.* at 398, 892 N.E.2d at 1023.

118. *Id.* at 397, 892 N.E.2d at 1022.

119. *Id.* at 403, 892 N.E.2d at 1028.

120. *Id.* at 404, 892 N.E.2d at 1029.

121. *Id.* at 406, 892 N.E.2d at 1031.

decisions and affords important guidance to attorneys involved in litigation where the collateral source rule is in play.

V. NEGLIGENT CREDENTIALING IN *FRIGO V. SILVER CROSS HOSPITAL AND MEDICAL CENTER*¹²²

On September 20, 2007, the Appellate Court of Illinois, First District, issued a modified opinion in the case of *Frigo v. Silver Cross Hospital and Medical Center*.¹²³ At trial, the jury awarded \$7,775,668.02 to the plaintiff, Jean Frigo, whose foot was amputated after an elective surgery.¹²⁴ Prior to trial, Frigo settled with Dr. Paul Kirchner, who performed the elective foot surgery, for \$900,000.¹²⁵ After setting off the amount of Dr. Kirchner's settlement, the court ordered Silver Cross Hospital and Medical Center (Silver Cross) to pay \$6,875,668.02.¹²⁶ Silver Cross appealed.¹²⁷

A. Background

Jean Frigo first went to Silver Cross and Dr. Kirchner in 1997 for a bunion operation on her right foot.¹²⁸ She had an ulcer on that foot, but her vascular surgeon had resolved the ulcer with antibiotic treatment prior to the operation by Dr. Kirchner.¹²⁹ The next year, Frigo went back to Dr. Kirchner for treatment of a bunion and diabetic ulcer on her left foot.¹³⁰ Dr. Kirchner prescribed an antibiotic on September 22, 1998, because her foot appeared to

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123. *Frigo v. Silver Cross Hosp. and Medical Center*, 377 Ill. App. 3d 43, 876 N.E.2d 697 (1st Dist. 2007).

124. *Id.* at 390, 876 N.E.2d at 702.

125. *Id.* at 391, 876 N.E.2d at 703.

126. *Id.* at 399, 876 N.E.2d at 711.

127. *Id.* at 390, 876 N.E.2d at 702.

128. *Id.* at 394, 876 N.E.2d at 706.

129. *Id.*

130. *Id.*

be infected.¹³¹ On October 9, 1998 Dr. Kirchner operated on Frigo's left foot, placing a screw in her foot with the ulcer still present.¹³² Dr. Kirchner cut through the ulcer during surgery, and likely carried the bacteria from the ulcer to the screw.¹³³ After the surgery, an infection spread to the surgical site, and Frigo's metatarsal fractured.¹³⁴ Dr. Kirchner unsuccessfully attempted to remove the screw on February 18, 1999,¹³⁵ but ultimately Frigo's foot had to be amputated on August 30, 1999.¹³⁶

In her original complaint, Frigo alleged that Dr. Kirchner was negligent in his decision to perform elective bunion surgery on her left foot before the ulcer on that foot healed.¹³⁷ Frigo also alleged that Silver Cross "improperly managed and maintained the hospital," resulting in injury caused by its agent, Dr. Kirchner.¹³⁸ Frigo later learned that the hospital had granted Dr. Kirchner category II surgical privileges, prompting her to file an amended complaint alleging that Silver Cross was negligent in "awarding Dr. Kirchner category II surgical credentials even though he had not completed a twelve-month podiatric surgical residency and was not board certified as required by Silver Cross's bylaws and by the Joint Commission for Accreditation of Health Care Organizations' (JCAHO) standards."¹³⁹

In response, Silver Cross alleged on appeal that Frigo's negligent credentialing claim was barred by the statute of limitations because the claim did not relate back to the statements in her original complaint.¹⁴⁰ Silver Cross also argued that both the Medical Studies Act and the Hospital Licensing Act barred Frigo's negligent credentialing claim.¹⁴¹ Silver Cross then argued that it had not been negligent in granting category II surgical privileges to Dr. Kirchner, and that the trial court erred when it used Illinois Pattern Jury Instruction, Civil No. 30.23 to instruct the jury.¹⁴² For the purposes of this paper, we will primarily address the issues that pertain to Frigo's negligent credentialing claim.

131. *Id.*

132. *Id.* at 413, 876 N.E.2d at 725.

133. *Id.*

134. *Id.* at 394, 876 N.E.2d at 706.

135. *Id.*

136. *Id.* at 396, 876 N.E.2d at 708.

137. *Id.* at 390, 876 N.E.2d at 702.

138. *Id.* at 391, 876 N.E.2d at 703.

139. *Id.*

140. *Id.* at 399, 876 N.E.2d at 711.

141. *Id.* at 399, 876 N.E.2d at 711 (referring to 735 ILL. COMP. STAT. 5/8-2101, 5/8-2102 (West 2006); 210 ILL. COMP. STAT. 85/2(a), 85/10.2) (West 2006).

142. *Id.* at 391, 876 N.E.2d at 703.

B. Statute of Limitations

On appeal, the court dismissed Silver Cross's statute of limitations defense by holding Frigo's original complaint sufficient to notify Silver Cross of a possible negligent credentialing claim.¹⁴³ In her original complaint, Frigo alleged that Silver Cross was negligent in that it "[c]arelessly and negligently managed, maintained, controlled, owned and operated said medical centers in such manner causing the Plaintiff to be injured."¹⁴⁴ Frigo's amended complaint added several paragraphs including allegations Silver Cross failed to adequately supervise treatment by Dr. Kirchner, failed to exercise due care in selecting and credentialing Dr. Kirchner, failed to determine Dr. Kirchner's qualifications, and negligently allowed Dr. Kirchner to perform surgery on Frigo, all in violation of JCAHO standards and Silver Cross's own bylaws.¹⁴⁵ The court held these allegations as merely an extension of Frigo's earlier allegations, arising out of the same transaction or occurrence, and providing Silver Cross with ample opportunity to defend against the claim.¹⁴⁶

C. Frigo's Negligent Credentialing Claim

The court held that negligent credentialing was a valid cause of action in Illinois, even though no Illinois court has explicitly addressed it.¹⁴⁷ The court looked to the Illinois Supreme Court's decision in *Darling v. Charleston Community Memorial Hospital*,¹⁴⁸ as support for the negligent credentialing cause of action.¹⁴⁹ In *Darling*, the court "recognized that hospitals may be held liable for institutional negligence and acknowledge that hospitals have an independent duty to assume responsibility for the care of their patients."¹⁵⁰

Based on *Darling* and guidance from other state and federal courts, the court held that to state a cause of action for negligent credentialing, a plaintiff would need to prove three elements.¹⁵¹ First, the plaintiff "must prove the hospital failed to meet the standard of reasonable care in the selection of the physician it granted medical staff privileges to whose treatment provided the

143. *Id.* at 404, 876 N.E.2d at 716.

144. *Id.* at 403, 876 N.E.2d at 715.

145. *Id.*

146. *Id.* at 404, 876 N.E.2d at 716.

147. *Id.* at 411, 876 N.E.2d at 723.

148. *Darling v. Charleston Cmty. Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965).

149. *Frigo v. Silver Cross Hosp. and Medical Center*, at 408-09, 876 N.E.2d at 720-21 (1st Dist. 2007).

150. *Id.*

151. *Id.* at 409-11, 876 N.E.2d at 721-23.

basis for the underlying medical malpractice claim.”¹⁵² Second, “the plaintiff must prove that, while practicing pursuant to negligently granted medical staff privileges, the physician breached the applicable standard of care.”¹⁵³ Lastly, “the plaintiff must prove that the negligent granting of medical staff privileges was a proximate cause of the plaintiff’s injuries.”¹⁵⁴

The evidence at trial showed Silver Cross was accredited by the JCAHO, and, accordingly, followed JCAHO standards regarding credentialing.¹⁵⁵ The JCAHO standards required the hospital’s board of directors to follow the hospital’s bylaws and the rules, regulations, and policy of the hospital’s medical staff.¹⁵⁶ According to the hospital’s policy, a physician’s application for staff privileges is reviewed first by a credentials committee, then sent to a medical staff executive committee for recommendation, and finally to the hospital’s board of directors for an ultimate decision.¹⁵⁷

Dr. Paul Kirchner first applied for medical staff privileges in 1992.¹⁵⁸ He sought category II privileges, which include the authority to perform foot surgery.¹⁵⁹ In 1992, the hospital’s rules required podiatrists seeking category II privileges to demonstrate that he or she:

has had additional post-graduate surgical training: e.g. completion of approved surgical residency or has become Board Certified by the American Board of Podiatric Surgery, or Board Eligible by the American Board of Podiatric Surgery, and in this instance must submit documentary proof of having performed the surgical procedures to the satisfaction of the Department of Surgery.¹⁶⁰

A change to the rules in 1993 allowed category II privileges to:

Any Illinois licensed podiatrist who has completed a 12 month podiatric surgical residency program accepted by the [American Board of Podiatric Surgery] ABPS and approved by the [Council on Podiatric Medical Education] CPME of the [American Podiatric Medical Association] APMA. In addition, the candidate shall have completed successfully the written eligibility examination. Podiatrists requesting this category must submit

152. *Id.* at 411, 876 N.E.2d at 723.

153. *Id.*

154. *Id.*

155. *Id.* at 391, 876 N.E.2d at 703.

156. *Id.* at 391-92, 876 N.E.2d at 703-04.

157. *Id.* at 391, 876 N.E.2d at 703.

158. *Id.* at 394, 876 N.E.2d at 706.

159. *Id.* at 397, 876 N.E.2d at 709.

160. *Id.* at 392, 876 N.E.2d at 704.

documentation of prior performance of requested procedures, including 30 Category II operative reports reflecting procedures performed during the past 12 months.¹⁶¹

Dr. Kirchner applied for recredentialing in 1998, pursuant to JCAHO guidelines.¹⁶² Both at the time of his initial application for category II privileges, and at the time of his application for recredentialing in 1998, Dr. Kirchner had not completed a surgical residency, nor was he board certified.¹⁶³ Dr. Kirchner had, however, completed a primary care residency, through which he participated in “five to six category II procedures related to the foot.”¹⁶⁴ However, Dr. Kirchner had only participated more than fifty percent in one surgery.¹⁶⁵

Silver Cross unsuccessfully argued that Dr. Kirchner’s application met the hospital’s standards for category II privileges in 1992, and, consequently, did not need to meet the new requirements in 1993.¹⁶⁶ The court relied on testimony showing that the hospital’s bylaws did not explicitly provide for such “grandfathering” in finding sufficient evidence that Silver Cross breached the standard of care in granting category II surgical privileges to Dr. Kirchner.¹⁶⁷

D. Medical Studies Act

Silver Cross asserted the Medical Studies Act¹⁶⁸ as a bar to “the introduction of evidence about what its credentials committee reviewed” in granting category II privileges to Dr. Kirchner.¹⁶⁹ Frigo, however, asserted that her claims did not rely on any information falling within the purview of the Act.¹⁷⁰ The Act states that information used in internal quality control is privileged, and may only be used for limited purposes, such as granting staff privileges.¹⁷¹ The Act’s purpose is to protect “effective professional self-evaluation and to improve the quality of healthcare.”¹⁷² The court held that

161. *Id.* at 392, 876 N.E.2d at 704.

162. *Id.* at 412, 398, 876 N.E.2d at 724, 710.

163. *Id.* at 412, 876 N.E.2d at 724.

164. *Id.*

165. *Id.*

166. *Id.* at 413, 876 N.E.2d at 725.

167. *Id.*

168. 735 ILL. COMP. STAT. 5/8–2101, 5/8–2102 (2007).

169. *Frigo*, 377 Ill. App. 3d at 404, 876 N.E.2d at 716.

170. *Id.* at 405, 876 N.E.2d at 717.

171. 735 ILL. COMP. STAT. 5/8–2101 (2007).

172. *Frigo*, 377 Ill. App. 3d at 405, 876 N.E.2d at 717.

Frigo's claims were based on Silver Cross's bylaws and JCAHO standards, and not on privileged peer-review information.¹⁷³ Accordingly, Frigo's claims were not barred by the Medical Studies Act.¹⁷⁴

E. Hospital Licensing Act

Similar to its claim that Frigo's claims were barred by the Medical Studies Act, Silver Cross likewise argued that her claims were also barred by the Hospital Licensing Act.¹⁷⁵ The Hospital Licensing Act provides that hospitals are not liable for the decisions of its internal quality control or professional discipline committees, unless the decision involved willful or wanton misconduct.¹⁷⁶ The purpose of the Licensing Act is also to encourage peer-review and regulate internal controls.¹⁷⁷ Moreover, the Hospital Licensing Act has "routinely been at issue in cases where physicians have filed lawsuits against hospitals."¹⁷⁸ Specifically, the court held section 10.2 of the Act to be a "limitation on the remedies available to physicians aggrieved by a hospital's peer-review process."¹⁷⁹ Thus, the Hospital Licensing Act does not immunize a hospital from allegations of negligent patient treatment, and it did not apply to Frigo's claims.¹⁸⁰

F. Conclusion

Frigo v. Silver Cross Hospital provides guidance to hospitals in their physician credentialing decisions. A cause of action for negligent credentialing is now more clearly defined and is a clear risk for hospitals and hospital medical staffs which fail to follow their own medical staff bylaws and the underlying statutes, regulations, rules and guidelines which support such bylaws. The decision also suggests limits upon the protective scope of the Medical Studies Act and the quality control and peer review immunity provisions of the Hospital Licensing Act. Courts generally do not favor overzealous application of evidentiary privilege and Frigo is yet another example

173. *Id.* at 406, 876 N.E.2d at 718.

174. *Id.*

175. 210 ILL. COMP. STAT. 85/10.2 (2007); *Frigo*, 377 Ill. App. 3d at 407, 876 N.E.2d at 719.

176. *Frigo*, 377 Ill. App. 3d at 407, 876 N.E.2d at 719.

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.* See also *Longnecker v. Loyola University Medical Center*, 383 Ill. App. 3d 874, 891 N.E.2d 954 (1st Dist., 2008) (finding hospital institutional liability even in the absence of physician negligence in a heart transplant case).

of an appellate decision constraining the breadth of the Medical Studies Act privilege for information arising out of peer review and credentialing processes. In addition, the case suggests that the Hospital Licensing Act's immunity for participants in the peer review and credentialing process is intended to apply only when directly affected physicians seek remedy after an adverse peer review and/or credentialing decision. Frigo stands for the proposition that such immunity does not apply to negligent medical treatment provided to a hospital patient.

VI. SCOPE OF HEALTH CARE PROFESSIONAL PRACTICE CHANGES¹⁸¹

Illinois licenses dozens of healthcare professionals under its police powers as a sovereign state. The purpose for licensure is the protection of the public health, safety, and welfare of the citizens of Illinois by regulating or establishing minimum qualifications for the practice of various professions in the state.¹⁸² Licensed healthcare professionals include physicians,¹⁸³ dentists,¹⁸⁴ podiatrists,¹⁸⁵ optometrists,¹⁸⁶ advanced practice nurses,¹⁸⁷ physician assistants,¹⁸⁸ pharmacists,¹⁸⁹ and others.¹⁹⁰ In recent years, numerous changes

181. This section of the Survey article is by Robert John Kane, an Adjunct Assistant Professor of Medical Humanities at the Southern Illinois University School of Medicine and Secretary-Treasurer of the Illinois Association of Healthcare Attorneys. He is co-author/editor of the *Law of Medical Practice in Illinois* (2007 Third Edition, Thomson/West).

182. 20 ILL. COMP. STAT. 2105/2105-10 (2007).

183. 225 ILL. COMP. STAT. 60/1-63 (2007).

184. 225 ILL. COMP. STAT. 25/1-57 (2007).

185. 225 ILL. COMP. STAT. 100/1-45 (2007).

186. 225 ILL. COMP. STAT. 80/1-29 (2007).

187. 225 ILL. COMP. STAT. 65/65-5-65-65 (2007).

188. 225 ILL. COMP. STAT. 95/1-24 (2007).

189. 225 ILL. COMP. STAT. 85/1-41 (2007).

190. 225 ILL. COMP. STAT. 65/55-5 *et seq.* (2007) (nurses); 225 ILL. COMP. STAT. 15/1 *et seq.* (2007) (clinical psychologists); 225 ILL. COMP. STAT. 20/1 *et seq.* (2007) (social workers); 225 ILL. COMP. STAT. 90/0.05 *et seq.* (2007) (physical therapists); 225 ILL. COMP. STAT. 75/1 *et seq.* (2007) (occupational therapists); 210 ILL. COMP. STAT. 50 (2007) (paramedics and emergency medical technicians); 225 ILL. COMP. STAT. 5/1 *et seq.* (2007) (athletic trainers); 225 ILL. COMP. STAT. 30/1 *et seq.* (2007) (dietitians); 225 ILL. COMP. STAT. 63/1 *et seq.* (2007) (naprapaths); 225 ILL. COMP. STAT. 70/1 *et seq.* (2007) (nursing home administrators); 225 ILL. COMP. STAT. 84/1 *et seq.* (2007) (orthotists, pedorthists, and prosthetists); 225 ILL. COMP. STAT. 106/1 *et seq.* (2007) (respiratory care practitioners); 225 ILL. COMP. STAT. 107/1 *et seq.* (2007) (professional or clinical professional counselors); 225 ILL. COMP. STAT. 110/1 *et seq.* (2007) (audiologists or speech language pathologists); 225 ILL. COMP. STAT. 125/1 *et seq.* (2007) (perfusionists); 225 ILL. COMP. STAT. 130/1-999 (2007) (surgical assistants or surgical technologists); 225 ILL. COMP. STAT. 135/1 *et seq.* (2007) (genetic counselors); 225 ILL. COMP. STAT. 55/1 *et seq.* (2007) (marriage and family therapists); 225 ILL. COMP. STAT. 50/1 *et seq.* (2007) (hearing instrument dispensers); 225 ILL. COMP. STAT. 51/1 *et seq.* (2007) (hearing instrument dispensers); 225 ILL. COMP. STAT. 51/1 *et seq.* (2007) (hearing instrument dispensers).

or modifications have been made in the licensure statutes or regulations for healthcare professionals. Under the Regulatory Sunset Act,¹⁹¹ the Illinois General Assembly regularly reviews licensure and other acts. This is done by establishing an automatic repeal of an act by a specified date, usually every ten years.¹⁹² This section will highlight a number of changes concerning physicians, dentists, podiatrists, optometrists, physician assistants, advanced practice nurses and pharmacists.

A. Physicians

Physicians are licensed under the Medical Practice Act of 1987.¹⁹³ A number of changes have been made in physician licensure in the past few years. Most notable of these changes was enacted by P.A. 94-677 which imposed a requirement on the Division of Professional Regulation, which licenses most health care professionals, to publish on the internet, profiles of physicians.¹⁹⁴ To implement this mandate, the Division adopted rules which reference the language of the Public Act and establish timeframes for compliance.¹⁹⁵ Illinois physician profiles are required to provide seventeen elements, including mandatory information on compliance for practical location, medical practice and specialty information, licensure information, discipline by licensure entities and hospitals, criminal conviction information, medical malpractice awards, judgments and settlements, and whether the physician participates in Medicaid or provides translating services.¹⁹⁶ Optional profile information concerns medical school faculty appointments, peer review publications, and professional or community service activities or awards.¹⁹⁷

The Division developed the software to provide this information and in the fall of 2007 required licensed physicians to access their online profiles and fill in various elements that the Division could not complete with information in its files, by January 1, 2008.¹⁹⁸ As of this writing, the physician profiles had not yet been published.¹⁹⁹

seq. (2007) (home medical equipment and services providers).

191. 5 ILL. COMP. STAT. 80/1 *et seq.* (2007).

192. 5 ILL. COMP. STAT. 80/12.

193. 225 ILL. COMP. STAT. 60/1 *et seq.* (2007); ILL. ADMIN. CODE tit. 68, § 1285 (2007).

194. 225 ILL. COMP. STAT. 60/24.1.

195. ILL. ADMIN. CODE tit. 68, § 1285.305.

196. 225 ILL. COMP. STAT. 60/24.1(b)(1)-(11), (15)-(17).

197. 225 ILL. COMP. STAT. 60/24.1(b)(12)-(14).

198. ILL. ADMIN. CODE tit. 68, § 1285.305.

199. February 4, 2008.

In addition, a number of changes were made to the administrative and enforcement provisions of the Medical Practice Act.²⁰⁰ Under the sunset review process, in 2006 the Medical Practice Act of 1987 was reauthorized for two years instead of the typical ten years and must be reauthorized again by December 31, 2008 or it will be repealed by operation of law.²⁰¹

B. Dentists

Illinois dentists are licensed under the Dental Practice Act.²⁰² Dentistry is generally the care and treatment of the “human oral cavity and adjacent tissues and structures.”²⁰³ In 2005, the Dental Practice Act was reauthorized until 2016.²⁰⁴ Recent substantive changes to the Act were made by three Public Acts (P.A.). First, P.A. 94–1028, added section 38.2 and amended sections 37 and 38.1 to allow for the continuation of a dental practice upon the death or incapacity of the practice owner.²⁰⁵ Second, P.A. 95–399 revised the current standards for dentists to administer anesthesia.²⁰⁶ Qualifications for dentists to receive permits (licenses) to administer anesthesia were added to the Practice Act. Further, deep sedation was added to the categories of anesthesia allowed to be performed by dentists with the proper permit. Finally, “sedation dentistry” was restricted to those dentists with the proper permit. It is unlawful for a dentist without the proper permit to advertise the performance of “sedation dentistry.”²⁰⁷ Finally, P.A. 95–639 rewrote the Nurse Practice Act to authorize dentists with the appropriate anesthesia permit to enter into a collaborative agreement with a certified registered nurse anesthetist.²⁰⁸

C. Podiatrists

Illinois podiatrists are licensed under the Podiatric Medical Practice Act of 1987.²⁰⁹ Podiatry is generally the care and treatment of the “human foot.”²¹⁰

200. P.A. 94–677 (effective Aug. 25, 2005).

201. P.A. 94–409 (effective Dec. 31, 2005).

202. 225 ILL. COMP. STAT. 25/1 *et seq.* (2007); ILL. ADMIN. CODE tit. 68, § 1220 (2007).

203. 225 ILL. COMP. STAT. 25/4(k).

204. P.A. 94–409 (effective Dec. 31, 2005).

205. P.A. 94–1028 (effective Jan. 1, 2007) (to be codified at 225 ILL. COMP. STAT. 25/37, /38.1, /38.2).

206. P.A. 95–399 (effective Jan. 1, 2008) (to be codified at 225 ILL. COMP. STAT. 25/8.1).

207. 225 ILL. COMP. STAT. 25/45.

208. P.A. 95–639 (effective Jan. 1, 2008); 225 ILL. COMP. STAT. 25/8.1.

209. 225 ILL. COMP. STAT. 100/1 *et seq.* (2007); ILL. ADMIN. CODE tit. 68, § 1360.

210. 225 ILL. COMP. STAT. 100/5(D) (2007).

In 2007, under the sunset review process a number of changes were made and the Act was reauthorized until January 1, 2018.²¹¹ Significant among the numerous changes in the Act are revisions of the scope of practice and continuing education requirements.²¹² Podiatrists are now authorized by law to amputate the human foot “limited to 10 centimeters proximal to the tibial talar articulation” (ankle joint).²¹³ Also, authority to perform general “anesthesia” was clarified by specifying the forms of anesthesia permitted are “topical and local anesthesia and moderate and deep sedation, as defined by Department rule adopted under the Medical Practice Act of 1987.”²¹⁴

Further, the number of continuing education hours a licensed podiatrist must complete each year was raised to fifty.²¹⁵ This is the same amount physicians must complete.²¹⁶

In addition, the sunset review’s amendment of the licensure act for nurses resulted in a significant change for podiatrists.²¹⁷ Changes to the new Nurse Practice Act²¹⁸ and the Podiatric Medical Practice Act both authorize podiatrists for the first time to enter into collaborative agreements with advanced practice nurses.²¹⁹ A collaborative agreement with a podiatrist may only authorize the advanced practice nurse to provide clinical patient services that are generally provided by the collaborating podiatrist.²²⁰

D. Optometrists

Illinois optometrists are licensed under the Illinois Optometric Practice Act of 1987.²²¹ Optometry is generally the care and “treatment of human visual system, the human eye, and its appendages without the use of surgery.”²²²

In 2006, a number of changes were made as the Act went through the sunset review process and the Act was reauthorized until January 1, 2017.²²³

211. P.A. 95–235 (effective Aug. 17, 2007).

212. *Id.*

213. 225 ILL. COMP. STAT. 100/5(D) (2007).

214. 225 ILL. COMP. STAT. 100/5(D) (2007) (referencing 225 ILL. COMP. STAT. 25/8.1 and ILL. ADMIN. CODE tit. 68, § 1285.340). *See also* P.A. 95–639 (effective Jan. 1, 2008).

215. 225 ILL. COMP. STAT. 100/14 (2007).

216. 225 ILL. COMP. STAT. 60/20 (2007); ILL. ADMIN. CODE tit. 68, § 1285.110(2007).

217. P.A. 95–639 (effective Oct. 5, 2007).

218. 225 ILL. COMP. STAT. 65/55–5 *et seq.* (2007).

219. 225 ILL. COMP. STAT. 65/65–35 (2007); 225 ILL. COMP. STAT. 100/20.5 (2007).

220. 225 ILL. COMP. STAT. 65/65–35(b); 225 ILL. COMP. STAT. 100/20.5(a).

221. 225 ILL. COMP. STAT. 80/1–29 (2007); ILL. ADMIN. CODE tit. 68, § 1320 (2007).

222. 225 ILL. COMP. STAT. 80/3(a) (2007).

223. P.A. 94–787 (effective May 19, 2006).

Sunset changes include the scope of practice, the category of licenses, and administrative and technical changes related to the licensure and discipline process. Most significant is the series of changes that phased out the licenses of all optometrists who did not meet the qualifications for use of therapeutic ocular pharmaceutical agents.²²⁴ As of January 1, 2007, all licensed optometrists have the authority to use therapeutic ocular pharmaceutical agents.²²⁵ Licensees who did not meet the qualifications for use of therapeutic ocular pharmaceutical agents had a one year grace period and then lost their licenses.²²⁶

Subsequently, P.A. 95–242 expanded the scope of the ocular pharmaceutical agents that may be used to include additional agents, limited injectables, and limited controlled substances.²²⁷ Prescription of Schedule II Controlled Substances was specifically prohibited.²²⁸

E. Physician Assistants

Illinois physician assistants are licensed under the Physician Assistant Practice Act of 1987.²²⁹ Physician assistants generally provide patient care services within the specialty of and under the supervision of a physician licensed to practice medicine in all its branches.²³⁰

In 2007, the Act was substantially revised under the sunset review process and reauthorized until January 1, 2018.²³¹ Almost all of the changes were administrative or technical to make the Act conform to the same practices and procedures set forth in other licensure acts. Under the Act, physician assistants must have a designated supervising physician.²³² Previously, if, for any reason, the supervising physician could not provide supervision for less than thirty days, then an alternate supervising physician must have been designated.²³³ The sunset revision removed the thirty day limitation and required the Department of Financial and Professional Regulation to adopt a rule further defining the requirements for an “alternate supervising physician”.²³⁴

224. *Id.*

225. 225 ILL. COMP. STAT. 80/15.1, /15.2.

226. 225 ILL. COMP. STAT. 80/15.2.

227. P.A. 95–242 (effective Jan. 1, 2008) (to be codified at 225 ILL. COMP. STAT. 80/15.1).

228. 225 ILL. COMP. STAT. 80/15.1(a–15).

229. 225 ILL. COMP. STAT. 95/1 *et seq.* (2007); ILL. ADMIN. CODE tit. 68, § 1350 (2007).

230. 225 ILL. COMP. STAT. 95/4(3).

231. P.A. 95–703 (effective Dec. 31, 2007).

232. 225 ILL. COMP. STAT. 95/4(3).

233. 225 ILL. COMP. STAT. 95/4(8).

234. *Id.*

F. Advanced Practice Nurses

Illinois advanced practice nurses are licensed under the Nurse Practice Act.²³⁵ Advanced practice nurses (APN) generally provide patient care services within the practice field of their collaborating physician or podiatrist or department in a hospital or ambulatory surgical treatment center.²³⁶

In 2007, the Nursing and Advanced Practice Nursing Act was reorganized, revised, and rewritten under sunset review and reauthorized until January 1, 2018.²³⁷ Significant scope of practice changes in the Act concern when a collaborative agreement is required, who may collaborate with an APN, and what prescriptive authority may be delegated and by whom. Under the new Nurse Practice Act, advanced practice nurses practicing in the office, clinical or non-licensed hospital, or ambulatory surgical treatment center setting are still required to have a collaborative agreement with a physician licensed to practice medicine in all its branches.²³⁸ Podiatrists may also now enter into a collaborative agreement with an advanced practice nurse.²³⁹

The requirements for a valid collaborative agreement still mandate services be limited to those generally provided by the collaborating physician or podiatrist, the practice orders and guidelines must be jointly developed, the APN and collaborating physician or podiatrist must meet once a month in person for collaboration and consultation, and the collaborating physician or podiatrist must be available by telephone for consultation or emergencies. The only substantive change is that the once a month visit does not have to be “on site.” Another change replaces the term “collaboration”²⁴⁰ for the term “medical direction” but is not substantive because the term is defined by the same, essentially unaltered, requirements set forth above. In essence, the collaboration requirement has not changed. Further, certified registered nurse anesthetists (CRNA) are also required to have a collaborative agreement outside the hospital or ambulatory surgical treatment center replacing the

235. 225 ILL. COMP. STAT. 65/65–5 *et seq.* (2007) (as amended by P.A. 95–639 (effective Oct. 5, 2007)).

236. *Id.* § 65/50–10, /65–30, /65–35(b), /65–45.

237. P.A. 95–639 (effective Oct. 5, 2007).

238. *Id.* § 65/65–35; *Id.* § 60/54.5.

239. 225 ILL. COMP. STAT. 65/65–35; 225 ILL. COMP. STAT. 100/20.5.

240. 225 ILL. COMP. STAT. 65/50–10. “‘Collaboration’ means a process involving 2 or more health care professionals working together, each contributing one’s respective area of expertise to provide more comprehensive patient care.”

previously required “practice agreement.” A CRNA may enter into a collaborative agreement with a physician, podiatrist, or dentist.²⁴¹

Under the collaborative agreement, a collaborating physician (or podiatrist) may delegate prescriptive authority for any medications generally prescribed by the physician or podiatrist, including Schedule III through V Controlled Substances as in the previous Act. The new Act also allows a physician to delegate Schedule II Controlled Substances prescriptive authority.²⁴² Delegation of Schedule II prescriptive authority is limited to five oral medications prescribed by the collaborating physician.

In a licensed hospital, advanced practice nurses (including CRNAs) may only practice with clinical privileges recommended by the hospital medical staff and granted by the hospital.²⁴³ These clinical privileges may also include authority to select, order, and administer medications including controlled substances. No prescriptive authority can be granted to an advanced practice nurse. Further, advanced practice nurses are not authorized to admit patients to a hospital.²⁴⁴ The requirements for practice in an ambulatory surgical treatment center are nearly identical; however, the “consulting committee” makes the recommendation for privileges not the “medical staff.”²⁴⁵

G. Pharmacists

Illinois pharmacists and pharmacies are licensed under the Pharmacy Practice Act.²⁴⁶ In 2007, similar to the Nurse Practice Act, the Pharmacy Practice Act was substantially revised and rewritten under the sunset review process and reauthorized until January 1, 2018.²⁴⁷ Major expansions and clarifications were made in the scope of practice for pharmacists.²⁴⁸

The “practice of pharmacy” in addition to implementing prescriptions and orders, dispensing, research, patient counseling and compounding, now includes.²⁴⁹

241. 225 ILL. COMP. STAT. 65/65–35(c)(3), (c–10); 225 ILL. COMP. STAT. 25/8.11(c) (only a CRNA may have a collaborative agreement with a dentist).

242. 225 ILL. COMP. STAT. 65/65–40(d).

243. 225 ILL. COMP. STAT. 65/65–45; 210 ILL. COMP. STAT. 85/10.7(3).

244. ILL. ADMIN. CODE tit. 77, §§ 250.150, 250.240, 250.320 (2006).

245. 225 ILL. COMP. STAT. 65/65–45; 210 ILL. COMP. STAT. 5/6.5(3) (2006).

246. 225 ILL. COMP. STAT. 85/1–41 (2007) (as amended by P.A. 95–681 (effective Oct. 29, 2007)); ILL. ADMIN. CODE tit. 68, § 1330 (2007).

247. P.A. 95–689 (effective Oct. 29, 2007).

248. 225 ILL. COMP. STAT. 85/3(d).

249. 225 ILL. COMP. STAT. 85/3(d)(3)–(5), (8)–(10).

- Participation in drug and device selection.
- Drug administration limited to the administration of oral, topical, injectable, and inhalation as follows: in the context of patient education on the proper use or delivery of medications; vaccination of patients 14 years of age and older pursuant to a valid prescription or standing order by a physician licensed to practice medicine in all its branches, upon completion of appropriate training, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures.
- Drug regimen review.
- The practice of telepharmacy.
- The provision of those acts or services necessary to provide pharmacist care.
- Medication therapy management.

With the advent of the Medicare Part D program, there has been greater demand for medication therapy management services. The revised Pharmacy Practice Act identifies that medication therapy management services can be offered "by licensed pharmacists, physicians licensed to practice medicine in all its branches, advanced practice nurses authorized in a written agreement with a physician licensed to practice medicine in all its branches, or physician assistants authorized in guidelines by a supervising physician."²⁵⁰ "Medication therapy management services" are defined as "a distinct service or group of services offered . . . that optimize therapeutic outcomes for individual patients through improved medication use. In a retail or other non-hospital pharmacy, medication therapy management services shall consist of the evaluation of prescription drug orders and patient medication records to resolve conflicts," with twelve enumerated items.²⁵¹ These services in a licensed hospital may consist of "reviewing assessments of the patient's health status; and following protocols of a hospital pharmacy and therapeutics committee with respect to the fulfillment of medication orders."²⁵²

The Pharmacy Practice Act also recognizes a physician's authority to "authorize these services by standing order" for "his or her identified patient or groups of patients under specified conditions or limitations."²⁵³

250. 225 ILL. COMP. STAT. 85/3(aa) (2007).

251. *Id.*

252. *Id.*

253. *Id.*

Additionally, all the previous classes of pharmacies are combined into one pharmacy license and various changes are made to the licensure and discipline process.

Overall, the revised Pharmacy Practice Act was rewritten. In the context of this rewrite, the General Assembly's stated mandate or purpose was that: "Nothing in this Act shall be construed to authorize a pharmacist to prescribe or perform medical diagnosis of human ailments or conditions."²⁵⁴

H. Conclusion

In conclusion, recent statutory changes have expanded or clarified the authority of health care professionals to practice in the State of Illinois. Attorneys representing health care facilities or health care professionals should be mindful of the statutory limitations or restrictions on individuals licensed to practice in Illinois.

VII. SUPREME COURT DECIDES MEDICAL PRACTICE ACT ALLOWS FLAT FEES FOR PROCESSING PHYSICAL CLAIMS MADE ON DISCOUNTED HEALTH SERVICE CONTRACTS²⁵⁵

In a decision limited to the regulatory restraints on physicians, the Illinois Supreme Court reversed the Fourth Appellate Court's decision that non-physician administrative flat fees charged by plan administrator HealthLink for the volume of claims submitted by a physician does not violate the fee-splitting prohibition provision of §22(A)(14) of the Illinois Medical Practice Act of 1987 ("Medical Practice Act").²⁵⁶ The Court affirmed the lower court's decision that HealthLink's requirement of physicians to pay an administrative fee equal to 5% of the amounts paid in its discounted rate schedule for medical services rendered to plan members constituted a percentage of the physicians' profit and therefore is in violation of the Medical Practice Act.²⁵⁷ The Court rejected the physicians' claim that the Medical Practice Act was meant to prohibit the division of fees between licensees and any other individual or entity that may render professional services under the Act, reasoning that "professional services" can only be performed by someone licensed to practice

254. *Id.* § 85/5(d).

255. This section of the Survey article is by Michael F. Daniels, an associate at Heyl, Royster, Voelker & Allen where he specializes in civil litigation, medical malpractice, and health care issues.

256. *Vine Street Clinic v. Healthlink, Inc.* 222 Ill.2d 276, 294-94; 856 N.E.2d 422, 435 (2006); 225 ILL. COMP. STAT. 60/22(A)(14) (2007).

257. *Vine Street Clinic*, 222 Ill.2d at 292-93, 856 N.E.2d at 434; *see* 225 ILL. COMP. STAT. 60/22(A)(14).

medicine.²⁵⁸ The Court decided that nothing in the Medical Practice Act prohibited a non-physician from receiving a fee for services rendered, apart from referral, as long as that fee is not a percentage of the physician's profit, or its equivalent.²⁵⁹

A. Procedural History

In the case of *Vine Street Clinic and Ursula Thatch M.D. v. Healthlink, Inc.*, Plaintiffs sought a declaration: (1) that a provider contract for health services charging physicians an administrative/patient referral ("percentage fee") violated the Medical Practice Act; (2) that a new administrative flat fee by Healthlink also violated the Act; (3) that HealthLink was barred from contracting for any administrative fees under the Illinois Insurance Code ("Insurance Code") (215 ILCS 5/1 et seq.) (West 2002); and (4) an award for injunctive relief and recovery of all administrative fees previously paid to Healthlink.²⁶⁰ The circuit court entered judgment on the pleadings, holding that the percentage fee violated the Medical Practice Act and the flat fee did not, and that the previous paid monies were not recoverable. The court also dismissed the counts alleging the Insurance Code bars Healthlink from collecting administrative fees and unjust enrichment. On appeal, the Appellate Court, upheld the court's decision with respect to the percentage fee violating the Medical Practice Act and the Plaintiff's inability to recover monies previously paid, but reversed the lower court's decision holding the flat fee did not violate the Medical Practice Act.²⁶¹ The appellate court did not address Plaintiffs' argument that the Insurance Code barred Healthlink from contracting for and collecting administrative fees.²⁶² The Supreme Court subsequently upheld the appellate court's ruling that Healthlink's percentage-fee based contract violated the Medical Practice Act while the flat fee did not, and held that the Plaintiffs are not entitled to reimbursement of the previously paid percentage based or flat fees.²⁶³ The issue of whether HealthLink is an "Administrator" as that term is defined in §§ 511.101 and 370g(g) of the Insurance Code and whether HealthLink violated the Insurance Code by

258. *Vine Street Clinic*, 222 Ill.2d at 289–91, 856 N.E.2d at 432–33; see 225 ILL. COMP. STAT. 60/22(A)(14).

259. *Vine Street Clinic*, 222 Ill.2d at 290–91, 856 N.E.2d at 433; see 225 ILL. COMP. STAT. 60/22(A)(14).
260. *Vine Street Clinic*, 222 Ill.2d at 278–79, 856 N.E.2d at 426.

261. *Vine Street Clinic*, 222 Ill.2d at 276–79, 856 N.E.2d at 422–26; see *Survey of Illinois Law: Physician Fee Splitting: A Survey of Case Law and Public Policy Influencing—Vine Street Clinic and Ursula Thatch, M.D., v. Healthlink, Inc.*, 29 S. Ill. U. L.J. 673, (2005).

262. *Vine Street Clinic*, 222 Ill.2d at 278–80, 856 N.E.2d at 426.

263. *Id.* at 289–300, 856 N.E.2d at 432–38.

collecting unauthorized fees from health-care providers was dismissed without review of the merits in the interest of judicial economy.²⁶⁴

B. Background

Vine Street Clinic is a partnership of physicians providing psychiatric services in Springfield, Illinois, and Ursula Thatch M.D. is a Madison County, Illinois, physician specializing in obstetrics and gynecology.²⁶⁵ HealthLink is described by the Supreme Court as an Illinois corporation that enters into participating physician agreements with physicians, creating a network of health-care providers, and makes them available to members of health plans that are offered by insurance carriers, self-funded employer groups, governmental entities, and union trusts known as payors.²⁶⁶ Vine Street's contract with HealthLink was from 1989 until 2001, and Dr. Thatch was a provider from 1993 until June 30, 2002.²⁶⁷

C. Percentage and Flat Administrative Fees

i. Percentage Fees

Prior to May 30, 2002, HealthLink's participating physician contract stated: "In consideration of the services provided hereunder by HealthLink, each PHO Participating Provider shall pay HealthLink an administrative fee equal to five percent (5%) of the amounts allowed to the PHO Participating Provider."²⁶⁸ HealthLink argued a Florida court's decision involving § 22(A)(14) of the Medical Practice Act did not preclude physicians from agreeing to pay a percentage of their profits to an unlicensed entity in exchange for marketing and management services.²⁶⁹ The Court disagreed with the Florida court's interpretation of the intent of § 22(A)(14) to limit only traditional fee splitting and to allow nonprofessional corporations like HealthLink to fall outside the conduct proscribed by the Medical Practice Act.²⁷⁰ Plaintiffs argued that the meaning of "professional services" in §

264. *Id.* at 299–302, 856 N.E.2d at 438–39.

265. *Vine Street Clinic*, 222 Ill.2d at 278–80, 856 N.E.2d at 426; *See* 29 S. Ill. U. L.J. 707 (2005).

266. *Vine Street Clinic*, 222 Ill.2d at 278–81, 856 N.E.2d at 426–27.

267. *Vine Street Clinic*, 222 Ill.2d at 283–85, 856 N.E.2d at 428–29; *see* 29 S. Ill. U. L.J. 707 (2005).

268. *Vine Street Clinic*, 222 Ill.2d at 283–85, 856 N.E.2d 428–29.

269. *Practice Management Associates, Inc. v. Orman*, 614 So. 2d 1135 (Fla. App. 1993), (construing § 22(A)(14) of the Act).

270. *See Practice Management Associates, Inc.*, 614 So. 2d at 1138; *Vine Street Clinic*, 222 Ill.2d at 289–90, 856 N.E.2d at 432.

22(A)(14) of the Medical Practice Act is not limited to only medical services, but also includes the marketing and management services HealthLink charged Plaintiffs as part of their health services contract.²⁷¹ The Court dismissed Plaintiffs argument as meritless and confusing to the main argument against fee splitting and reasoned that the Medical Practice Act supports the Court's holding that only the sharing of a percentage of a physician's fees for medical "professional services not actually performed and personally performed" by the physician was meant to be prohibited.²⁷² In the end, the Court agreed with Plaintiffs that § 22(A)(14) of the Medical Practice Act prohibits: "(1) 'traditional' fee splitting for patient referrals between licensees, except those in a partnership or corporate-type relationship and licensees concurrently rendering professional services to a patient; and (2) fee-sharing agreements whereby a licensee 'divides with anyone,' for any service rendered to the licensee, a percentage of the monies earned by the licensee for medical services he or she has performed."²⁷³ Agreeing with the appellate court, the Supreme Court also ruled that "[n]onphysicians can receive a fee for services rendered, apart from referral, but cannot receive a percentage of the physician's profit, or its equivalent."²⁷⁴

ii. Flat Fees

HealthLink argued that its flat fee was established in response to a prior Illinois Attorney General's opinion finding its percentage-based fees in violation of the Medical Practice Act.²⁷⁵ The Court agreed with HealthLink that its flat fee is for administrative services and not for patient referrals. The reasoning incorporated into the Court's ruling is based on a finding that the flat fee is based on the volume of claims that HealthLink processed for a physician during the prior year and the physician's specialty.²⁷⁶ The flat fee arrangement allowed HealthLink to process claims and charge participating physicians for a fair compensation without a prohibitive division of the physicians' fee for medical services.²⁷⁷ The Court also rejected Plaintiffs' argument that "professional services" included marketing and management services under

271. *Vine Street Clinic*, 222 Ill.2d at 289–90, 856 N.E.2d at 432; see 225 ILL. COMP. STAT. 60/22(A)(14).

272. *Vine Street Clinic*, 222 Ill.2d at 289–94, 856 N.E.2d at 432–34.

273. *Vine Street Clinic*, 222 Ill.2d at 293–94, 856 N.E.2d at 434.

274. *Vine Street Clinic*, 222 Ill.2d at 293–94, 856 N.E.2d at 434; *Vine Street Clinic v. HealthLink, Inc.*, 353 Ill. App. 3d 929, 935, 819 N.E.2d 363 (4th Dist. 2004).

275. *Vine Street Clinic*, 222 Ill.2d at 293–94, 856 N.E.2d at 434; 29 S. Ill. U. L.J. 707–08 (2005); 2002 Ill. Att'y Gen. Op. No. 02–005.slip op. at 4.

276. *Vine Street Clinic*, 222 Ill.2d at 293–94, 856 N.E.2d at 434.

277. *Id.*

the Medical Practice Act.²⁷⁸ As further basis for its ruling the Court stated “[t]his reading of § 22(A)(14) gives the statutory language its plain and ordinary meaning without reading into it exceptions, limitations or conditions which conflict with the express legislative intent.”²⁷⁹ Thus the Court ruled the flat fee does not violate § 22(A)(14) of the Medical Practice Act, nor was it against public policy.²⁸⁰

iii. HealthLink’s Retention of Fees In Pari Delicto

Plaintiffs argued the lower court had failed to recognize the exceptions to the doctrine of in pari delicto, which stands for the principle that those who participate in wrongdoing may not recover damages resulting from that wrongdoing.²⁸¹ The lower court’s decision not to reimburse Plaintiffs for the fees paid under the HealthLink contracts reflects the maxim that “the law will not aid either party to an illegal act, but will leave them without remedy as against each other, with the caveat that they are of equal knowledge, willfulness and wrongful intent or in pari delicto.”²⁸² Plaintiffs argued two exceptions: (1) there is no parity in the culpability of the parties; and (2) there exists a necessity to support the public interest or policy.²⁸³ The Supreme Court found neither of these arguments persuasive stating neither exception existed under the facts of the case. As to the first exception, Plaintiffs argued they were coerced into signing the contracts in order to have access to HealthLink’s patients. Finding nothing in the record to suggest that the contracts were nothing other than arms-length transactions between HealthLink and the physicians, the Court agreed with the appellate court’s finding that Plaintiffs failed to seek timely relief and in fact were the wrongdoers under the Medical Practice Act.²⁸⁴ The Court was similarly unimpressed with Plaintiffs’ argument that payment was not voluntary but instead was the result of compulsion.²⁸⁵ The Court reasoned that absent an argument of fraud, misrepresentation, or mistake of fact, Plaintiffs’ allegation that the transactions were illegal and against public policy was not valid. The

278. *Vine Street Clinic*, 222 Ill.2d at 294, 856 N.E.2d at 435; see 225 ILL. COMP. STAT. 60/22(A)(14).

279. *Vine Street Clinic*, 222 Ill.2d at 296–97, 856 N.E.2d at 436; see 225 ILL. COMP. STAT. 60/22(A)(14).

280. *Vine Street Clinic*, 222 Ill.2d at 289–90, 856 N.E.2d at 432; see 225 ILL. COMP. STAT. 60/22(A)(14).

281. *Vine Street Clinic*, 222 Ill.2d at 296–97, 856 N.E.2d at 436.

282. *Vine Street Clinic*, 222 Ill.2d at 296–97, 856 N.E.2d at 436; *Rees v. Schmits*, 164 Ill. App. 250, 258 (1911); see also *King v. First Capital Fin. Services Corp.*, 215 Ill.2d 1, 33–34 (2005).

283. *Vine Street Clinic*, 222 Ill.2d at 298, 856 N.E.2d at 436–37; see *Evans v. Funk*, 151 Ill. 650, 657–58 (1894).

284. *Vine Street Clinic*, 222 Ill.2d at 298, 856 N.E. 2d at 436–37.

285. *Id.*

Court stated that no rule of law is better settled than the rule that money voluntarily paid under a claim of right to the payment and with knowledge of the facts by the person making the payment, cannot be recovered by the payor solely because the claim was illegal.²⁸⁶

D. Conclusion

Under the Court's decision, physicians who willingly enter into discounted health service contracts with healthcare plan representatives and agree to pay administrative fees for processing their discounted fee claims are not in violation of the Medical Practice Act of 1987. For now, the Court has declined to examine the merits of the physicians' arguments that HealthLink is regulated and prohibited by the Insurance Code from contracting for certain administrative fees like claims processing, leaving the door open for future courts to determine whether Illinois law prohibits healthcare plan administrators to shift their business costs to healthcare providers.

286. *Vine Street Clinic*, 222 Ill.2d at 298, 856 N.E2d at 437; *Kanter & Eisenberg v. Madison Associates*, 116 Ill.2d 506, 512 (1987); *see also* *Harris v. Johnson*, 218 Ill. App. 3d 588, 594 (1991).

