December 2009 Vol. 26, No. 2

ILLINOIS STATE BAR ASSOCIATION

# HEALTH CARE LAWYER

*The newsletter of the Illinois State Bar Association's Section on Health Care Law*

## All the latest developments in health care law

*By W. Eugene Basanta and Jennifer Wagner*

### Cases

### Federal decisions

**Racial discrimination claim by nurse manager at VA hospital rejected by court**

Plaintiff, an African-American woman, was hired for a supervisory position as a clinical nurse manager in a Veterans Affairs (VA) hospital emergency department. After approximately two years on the job, plaintiff's supervisors discovered that the entire department was in revolt against her due to her attitude. Plaintiff failed to comply with a supervisory request to submit a plan to improve morale in her department, and she was demoted temporarily, with a less-qualified white nurse replacing her on an interim basis. The supervisors advised plaintiff these actions were taken due to her lack of supervisory skills, the complaints against her, and her failure to improve morale. Plaintiff was subsequently offered three non-supervisory positions for permanent reassignment, but she declined to accept any of them. A new permanent position was then selected for plaintiff after her failure to

*Continued on page 2*

## Illinois Medical Fee Splitting Statute amended to allow percentage billing contracts

*By Rick L. Hindmand**

On August 24, 2009, Illinois Governor Patrick Quinn approved Public Act 96-0608, which amended the fee splitting prohibitions of the Illinois Medical Practice Act and the Illinois Optometric Practice Act to allow percentage billing contracts and to provide additional detail regarding the scope of the prohibitions. This article focuses principally on the medical fee splitting prohibition in the Medical Practice Act, and provides a brief discussion of several differences between the new medical and optometry fee splitting sections, which are generally similar.

### Prior Medical Fee Splitting Statute

The prior medical fee splitting provision was contained in Section 22(A)(14) of the Illinois Medical Practice Act of 1987,[1] which subjected licensees (i.e., physicians and chiropractors)[2] to potential discipline for "dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company, or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered." That section set forth exceptions for group practices, joint ventures of medical corporations and concurrent physician services.

In 2006, the Illinois Supreme Court interpreted the prior medical fee splitting statute for the first time, in *Vine Street Clinic v. HealthLink, Inc.*[3] The Illinois Supreme Court held in *Vine Street* that Section 22(A)(14) prohibited the administrator of a network of health care providers from charging participating physicians a percentage of their medical fees as payment for administrative ser-

*Continued on page 9*

## INSIDE

**All the latest developments in health care law . . . . . 1**

**Illinois Medical Fee Splitting Statute amended to allow percentage billing contracts. . . . . 1**

**Upcoming CLE programs . . . . . 12**

IF YOU'RE GETTING THIS NEWSLETTER BY POSTAL MAIL AND WOULD PREFER ELECTRONIC DELIVERY, JUST SEND AN E-MAIL TO ANN BOUCHER AT ABOUCHER@ISBA.ORG

## All the latest developments in health care law

*Continued from page 1*

choose one, and she filed a formal administrative EEO complaint alleging racial discrimination and retaliation. Plaintiff then filed the instant suit, alleging racial discrimination, retaliation, and a hostile work environment in violation of Title VII of the Civil Rights Act of 1964. The trial court granted defendant summary judgment following discovery. Plaintiff appealed to the Seventh Circuit.

The appellate court first determined that all of plaintiff's claims were properly before the court and that none exceeded the scope of the administrative complaint, since all claims had to involve the same conduct and people in both the administrative and court complaints. *Ezell v. Potter*, 400 F.3d 1041 (7th Cir. 2005). The court then considered plaintiff's indirect theory of racial discrimination. The primary points of contention were whether plaintiff was meeting her employer's reasonable expectations and whether similarly situated employees outside the protected class were treated more favorably. With regard to employer expectations, the court looked to whether plaintiff was performing adequately at the time of the adverse employment action. *Hong v. Children's Memorial Hosp.*, 993 F.2d 1257 (7th Cir. 1993). An examination of the record revealed that there were definite reasons to believe that plaintiff lacked the necessary supervisory skills for her position, and she had failed to comply with her supervisor's orders regarding morale. The court further found that plaintiff had not found a similarly situated employee for comparison. The court looked to possible candidates but found none to be satisfactory; in particular, the white nurse who replaced plaintiff was not considered a viable candidate because an assignment on an interim basis was not, in the court's opinion, a similar situation. The appellate court thus held that the district court was correct in granting summary judgment for defendant on the race discrimination claim.

The appellate court then examined plaintiff's claim that she suffered retaliation as a result of filing an EEO claim. The court found that, even though plaintiff had engaged in a statutorily protected activity by seeking administrative remedies and had suffered an adverse employment action, she had failed to produce enough evidence for jury consideration that she was performing her job satisfactorily and whether any similarly situated people were treated more favorably. Thus, the court held that the district court was correct in granting summary judgment as to the retaliation claim.

Lastly, the appellate court examined the hostile work environment claim. Plaintiff's only evidence to support this contention were her own allegations that only white employees were involved in her problems, and these allegations were not supported by the record. Specifically, plaintiff's second-level supervisor, who participated in plaintiff's demotion, was African-American. Due to the lack of evidence of plaintiff's workplace being hostile for African-Americans, the court held that the district court was correct to grant summery judgment on this claim as well. *Dear v. Shinseki,* 578 F.3d 605. (7th Cir. 2009).

### Illinois decisions

#### Expert medical testimony not required for emotional distress claim

In October, the Illinois Supreme Court ruled that a plaintiff need not present expert medical testimony to support a claim for negligent infliction of emotional distress in connection with the labor and delivery of her premature infant who died. In this case suit had been filed against the plaintiff's obstetrician, the hospital where she delivered, and several nurses at the hospital, following the infant's death. The infant was partially delivered in the breach position with his head stuck in plaintiff's vagina. The defendant-physician, who was at home, instructed the nurses not to deliver the infant given the risk of decapitation. The plaintiff then waited over an hour with her son partially delivered, while the physician showered and drove to the hospital. After he arrived, the physician completed the delivery, but by this time the infant was dead.

Plaintiff filed suit for wrongful death and survival claims, as well as for the intentional infliction of emotional distress. The hospital and nurses settled the matter and the physician remained as the sole defendant. At trial the plaintiff testified as to her emotions following the delivery episode, including her depression, difficulty eating and sleeping, and her suicidal thoughts. After amendment of the compliant to conform to the proof, the case went to the jury with a claim for negligent, rather than intentional, infliction of emotional distress. The jury found for the defendant-physician on the wrongful death and survival claims, but for plaintiff on the emotional distress claim. In a post trial motion the defendant argued that plaintiff had failed to make a case for emotional distress given the lack of supporting expert testimony. The trial court rejected this argument, as did the appellate court. *Thornton v. Garcini*, 382 Ill. App. 3d 813, 888 N.E.2d 1217 (3d Dist. 2008). The defendant sought review by the Illinois Supreme Court.

Initially, the supreme court rejected the defendant's argument that under *Corgan v. Muehling,* 143 Ill.2d 296, 574 N.E.2d 602 (1991) expert testimony is required to make out a case for emotional distress damages. Under *Corgan*, the absence of expert testimony, the court said, goes to the weight of the evidence, but does not bar recovery for emotional distress. The court then went on to cite *People v. Hudson*, 228 Ill. 2d 181, 886 N.E.2d 964 (2008) in support of the position that a jury need not hear expert medical testimony to support a claim for emotional distress. "Based on personal experience alone, the jury could reasonably find that the circumstances of this case caused plaintiff emotional distress. Plaintiff explicitly testified on her experience of having the deceased infant protrude from her body for over an hour while awaiting [the defendant-physician's] arrival. Plaintiff, the infant's father, and plaintiff's mother all testified about plaintiff's behavior and emotional state following the event. The record sufficiently established that plaintiff suffered emotional distress." The court then went on to reject the defendant's argument that to show causation in terms of emotional distress, expert testimony was required in this case. "Viewing the evidence in the light most favorable to the plaintiff as we must here, the trial testimony established that she suffered emotional distress because of defendant's delay in delivering the deceased baby. We cannot say that the evidence so overwhelmingly favored defendant that no contrary verdict could ever stand." *Thornton v. Garcini*, No. 107028 (Ill. Sup., Oct. 29, 2009).

**Illinois Supreme Court rejects *Tarasoff* and claim for failure to warn**

Plaintiffs filed suit against defendants, several health care providers, following the death of their daughter, who was murdered by her husband, a patient of defendants'. Decedent's husband was under defendants' care for mental health issues, including paranoid delusions which made him feel the urge to kill his wife. After he finally acted on these impulses, the plaintiffs brought suit, alleging that the defendants knew or should have known about the husband's delusions and threats, that they knew or should have known that he posed a specific threat to his wife, and that they had a duty to warn and protect her from the husband's actions. Notably, because the decedent was not a patient of any of the defendants, the issue of duty involved a nonpatient third party.

The trial court dismissed the complaint, stating that there was no allegation of a recognized duty owed to decedent by any of the defendants, nor did a special relationship exist such that negligence could be transferred to the decedent. The appellate court reversed, finding that sufficient factual allegations had been made to establish a cause of action based on a duty owed through a voluntary undertaking and transferred negligence. The Illinois Supreme Court reviewed the motion for dismissal under 735 ILCS 5/2–615. A section 2-615 dismissal motion challenges the legal sufficiency of the complaint on its face.

The supreme court agreed with defendants' contention that under Illinois law, a medical malpractice action cannot be maintained unless there is either a physician-patient relationship between the physician and the plaintiff or a special relationship between the patient and the plaintiff citing *Kirk v. Michael Reese Hospital & Medical Center*, 117 Ill. 2d 507, 513 N.E.2d 387 (1987), and *Doe v.McKay*, 183 Ill. 2d 272, 700 N.E.2d 1018 (1998).

Plaintiffs argued that the absence of these relationships was immaterial and that defendants owed decedent a duty to warn and protect based on their voluntary undertaking to treat decedent's husband. Plaintiffs base this argument on section 324A of the Restatement (Second) of Torts, which provides in pertinent part, "One who undertakes… to render services… which he should recognize as necessary for the protection of a third person… is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking" if such failure increases the risk of harm or the harm is suffered due to reliance of the third person on the undertaking. Restatement (Second) of Torts §324A (1965). The supreme court adopted this section of the Restatement (Second) of Torts in its decision in *Pippin v. Chicago Housing Authority*, 78 Ill. 2d 204, 399 N.E.2d 596 (1979). However, the court in the instant case distinguished *Pippin* and related cases cited by plaintiffs, saying none of those cases involved a malpractice action involving a nonpatient third party.

Both defendants and plaintiffs cited *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal.Rptr. 14 (1976), as the leading case on the issue of when mental health care providers have a duty to warn and protect a nonpatient third party. However, the supreme court stated that it declined to follow the *Tarasoff* analysis. Instead, it held that the established principles of *Kirk* and *Doe* would not be disturbed and that the judgment of the appellate court with respect to the theory of duty to warn due to a voluntary undertaking was reversed.

The court then examined the theory of transferred negligence put forward by plaintiffs. In *Renslow v. Mennonite Hospital*, 67 Ill. 2d 348, 367 N.E.3d 1250 (1977), the court held that a nonpatient third party who was injured as a result of a hospital's negligence regarding a patient could maintain an action against the hospital if a special relationship existed between the third party and the patient. In *Renslow*, the special relationship was that of a mother and fetus. However, the court in *Doe* did not find that such a relationship existed between a parent and an adult child, and since those decisions, the courts have been reluctant to define other relationships of a similar nature as that in *Renslow.*

The appellate court, when examining the instant case, had held that the relationship between husband and wife was a special relationship such that negligence could be transferred. However, the supreme court rejected this analysis and held that the marital relationship does not rise to the level of that of a mother and fetus. Therefore, the judgment of the appellate court with respect to the theory of transferred negligence was reversed. *Tedrick v. Community Resource Center, Inc.*, Nos. 104861, 104876 (Ill. Sup., Sept.24, 2009).


## Health Care Lawyer

*Published at least four times per year.*

*Annual subscription rate for ISBA members: $20.*

*To subscribe, visit www.isba.org or call 217-525-1760*

### Office
Illinois Bar Center
424 S. Second Street
Springfield, IL 62701
Phones: 217-525-1760 OR 800-252-8908
www.isba.org

### Editor
W. Eugene Basanta
Southern IL University School of Law
Lesar Law Bldg
1150 Douglas Drive
Carbondale, IL 62901-6804

### Associate Editors
Nancy McKenna
9840 South Hamilton
Chicago, IL 606043

Theodore R. LeBlang
SIU School of Medicine
P.O. Box 19603
Springfield, IL 62794-9603

### Managing Editor/ Production
Katie Underwood
kunderwood@isba.org

### Health Care Law Section Council
Leonard A. Nelson, Chair
Michael F. Daniels, Vice Chair
Monique A. Anawis, Secretary
Ann K. Ford, Ex-Officio

W. Eugene Basanta
Edward Clancy
Wes Cleveland
Teresa Sue Coles
Thomas P. Conley
Keith E. Emmons
Anna N. Evans
Michael V. Favia
Gerald G. Goldberg
Guy C. Hall
Rick L. HIndmand
Alice Rae Kush
Theodore R. LeBlang
Mary E. Lucie
Carolyn V. Metnick
Mark A. Mosby
Harold Baker Oakley
William F. Sherwood
Herbert Sohn
Lawrence J. Stark
Elizabeth A. Zurek

April G. Troemper, Board Liaison
Mary M. Grant, Staff Liaison
Carolyn V. Metnick, CLE Coordinator
Frank V. Ariano, CLE Committee Liaison




Postmaster: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

**Court rejects patient claim based on professional component billing**

For billing purposes, hospital-based physicians such as pathologists, furnish two general types of services in the course of their work. Some services are directly related to the treatment and care of a patient, such as reviewing a patient's tissue or specimen. Additionally, a hospital-based physician may furnish services to the hospital, including for example administrative services like designing and evaluating testing protocols, which benefit the hospital's patients as a group, rather than directly benefiting a particular patient. A recent decision from the Third District Appellate Court involved a class action claim in connection with so-called "professional component billing for clinical pathology services" (PC-CP).

The plaintiff in this suit, who had no health insurance, went to the defendant-hospital at his physician's direction for lab tests. At the time, he signed a hospital treatment authorization form that explained that he would receive services from independent physicians who were not hospital employees, including pathologists, who would bill separately for their services. Thereafter, the plaintiff received a bill from the hospital ($609) and one from the pathology group ($73). The pathology group's bill included an explanation that the bill might include amounts for the pathologist's "professional component services" such as "supervising laboratory technical personnel." In the suit that followed, the plaintiff alleged that the billings for these services violated the Medical Practice Act, 225 ILCS 60/1 et seq.; the Consumer Fraud and Deceptive Business Practices Act, 815 ILCS 505/1 et seq.; and the Medical Patient Rights Act, 410 ILCS 50/1 et seq. Further he asserted a claim for unjust enrichment. The trial court dismissed all of these claims and the plaintiff appealed.

Initially, the plaintiff argued that the pathology group's billing for PC-CP violated the Medical Practice Act's fee splitting provisions found in 225 ILCS 60/22(A)(14). In rejecting this claim, the appellate court observed that the intent behind the Act's fee splitting prohibition is to prevent fee splitting for patient referrals, as well as fee sharing between a physician and another party based upon a percentage of the fees earned by the physician. In the instant case, the court, assuming without deciding the point that a private right of action exists for a violation of the Medical Practice Act, held that there was no improper fee splitting involved because the hospital and the pathology group had simply billed the plaintiff for separate services provided to him.

The plaintiff also argued that by billing him for services not directly provided to him as a patient, the defendants had engaged in an "unfair and deceptive practice" in violation of the Consumer Fraud Act, 815 ILCS 505/1 et seq. Further, the plaintiff asserted that by violating the Medical Practice Act, the defendants had also violated the Consumer Fraud Act under 815 ILCS 505/2Z. As to this latter claim, the appeals court ruled that, while the General Assembly had identified an array of statutes the violation of which also is a violation of the Consumer Fraud Act, the Medical Practice Act was not among these statutes. As to the former claim, that PC-CP billing was unfair and deceptive, the Third District concluded that, base upon the majority of court rulings from other courts, the practice of billing for professional component services is not unfair or deceptive. As the majority observed, the plaintiff had agreed before any tests were performed, to pay for any services "provided directly or indirectly" to him. Thus, in the court's view the plaintiff had expressly agreed to pay for indirect professional component services.

The appeals court next turned to the plaintiff's unjust enrichment claim. As the court explained, to assert unjust enrichment, a party must show that the other party has received a valuable benefit under circumstances which make the retention of that benefit violative of principles of justice, equity, and good conscience. Because the plaintiff had expressly agreed to pay for all direct and indirect services provided to him, the court here saw no basis for an unjust enrichment claim.

Lastly, the court considered the plaintiff's theory under the Medical Patient Rights Act, 410 ILCS 50/1 et seq. Specifically, the plaintiff looked to section 50/3(b) under which a patient has a right to "a reasonable explanation of his total bill." In the court's view, the defendants here had met the obligations imposed by this provision in the billing statement provided to the plaintiff.

The court's majority thus upheld dismissal of the suit. However, Justice McDade while concurring in part, also dissented in part. In particular, Justice McDade found that plaintiff had stated a cognizable claim that professional component services billing violated the Medical Practice Act's fee splitting provision. Further, in his analysis, a violation of the Medical Practice Act could properly be seen as a violation of the Consumer Fraud Act. *Martis v. Pekin Memorial Hosp., Inc.,* No. 3-08-0543 (Ill. App. 3d Dist., Oct. 20, 2009).

**Physicians under contract with exclusive provider classified as employees**

Contemporary hospitals often contract with professional corporations or other associations to provide physicians to staff certain of the hospital's clinical services. One of the most common such arrangements involves hospital emergency departments. In September, the First District Appellate Court ruled that the physicians engaged by the plaintiff-corporation pursuant to its contract with a hospital to staff its emergency room, as well as the plaintiff's scheduler and auditor (who worked from their homes), were employees of the plaintiff for purposes of unemployment insurance under the Illinois Unemployment Insurance Act, 820 ILCS 405/100 et seq.

The plaintiff-corporation had agreed with a hospital to be the exclusive provider of emergency services at the hospital. Thereafter, following a random audit, the Director of the Illinois Department of Employment Security (IDES) determined that the plaintiff had failed to pay sufficient unemployment insurance contributions for its employees, including its physicians. Claiming that the physicians were independent contractors and not its employees and that the IDES decision violated due process, the plaintiff sought judicial review. After the trial court upheld the IDES ruling, the plaintiff appealed to the First District Appellate Court. The appeals court affirmed.

Under its contract with the hospital, the plaintiff-corporation agreed to recruit, set compensation for, and schedule licensed physicians to cover the hospital's emergency room. The physicians became members of the hospital's medical staff, subject to its bylaws and rules. The hospital was responsible for providing space and supplies for the plaintiff's physicians. While the hospital provided liability coverage for the physicians, it did not include them in its employee insurance or benefit plans. One of plaintiff's physicians was designated as the medical director of the hospital's emergency room with responsibility for performing various management tasks such as performing evaluations

of physicians and nurses in the department.

The plaintiff in turn contracted with physicians to staff the hospital's emergency department. The physician contracts specified that they were independent contractors. However, the contracts also specified that the physicians were to comply with the terms of the plaintiff's contract with the hospital, including meeting CME requirements, maintaining staff privileges, and participating in meetings and training sessions. The physician contracts were terminable without cause by the plaintiff. While the contracts allowed physicians to secure other employment, physicians were required to notify plaintiff of such commitments, to allow plaintiff to review the other employment, and to give plaintiff first priority over any other commitments. Physicians had the opportunity to make scheduling requests to the plaintiff's scheduler, but the scheduler made both scheduling and time-off decisions. Each month, physicians were required to submit time sheets to the plaintiff's auditor who handled their pay. Physicians were required to pay all taxes and contributions. Plaintiff did not pay for workers' compensation, retirement, vacation, or other such benefits.

On appeal, the plaintiff raised several claims. One was that, because the IDES would benefit financially from any decision by its Director against plaintiff, plaintiff's due process rights had been violated. The court observed that basic due process requires a fair hearing before an impartial tribunal and that this standard includes administrative adjudications. Still, the court said, the plaintiff must present evidence to overcome a presumption that an agency official acts with honesty and integrity and establish that the risk of unfairness in a given case is "intolerably high."

Plaintiff argued that its evidence showed that the de facto source of much of the funding for IDES was from the interest and penalties collected by IDES from delinquent employers based upon its Director's decision. The Director argued in response that her decision making authority was limited by statutory standards and that her salary was not impacted by any decision she might make. Further, she argued that the evidence did not show that a significant part of IDES funding comes from interest and penalties. The appellate court agreed with the Director, finding no showing that under these circumstances, the risk of unfairness to plaintiff was "intolerably high."

Plaintiff also argued on appeal that the Director's conclusion that the physicians, scheduler, and auditor were employees of the plaintiff was incorrect. In examining this argument, the court said this raised a mixed issue of law and fact, and that the Director's decision should only be rejected if clearly erroneous.

To begin its analysis, the court noted that under the Illinois Unemployment Insurance Act, 820 ILCS 405/212, where services are provided by an individual to an "employment unit", an "employment" relationship is deemed to exists with the individual unless it is shown that the individual "is free from control or direction" in performing the services, such services are "outside the usual course of the business" of the unit or performed outside "all the places of business" of the unit, and the individual is "engaged in an independently established trade, occupation, profession, or business." The court further noted that the employer has the burden to establish each of these three conditions and that if any one of them is not met, the claim of independent contractor status fails.

The court agreed with the Director that the plaintiff had failed to meet any of the three conditions needed to establish an independent contractor relationship. However, it focused its attention on the second condition, whether the services are outside the employment unit's usual course of business or not performed at its usual places of business. The court concluded that the physicians, the scheduler, and the auditor were all integral parts of the plaintiff. "Without these parties," the court observed, "there would be no business" for the plaintiff. Further, while the plaintiff had a business office to which neither the physicians, nor the scheduler or auditor, were required to come, the court held that the hospital where the physicians worked was also the plaintiff's place of business under the Unemployment Insurance Act. Further, the court noted that the evidence showed that, while the scheduler and the auditor worked at home, the plaintiff paid the expenses associated with their home-based offices. *Emergency Treatment, S.C. v. The Department of Employment Security,* No. 1-08-1437 (Ill. App. 1st Dist., Sept. 30, 2009).

**Liability insurer's good faith duty to settle considered by appellate court**

As a by-product of a medical malpractice action against a hospital and a physician employed by the hospital, the Second District Appellate Court ruled in September that an insurer may owe a physician a good faith duty to settle within policy limits.

The underlying liability suit was filed against the hospital and physician following an allegedly negligent cardiac biopsy on a child by the physician. The procedure left the child disabled and disfigured. The hospital self-insured for $1.5 million and maintained a $25 million excess liability policy as well. Further, the hospital provided a $1 million liability policy from the defendant-insurer for its employed physician. The defendant-insurer accepted and defended the physician in the malpractice action paying for an attorney to represent him. After discovery, a $5 million settlement was reached. However, the defendant-insurer refused to join in the settlement or to pay on the $1 million coverage. This, despite the fact that the defendant's claims manager felt that there was only an even chance for a successful defense of the claim before a lay jury and that in all likelihood the insurer would have to pay the $1 million coverage because of the potential for a multi-million dollar verdict.

After the case settled for $5 million without participation by the defendant, the physician assigned his rights against the defendant-insurer to the hospital and its excess liability insurer. Thereafter, the hospital and excess carrier filed suit against the defendant for $1 million on various theories, including equitable contribution and unjust enrichment, for its failure to participate in the settlement. The defendant relied on various defenses including a "no action" clause in its policy with the physician. This clause provided that no action could be brought against the insurer on the policy unless there was a judgment after a trial or a written agreement with it to pay. The trial court agreed with the insurer that the no action clause was controlling and that, given the failure to meet the specified requirements, the hospital could not prevail in its claim. Summary judgment was granted to the defendant-insurer and plaintiffs appealed.

On appeal, the appellate court disagreed with the trial court's finding that the no action clause controlled the result. Looking to a number of decisions from other jurisdictions, the appeals court concluded that, "it would be unfair to enforce the no action clause against [the physician] for securing a reasonable settlement if [the insurer] breached its good-faith duty to settle and exposed [the physician] to liability exceeding policy limits,

despite the case not having been tried and [the insurer's] initial fulfillment of its duty to defend. Breach of the good-faith duty to settle is . . . an extension of the duty to defend."

The court then addressed the good faith issue. The insurer argued that the physician (and in turn the hospital and the excess insurer) had suffered no harm here by its failure to contribute $1 million to the settlement as there was no judgment or settlement exceeding policy limits. The insurer asserted that the physician's decision to join in the settlement without its consent should not mean that it should be forced against its will to contribute to that settlement. The appellate court found that the core question here was a question of fact, namely whether the physician's decision to settle was a reasonable one in light of the potential for liability in excess of the policy limits. Given this factual question at the heart of the good faith issue, the appeals court ruled that summary judgment was improper. *SwedishAmerican Hospital Asso. v. Illinois State Medical Inter-Insurance Exchange,* No. 2-08-0136 (Ill. App. 2d Dist., Sept. 18, 2009).

**Medical doctor may not testify as to advanced practice nurse standard of care**

Plaintiff filed suit against the defendant-nurse and several physicians following the death of her three year old daughter. The complaint alleged that defendants were negligent in failing to administer the meningitis vaccine Prevnar to the daughter, who succumbed to bacterial meningitis. Plaintiff's daughter had been seen at defendants' clinic on six occasions for what were termed "focused visits", i.e., a visit to address a specific problem. Each time, plaintiff's daughter saw the defendant-nurse, who was characterized as an advanced practice nurse, and never saw any of the physicians named in the complaint. The vaccine Prevnar was never offered to plaintiff at any of these six visits.

At trial, defendants moved to preclude the testimony of plaintiff's expert witness regarding the standard of care applicable to advanced practice nurses on the grounds that this expert was a medical doctor, did not hold the same license as the defendant-nurse, and was therefore not fit to testify about the standard of care applicable to the nurse. The trial court granted this motion and then entered a directed verdict for the nurse. The trial court also held that plaintiff was unable to establish the existence of a physician-patient relationship between the named defendant-physicians and her daughter and so could not show the physicians owed her daughter a duty of care. The trial court entered directed verdicts in favor of the physicians.

The appellate court's review of the directed verdicts was *de novo.* The court found that the defendant-nurse was licensed as an advanced practice nurse under the Nursing and Advanced Practice Nursing Act, 225 ILCS 65/15-5 et seq. The nurse worked independently of physicians at the clinic, but was technically under the medical direction of a collaborating physician who authorized the treatments and procedures to be performed. Plaintiff had provided a medical doctor to testify as to the standard of care applicable to the defendant-nurse, arguing that she was basically acting as a physician and not as a nurse, and that therefore, a physician was qualified to testify as to the relevant standard of care.

The court observed the rule regarding expert testimony and the standard of care in a given school of medicine, requires that the witness be licensed in that same school. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 806 N.E.2d 645 (2004). The Illinois Supreme Court in *Sullivan* expressly declined to retreat from this rule, holding that the legislature had established nursing as a distinctly separate school of medicine from that of a physician. The court found that defendant was acting as an advanced practice nurse within the bounds of the Nursing and Advanced Practice Nursing Act, and so the testimony of an expert licensed in the same school was required to establish the standard of care. Since the plaintiff had no other expert prepared to testify as to the standard of care, she failed to establish a crucial element of her cause of action, and the court held that the entry of the directed verdict with regard to the defendant-nurse was proper.

The appellate court then examined the directed verdicts with regard to the defendant-physicians. There was no dispute that these defendants never saw plaintiff's daughter as a patient, nor did they ever provide any services to her indirectly, such as interpretation of test results. The only connection to plaintiff's daughter was that defendants electronically signed the records indicating that they were supervising the defendant-nurse on the days that she saw plaintiff's daughter. No evidence was produced to show that any of the defendant-physicians were consulted with regard to the daughter's treatment.

The court observed that a physician-patient relationship attaches either through direct contact or through a special relationship, such as conducting tests or interpreting results, such that a physician need not always come into contact with the patient. *Lenahan v. University of Chicago*, 348 Ill. App. 3d 155, 808 N.E.2d 1078 (1st Dist. 2004). In the instant case, defendant-physicians had no dealings whatsoever with plaintiff's daughter and never provided any services on her behalf. Therefore, the court held that the directed verdicts in favor of defendants were proper. *Smith v. Pavlovich,* ___ Ill. App. 3d ___, 914 N.E.2d 1258 (5th Dist. 2009).

**CDC guidelines establish standard of care for administering vaccine**

Plaintiff was admitted to defendant-hospital on January 1, 2000, and was seen by defendant-physicians, who diagnosed him with and treated him for a pneumococcal infection. At one point during plaintiff's treatment, defendant-physicians informally suggested that when his infection was completely resolved, plaintiff might consider availing himself of the pneumococcal vaccine Pneumovax. Plaintiff continued inpatient treatment, and subsequent to being released from the hospital, had follow-up visits with another defendant-physician. His last contact with this physician was on February 11, 2000. In June 2002, while under the care of a new physician, plaintiff was diagnosed with Streptococcus pneumoniae septicemia and aortic valve endocarditis, which required an aortic valve replacement.

Plaintiff filed suit against the defendant-hospital and physicians, alleging that the physicians negligently failed to administer the pneumococcal vaccine during his inpatient stay and/or his follow-up visits. He maintained that failure to administer the vaccine resulted in the 2002 infection as well as the endocarditis and subsequent aortic valve replacement, as well as a coronary artery bypass graft and future risk.

At trial, defendants testified that the prevailing standard of care regarding the pneumococcal vaccine is reflected in the guidelines set by the Centers for Disease Control (CDC), and that these guidelines did not suggest plaintiff had any heightened risk of contracting the disease again in the future on the basis of his prior infection, nor did he meet any other high risk criteria as delineated in the guidelines. In addition, the Phy-

sicians Desk Reference (PDR) warned against administering the vaccine to patients with an active infection, so it was actually contraindicated for plaintiff, and to administer the vaccine would have been against the standard of care. Each of defendants' expert witnesses concurred with this assessment.

Plaintiff's expert witnesses agreed with defendants that to administer the vaccine during an active infection would have been improper. Plaintiff's experts also testified, however, that plaintiff should have been given the vaccine on the basis of his prior infection, but neither expert was able to cite to any article or textbook to support this conclusion. The jury returned a verdict in favor of all defendants. Plaintiff moved for judgment notwithstanding the verdict, or alternatively, for a new trial. Both motions were denied.

The appellate court reviewed the decision on the motion for judgment notwithstanding the verdict *de novo*, and the decision to deny a new trial under the abuse of discretion standard. The appellate court observed that the evidence in this case overwhelmingly indicated that the CDC guidelines were the prevailing standard of care. Plaintiff's expert witnesses were unable to establish any alternative standard of care to support their opinion that plaintiff should have been administered the vaccine on the basis of his prior infection. In addition, both defendants and all expert witnesses agreed that to administer the vaccine during the course of an active infection would have been against the standard of care. The court stated that "where there is a 'classic battle of the experts', we should not usurp the function of the jury and substitute our judgment".

The court further opined that, even if the plaintiff had established a breach of the standard of care, he was unable to establish proximate cause. Plaintiff pointed to *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 679 N.E.2d 1202 (1997), to support his assertion that the alleged negligence in this case caused a loss of chance for a better result. The *Holton* court observed that the loss of chance doctrine refers to the resultant harm to a patient when medical negligence decreases the chance for recovery or increases the risk of harm. However, proximate cause still requires the plaintiff to prove that defendants' negligence "more probably than not" caused the injury. In the instant case, the court observed that no evidence was produced showing the 2002 infection and the endocarditis that resulted were more probably than not caused by defendants' failure to administer the vaccine in 2000. Furthermore, at trial, all expert witnesses had agreed that the vaccine is not 100% effective and only protects against a limited number of strains of the disease. Even if the vaccine had been administered, the court stated, plaintiff still could have become infected in 2002.

For these reasons, the appellate court held that the evidence overwhelmingly supported the defendants, so denial of plaintiff's motion for judgment notwithstanding the verdict was appropriate. In addition, the jury's verdict was not against the manifest weight of the evidence, and therefore the trial court did not abuse its discretion in denying plaintiff's motion for a new trial. *Matthews v. Aganad*, ___ Ill. App. 3d ___, 914 N.E.2d 1233 (1st Dist. 2009).

**Third District Appellate Court considers malpractice report requirements**

The Third District Appellate Court was recently asked to consider who is qualified to furnish the professional report called for in a malpractice action under 735 ILCS 5/2-622 and the right of a plaintiff to file a new report.

Plaintiff brought a medical malpractice suit against two defendants, a physical therapy assistant and a rehabilitation center alleging that plaintiff suffered injury through the defendant-therapy assistant's negligence in administering physical therapy. Plaintiff filed an attorney affidavit stating that he was unable to obtain the health professional consultation that was required by section 2-622 and that the statute of limitations was nearly expired; the trial court granted a 90 day extension to plaintiff. Thereafter, plaintiff filed a second attorney affidavit and a report submitted by a board-certified physician specializing in physical medicine and rehabilitation. This report was filed within the 90 day extension timeframe.

Both defendants filed motions to dismiss, stating that, since the report was written by a person with a different professional license than the defendant-physical therapy assistant, the report did not meet the requirements of section 2-622. Additionally, defendant argued that since the statute of limitations had expired and since plaintiff had used the allowed 90 day extension, that plaintiff should not be permitted to file any additional or supplemental reports.

In response, plaintiff filed a motion to file an amended attorney affidavit and a report written by a physical therapy assistant in order to meet the requirements of section 2-622. The trial court however granted defendants' motion to dismiss plaintiff's claim with prejudice, and also denied plaintiff's motion to file the amended affidavit and new report. The trial court found that plaintiff had not met the statutory requirements, that plaintiff was attempting to substitute a new report which was not timely filed rather than amend the existing report, and that the fatal defect in the original report could not be cured by amendment.

The appellate court examined the trial court's decisions for error using the abuse of discretion standard. Plaintiff argued on appeal that the central issue is whether he has a meritorious claim; since he does, the purpose of section 2-622 would be frustrated by the trial court's denial of his motion to amend the complaint. Plaintiff also argued that the statute does not bar allowance of amendments beyond the expiration of the 90 day extension period.

The appellate court observed that section 2-622 requires that a plaintiff file an attorney affidavit and a report written by a person in the same profession and holding the same license as the defendant,, stating that a meritorious claim exists. The statute allows for one 90 day extension if the statute of limitations would impair the action, but further extensions are not permitted unless plaintiff's counsel withdraws. The court also observed that the rule at common law is that "a medical malpractice plaintiff should be allowed every opportunity to establish his case and amendments to such complaints should be liberally allowed; technical rules should not bar the merits of a claim." *Avakian v. Chulengarian*, 328 Ill. App. 3d 147, 766 N.E.2d 283 (2d Dist. 2002). Additionally, the trial court may grant leave to file an amended complaint which includes a new affidavit and health professional report to rectify a defect in the original complaint. *McCastle v. Sheinkop*, 121 Ill. 2d 188, 520 N.E.2d 293 (1987).

The appellate court found that, since the purpose of section 2-622 is to prevent frivolous medical malpractice lawsuits, this purpose would not be undermined by allowing plaintiff to file his amended attorney affidavit and health professional report. Both of the health professionals that plaintiff consulted for reports agreed that his claim was meritorious; also, the defendant did not argue, and the trial court did not ascertain, that plain-

tiff's cause of action was without merit. The appellate court also found no evidence of bad faith as to the filing of the original, defective report. Plaintiff made clear that he was under the impression that a professional with greater qualifications than defendant would suffice under section 2-622; when the error was realized, plaintiff filed for leave to amend and obtained a proper report in a timely fashion. The court concluded that nothing in the record suggested that defendant would be prejudiced by allowing plaintiff to amend the complaint.

The court further opined that to bar plaintiff from amending affidavits and reports "would elevate the pleading requirements set forth in section 2-622 to a substantive defense contrary to both the spirit and purpose of the statute." The court therefore held that the trial court abused its discretion in denying plaintiff leave to amend the complaint and in dismissing the complaint with prejudice.

Justice Wright wrote an opinion in which she concurred specially. She noted how plaintiff had attempted to comply with the statutory guidelines, and upon realizing the error of the original report, had acted with due haste in correcting it. Justice Wright noted that "good faith should be rewarded, not discouraged" and that defendants' reliance on statutorily imposed deadlines acted against the purpose of the legislation by unfairly punishing a plaintiff who had acted with good faith. *Cookson v. Price,* 393 Ill. App.3d 549, 914 N.E.2d 229 (3d Dist. 2009). ■

## Illinois Medical Fee Splitting Statute amended to allow percentage billing contracts

*Continued from page 1*

vices, but that a subsequent administrative fee based on the volume of claims processed and the specialty of the physician did not violate Section 22(A)(14).[4]

Illinois courts interpreted the prior fee splitting statute to prohibit a broad range of business arrangements involving payment by a physician or physician group to a non-physician (and in some cases even to another physician) under a formula based on physician practice revenue or collections. In particular, Illinois appellate courts had held that Section 22(A)(14) and a predecessor statute prohibited the payment of a percentage of collections generated by promotional activities of a marketing firm,[5] a percentage of net income for management services and the referral of patients,[6] a percentage of future professional income as the purchase price for a medical practice,[7] and administrative fees directly related to professional revenues even when the fees are not calculated on a percentage basis.[8]

The prior fee splitting statute created particular concerns for Illinois physicians and medical billing companies. Compensation for billing services in Illinois, as well as other states, is typically based on a percentage of fees collected. In recent years, however, Illinois courts invalidated percentage billing arrangements under the medical fee splitting statute. For example, in *Center for Athletic Medicine, Ltd. v. Independent Medical Billers of Illinois, Inc.*,[9] the First District Appellate Court invalidated a percentage billing contract, leaving a contracting physician group with no remedy on its claim that the billing company breached the contract and caused over $4.4 million in damages. Thus, under the prior fee splitting prohibition, percentage billing contracts were widespread but were unenforceable in Illinois, so that neither the billing company nor the physician practice would have a remedy for breach by the other party. Furthermore, Illinois physicians who entered into the percentage arrangements could, at least in theory, face disciplinary exposure under the prior fee splitting statute.

### New Medical Fee Splitting prohibition

Public Act 96-0608 added a new provision (Section 22.2)[10] to the Illinois Medical Practice Act, setting forth the fee splitting prohibition and related exceptions. Subsection (a) of this new section sets forth the general fee splitting prohibition as follows:

> A licensee under this Act may not directly or indirectly divide, share or split any professional fee or other form of compensation for professional services with anyone in exchange for a referral or otherwise, other than as provided in this Section 22.2.

Section 22.2 also added a provision (subsection (f)) prohibiting the payment of a percentage of professional service fees, revenues or profits, or other payment based on a share of professional fees, for any of the following purposes, unless the payment is to owners or physicians of physician practice entities recognized under Section 22.2(c):

- Marketing or management of a physician practice;
- Including a physician on any preferred provider list;
- Allowing a physician to participate in any network of health care providers;
- Negotiating fees, charges or terms of service or payment; or
- Including the physician in a program providing an incentive for patients or beneficiaries to use a physician's services.

Section 22(A)(14) continues to provide that a fee splitting violation will be a ground for discipline, but now cross-references new Section 22.2, rather than setting forth the fee splitting prohibition directly.

Section 22.2 establishes four exceptions to the medical fee splitting prohibition. Subsections (b), (d) and (e) set forth exceptions for concurrent professional services, medical billing contracts and security interests in medical accounts receivable, respectively. Section 22.2(c) recognizes physician practice structures that are outside the scope of the fee splitting prohibition.

### Professional fees

A threshold issue relating to the medical fee splitting section is the scope of the "professional fees" and "professional services" that potentially implicate the fee splitting prohibition. These terms are not defined within Section 22.2.

Presumably, the terms "professional fees" and "professional services" are intended to apply to physician medical services and

closely related fees. This would be consistent with the Illinois Supreme Court's opinion in the *Vine Street* case regarding the prior medical fee splitting prohibition, which applied to fees for "professional services not actually and personally rendered." In that opinion, the Illinois Supreme Court interpreted "professional services" to mean medical professional services, and stated that it is impossible for nonphysicians to render "professional services" to a patient.[11] As the current fee splitting section omits the prior statutory reference to "actually and personally rendered" services and the Illinois Supreme Court's *Vine Street* discussion of the scope of "professional services" did not address ancillary services within a physician practice, it is possible that the current statute could be read to apply to a somewhat broader class of services that are performed within a physician practice even by nonphysicians.

Some uncertainty may arise when trying to apply the medical fee splitting prohibition to professional services of nonphysician professionals, as well as ancillary services, that are ordered or supervised by physicians and performed within a physician practice, such as therapy and nursing services, and perhaps even diagnostic tests. In some cases it may not be clear where to draw the line to determine when services performed by nonphysicians within a physician practice (or perhaps even by an affiliate) are deemed to be professional services and therefore potentially subject to the fee splitting prohibition.

When other professionals are involved, it may also be necessary to coordinate Section 22.2 with any relevant statutes regulating the nonphysician professionals involved. For example, prior to the passage of Public Act 96-0608, the Illinois Department of Financial and Professional Regulation had indicated that the fee splitting provision of the Physical Therapy Act may be interpreted to prohibit physical therapists from being employed by physicians. Moreover, it is possible that licensing statutes for other health care professionals may be revised.

## Concurrent professional services

Section 22.2(b) recognizes the right of licensed health care workers who concurrently render services to receive adequate compensation for their services, so long as the patient has full knowledge of the division and the division is in proportion to the services personally performed and the responsibility assumed. The prior statute contained a similar concurrent services exception, although it was limited to physicians.

## Percentage billing contracts

The new exception for medical billing arrangements is contained in Section 22.2(d), and allows payment by a physician (or physician practice) for billing, administrative preparation or collection services, but only if three conditions are satisfied. First, the billing company's compensation must be consistent with fair market value. Second, the physician or physician practice must control the amount of fees charged and collected. Third, all collections must either be paid directly to the physician (or physician practice) or deposited directly into an account in the name and under the sole control of the physician (or physician practice), or into a trust account by a licensed collection agency in compliance with the Illinois Collection Agency Act.

The fee splitting sections do not directly address the issue of whether billing contracts that were in existence prior to the August 24, 2009, effective date of Public Act 96-0608, survive. As medical percentage billing contracts were "void as against Illinois law"[12] prior to August 24, 2009, the revision is unlikely to create any remedy for breaches occurring prior to the effective date. If a billing company continues to provide services under a billing contract that was entered into prior to August 24, 2009, and the parties have not formally ratified or amended the agreement, it may be unclear whether the written contract continues to govern the billing arrangement between the parties. On the one hand, Section 22.2(d) provides that percentage fees are legal (at least when the three conditions of subsection (d) are satisfied), and the continuation of the relationship may be deemed to implicitly ratify the contract terms. On the other hand, percentage billing contracts were void under the prior fee splitting prohibition. Presumably, some remedy for breach would be available, although it is possible that the remedy may be more in the nature of quasi-contract or similar theories, rather than contract.

A cautious approach with respect to existing billing contracts may therefore be for the parties to execute either a new contract or a written adoption of the existing contract. A new or amended contract could also address any deficiencies that may prevent the contract from satisfying the percentage billing exception of subsection (d).

## Fee sharing within physician practice entities

Section 22.2(c) allows physician practice entities to pool, share, divide or apportion professional fees and other revenues. This subsection (c) recognizes that the following four categories of physician practice entities qualify for this exception: (1) entities owned entirely by Illinois-licensed physicians, (2) medical or professional corporations, professional associations and medical limited liability companies, (3) entities allowed by Illinois law to provide physician services or employ physicians (hospitals, hospital affiliates and physician-owned surgery centers are specifically referenced), and (4) entities that are combinations or joint ventures of the entities within categories (1) through (3) above.

Subsection (c) broadens the types of physician practice entities that are allowed to share professional fees without violating the fee splitting prohibition. The prior medical fee splitting section expressly recognized only medical and professional corporations, professional associations, medical limited liability companies and physician partnerships, as well as joint ventures and partnerships of medical corporations. The statute now also recognizes hospitals, hospital affiliates and physician-owned ambulatory surgery center, as well as entities owned solely by physicians and a catchall category of any other entities that are allowed under Illinois law to provide physician services or employ physicians.

Section 22(c) does not require any safeguards limiting control of a physician practice entity by nonphysicians or ensuring the professional independence of physicians. While some of the physician practice entities allowed under subsection (c) are required under separate statutes to be owned and controlled by physicians[13] or to implement safeguards to protect the professional independence of physicians,[14] subsection (c) allows a broader range of practice entities that may not be subject to similar requirements.

## Lending

Section 22.2(e) allows physicians to grant security interests in their accounts receivable or fees as security for bona fide advances, as long as the physician retains control and responsibility for collection of the accounts receivable and fees.

While subsection (e) of both subsections recognizes the right of physicians to grant security interests in physician accounts receiv-

able, these provisions create some potential concerns for healthcare lenders. Subsection (e) is limited to the granting of a security interest and requires the physician to retain control over accounts receivable. An open issue is whether this subsection will be interpreted to implicitly allow the creditor to exercise its rights under the security agreement to foreclose on accounts receivable and take control of the accounts, in spite of the requirement that the physician retain control over the collection of accounts receivable. It is also possible that factoring arrangements could be construed to violate the fee splitting restrictions under a literal reading of subsections (a) and (e).

## Optometry Fee Splitting Statute

Public Act 96-0608 also amended the fee splitting restriction for optometrists by adding Section 24.2 of the Optometric Practice Act.[15] This optometry fee splitting provision is generally similar to the medical fee splitting provision, although these sections differ in several ways.

Section 24.2 of the Optometric Practice Act includes additional exceptions allowing the payment of rent for the use of space and fair market value payments for the use of staff, administrative services, franchise agreements, marketing or the use of equipment. These exceptions appear to open the door for percentage arrangements in connection with optometry fees.

A second difference is that the phrase "whether or not the worker is employed" is part of the optometry subsection (b) exception for concurrent professional services. The inclusion of this phrase in the optometry fee splitting statute, but not in the medical fee splitting statute, could be construed to suggest that the conditions of this exception (that the patient have full knowledge of the division and that the division be in proportion to services rendered by each professional) must be satisfied even if the professionals are employed by the same optometry entity. Subsection (c), however, provides a broad exception that would appear to apply to most group practice or hospital employment relationships.

## General Implications

Public Act 96-0608 brings Illinois fee splitting law more in line with accepted practices within the medical billing industry and with the evolution of physician practice structures in Illinois. In addition to allowing percentage billing contracts, the bill also provides some needed clarification on the scope of the fee splitting prohibition. In particular, the new fee splitting prohibition expands and clarifies the types of physician practice organizations that are exempt from the fee splitting prohibition, recognizes that nonphysician professionals can receive adequate compensation for their concurrent services, and clarifies that security interests are allowed in physician accounts receivable and fees.

The fee splitting prohibition continues to prohibit a broad scope of business arrangements involving the payment of compensation to nonphysicians based on professional fees billed or collected. Medical percentage billing contracts that fail to satisfy all three conditions of subsection (c) will likely continue to violate the medical fee splitting prohibition.

While the new medical and optometry fee splitting provisions clarify some issues, significant areas of uncertainty remain in applying the fee splitting restrictions to some common physician business arrangements. As noted above, open issues exist with respect to the application of the fee splitting prohibition to professional services performed by nonphysician professionals who practice within physician entities and health care lending and factoring arrangements, as well as to the impact of the fee splitting revisions on existing medical billing contracts.

The Illinois Department of Financial and Professional Regulation ("IDFPR") has traditionally not made enforcement of the prior fee splitting prohibition a priority. It remains to be seen whether IDFPR may take a more aggressive enforcement position now that the statute has been clarified and now exempts various arrangements that are commonly accepted but were held to violate the prior fee splitting statute or could have been construed to fall within the scope of the prior prohibition. ■

---

*Rick L. Hindmand is a member of the law firm of McDonald Hopkins, LLC, Chicago, IL. He focuses his practice on representing physicians, dentists and other professional and closely held businesses in connection with corporate, transactional and health care matters. He can be contacted at 312-642-2203, rhindmand@mcdonaldhopkins.com.

1. 225 ILCS 60/22(A)(14), as in effect immediately prior to the effective date of Public Act 96-0608.

2. This article uses the term "physicians" to apply to all licensees (i.e., physicians and chiropractors) under the Medical Practice Act.

3. *Vine Street Clinic v. HealthLink, Inc.,* 222 Ill. 2d 276, 856 N.E.2d 422 (2006).

4. For a discussion of the *Vine Street* case, see Rick L. Hindmand and Michael J. Favia, *Vine Street's Impact on PPO/Doctor Business Arrangements*, 95 Ill. B. J. 366 (2007).

5. *E&B Marketing Enterprises, Inc. v. Ryan*, 209 Ill. App. 3d 626, 568 N.E.2d 339 (1st Dist. 1991).

6. *Practice Management Ltd. v. Schwartz,* 256 Ill. App. 3d 949, 628 N.E.2d 656 (1st Dist. 1993).

7. *Lieberman & Kraff, M.D., S.C. v. Desnick*, 244 Ill. App. 3d 341, 614 N.E.2d 379 (1st Dist. 1993).

8. *TLC The Laser Center, Inc. v. Midwest Eye Institute II, Ltd*., 306 Ill. App. 3d 411, 714 N.E.2d 45 (1st Dist. 1999).

9. 383 Ill. App. 3d 104, 889 N.E.2d 750 (1st Dist., 2008).

10. 225 ILCS 60/22.2.

11. *Vine Street*, 222 Ill.2d at 290-2, 856 N.E.2d at 432-3.

12. *Center for Athletic Medicine, Ltd.,* 383 Ill. App.3d at 112, 889 N.E.2d at 758.

13. For example, the Medical Practice Act and Limited Liability Company Act require ownership and management by physicians.

14. For example, Section 10.8 of the Illinois Hospital Licensing Act, 210 ILCS 85/10.8, requires hospitals and hospital affiliates that employ physicians to recognize the professional independence of their physicians and to establish independent review processes.

15. 225 ILCS 80/24.2.

# Upcoming CLE programs

*To register, go to www.isba.org/cle or call the ISBA registrar at 800-252-8908 or 217-525-1760.*

## January

**Wednesday, 1/06/10 – Webcast—**Illinois New Rules of Professional Conduct. Presented by the Illinois State Bar Association. 12-1. <https://isba.fastcle.com/store/seminar/seminar.php?seminar=2963>.

**Thursday, 1/07/10 – Webinar—**Conducting Legal Research on Fastcase. Presented by the Illinois State Bar Association. *An exclusive member benefit provided by ISBA and ISBA Mutual. Register at: <https://www1.gotomeeting.com/register/478190937> 12-1.

**Thursday, 1/14/10 – Webcast—**Mentor Training. Presented by the Illinois State Bar Association. 12-1.

**Friday, 1/15/10 – Rockford, Radisson Hotel & Conference Center—Inside Divorce Mediation.** Presented by the ISBA Alternative Dispute Resolution Section, Co-sponsored by the ISBA Family Law Section. Cap 50. 12:30-4:45.

**Wednesday, 1/20/10 – Webcast—**Illinois New Rules of Professional Conduct. Presented by the Illinois State Bar Association. 12-1. <https://isba.fastcle.com/store/seminar/seminar.php?seminar=2964>.

**Friday, 1/22/10– Chicago, ISBA Regional Office—**Meet the Agencies 2009. Presented by the ISBA Labor and Employment Section.

**Friday, 1/29/10 – Fairview Heights, Four Points Sheraton—**Illinois New Rules of Professional Conduct. Presented by the Illinois State Bar Association. 12:30-4:45.

**Friday, 1/29/10 – Chicago, ISBA Regional Office—**Back to Basics: Tort Law. Presented By the ISBA Tort Law Section.

## February

**Thursday, 2/04/10 – Webinar—**Advanced Research on FastCase. Presented by the Illinois State Bar Association. *An exclusive member benefit provided by ISBA and ISBA Mutual. Register at: <https://www1.gotomeeting.com/register/825343825>. 12-1.

**Friday, 2/05/10 – Chicago, ISBA Regional Office—**2010 Federal Tax Conference. Presented by the ISBA Federal Taxation Section.

**Friday, 2/05/10 – O'Fallon, IL, Regency Conference Center, Hilton Garden Inn—**Documenting the Commercial Deal: Loans, Leases and Mortgages. Presented by the ISBA Commercial Banking and Bankruptcy Section. Cap 75. 9-4:30.

**Friday, 2/05/10 – Normal, Bloomington – Normal Marriott—**Hot Topics in Agricultural Law. Presented by the ISBA Agricultural Law Section and Co – Sponsored by the ISBA General Practice Solo & Small Firm Section. Cap 150.

**Thursday, 2/11/10 – Chicago, ISBA Regional Office—**Charitable Planning: Techniques to Help Your Client. Presented by the ISBA Trust and Estates Section. 9-3:45. ■

HEALTH CARE LAW
ILLINOIS BAR CENTER
SPRINGFIELD, ILLINOIS 62701-1779
DECEMBER 2009
VOL. 26 NO. 2

Non-Profit Org.
U.S. POSTAGE
PAID
Springfield, Ill.
Permit No. 820