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MEDICAL MALPRACTICE TRIAL NOTEBOOK

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Chapter 18

INSURANCE COVERAGE/ BAD FAITH/ GOVERNMENTAL DEFENDANTS and GOVERNMENT REGULATION OF HEALTH CARE PROFESSIONALS

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I. INSURANCE COVERAGE

Insurance coverage is essential to the success of litigating medical malpractice claims that often prove both costly and complicated. It is important that medical malpractice plaintiffs name all proper individuals and entities as defendants and make comprehensive claims so that there is ample coverage for their injuries. Insurance coverage issues in medical malpractice cases generally arise in connection with a covered entity and its relationship to the other named parties.

In Illinois, some hospitals either self-insure or pool their risk by creating a trust with other not-for-profit hospitals. The majority of Illinois physicians participate in the physician-owned Illinois State Medical Inter-Insurance Exchange (ISMIE). Because an insurer's duty to defend is broader than its duty to indemnify, *Hartford Fire Ins. Co. v. Whitehall Convalescent and Nursing Home,* 321 Ill.App.3d 879, 748 N.E.2d 674 (1st Dist. 2001), at the earliest opportunity a plaintiff's attorney must seek disclosure of every insurance policy that might be applicable to provide additional coverage when the claim exceeds the limits of the primary policy.

A. Parties Covered

When preparing a complaint, plaintiffs should investigate every possible entity associated with the potential defendants. A case against the hospital may involve more than one entity, including a separate entity under which staff physicians are covered, such as a physicians' foundation. Also physicians will often have a practice affiliation as an employee or partner. Any one or more of these entities may be an insured entity that is obligated to indemnify the physician. Your search should begin by reviewing the medical bills and conducting an Internet search.

In *Chicago Hosp. Risk Pooling Program v. Illinois State Medical Inter-Insurance Exchange*, 397 Ill.App.3d 512, 925 N.E.2d 1216 (1st Dist. 2010), the physician was insured under his own ISMIE policy and as an employee under the hospital policy. After the case settled, the insurers battled it out over which policy held primary status. The court held that once the insured physician exclusively sought coverage from the hospital trust, the trust had the sole responsibility to defend and indemnify him. ISMIE's duty was to provide standby coverage in the event the trust refused to defend, and it was relieved of its obligation to defend and indemnify for the loss to the extent that the defense and indemnity costs did not exceed the trust's primary limits of liability. This is called the "targeted" or "selective" tender doctrine which provides that an insured covered by multiple insurance policies may target or select which insurer will defend and indemnify it with regard to a specific claim. *Am. Serv. Ins. Co. v. China Ocean Shipping Co. (Americas) Inc.*, 2014 IL App (1st) 121895. This doctrine is used to determine which insurer has the duty to defend when the insured is covered by multiple policies. *Id. See also AMCO Ins. Co. v. Cincinnati Ins. Co.*, 2016 IL App (1st) 160562-U on targeted tender.

But see Vedder v. Continental Ins. Co., 2012 Ill. App. (5th) 110583: "relying on *Chicago Hosp. Risk Pooling Program* [*CHRPP*], Standard Mutual argues that where a claim is made under a theory of *respondeat superior*, the employee has an absolute right to target tender her defense to her employer's insurer. Standard Mutual's reliance on *CHRPP* is misplaced. That case involved a targeted tender to co-primary insurer, not an excess insurer."

If a physician has changed employers it is key to ascertain the type of policy in effect at the time of the injury and the effective date of termination. A doctor was not covered by a "claims made" medical malpractice policy on the date he filed his claim where his employment was terminated prior to filing the claim. *Geisler v. Everest Nat. Ins. Co.*, 2012 IL App (1st) 103834, 980 N.E.2d 1170. He was notified he would no longer receive coverage under the policy and the policy was later amended to reflect the change. *Id.*

B. Agency Issues

(1) Actual Agency

A hospital is liable for the acts of its actual agents under a theory of *respondeat superior.* This includes all hospital staff members, physicians, nurses, orderlies, lab technicians, etc. When the hospital acts through its agents, there is likely to be no question of coverage under the hospital insurance policy.

A widow in a wrongful death action against a hospital and other health care providers, could not establish vicarious liability for a physician's negligence based on actual agency because the professional service agreement and bylaws did not enable the hospital to control the physician's work sufficiently to establish a principal-agent relationship. *Hammer v. Barth*, 2016 IL App (1st) 143066, *appeal denied,* 50 N.E.3d 1139 (Ill. 2016).

(2) Apparent Agency

Hospitals' attempts to evade liability through independent contractor relationships with physicians were derailed when the Illinois Supreme Court firmly established a hospital's vicarious liability for its apparent agents regardless of employment status. *Gilbert v. Sycamore Municipal Hosp.*, 156 Ill.2d 511, 622 N.E.2d 788 (1993). This issue is inextricably tied to insurance coverage issues depending on the how the policy defines "insured parties" under the insurance agreement.

A hospital may be vicariously liable for the negligence of a physician even if he or she is an independent contractor. *Gilbert, supra; York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill.2d 147, 854 N.E.2d 635 (2006). In order for a hospital to be vicariously liable for the negligence

of a independent contractor physician under a doctrine of apparent authority, a plaintiff must show: (1) the hospital or its agent acted in a manner that would lead a reasonable person to conclude that the physician alleged to be negligent was an employee or agent of the hospital; (2) that the hospital had knowledge of acts of the agent which created the appearance of authority, where there were such acts, and it acquiesced in them; and (3) the plaintiff acted in reliance on the conduct of the hospital or its agent, consistent with ordinary care and prudence. *Id.* On the other hand, if a patient knows or should have known that the treating physician was an independent contractor, then the hospital escapes liability for the physician's acts. *Id.*

In *Dahan v UHS of Bethesda, Inc.*, 295 Ill.App.3d 770, 692 N.E.2d 1303 (1st Dist. 1998), the court held a physician who had a contract with the hospital that specifically provided the physician was an independent contractor was still vicariously liable for his negligence where the physician's contract required him to see employees of the hospital, such as the plaintiff, free of charge. Indeed, the apparent agency question focuses on what the patient knows -- not what is contained in a contract buried in a hospital personnel file.

Hospitals cannot "hold out" independent contractor physicians as an employee or agent of the hospital and then deny responsibility for the physicians' conduct. *Lamb-Rosenfeldt v. Burke Medical Group, Ltd.*, 2012 IL App (1st) 101558. A plaintiff needs to show only that the hospital generally held itself out as a provider of care without informing the patient that the care was to be provided by an independent contractor. *York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill.2d 147, 854 n.E.2d 625 (Ill. 2006)

Hospital consent forms can be crucial to the evaluation of the "holding out" factor of an apparent agency claim. Illinois courts consider role of consent forms as almost conclusive in determining the holding out factor. *Mizyed v. Palos Cmty. Hosp.,* 2016 IL App (1st) 142790 *appeal denied*, (Ill. Sept. 28, 2016). The courts recognize when a patient signs a hospital consent form that contains clear and unambiguous language identifying the physicians and health care providers as "independent contractors" and disclaiming responsibility for their conduct, this can be an "important factor" to consider with regard to the "holding out" element. These courts have reasoned that it is unlikely a patient who signs such a form can reasonably believe her treating physicians are employees or agents of the hospital when the form contains specific language to the contrary. Whether the consent form is one which will allow or defeat the "holding out" element of the apparent agency claim is a subject of much debate. *Lamb-Rosenfeldt*, 2012 IL App at p. 27; See also, *Gilbert*, 156 Ill.2d at 524; *Wallace v. Alexian Brothers Medical Center*, 389 Ill.App.3d 1081,

907 N.E.2d 490 (1st Dist. 2009); *James v. Ingalls Memorial Hospital*, 299 Ill.App.3d 627, 701 N.E.2d 207 (1st Dist. 1998); *Spiegelman v. Victory Memorial Hospital*, 392 Ill.App.3d 826, 911 N.E.2d 1022 (1st Dist. 2009); *Frezados v. Ingalls Memorial Hospital*, 2013 IL App (1st 121835), 991 N.E.2d 817 (1st Dist. 2013); *Lloyd v. Wollin*, 2017 IL App (1st) 162546-U. However,

The court found the consent form sufficient like that in *Frezados.* It also rejected the plaintiff's public policy argument that the ruling was against the Illinois Supreme Court's emphasis on the realities of hospital business practices and is therefore against public policy. Rather the court found apparent agency in the context of all business practices, including hospitals, to be based on principles of estoppel. *Gore v. Provena Hosp.*, 2015 IL App (3d) 130446.

After examining the line of cases on apparent agency generally and consent forms specifically, the federal district court concluded that summary judgment for the hospital was proper where the patient executed essentially the same consent form three times before her admission date. The consent form at issue was deemed to unambiguously state, (1) physicians using the hospital's facilities are independent contractors, not hospital employees, (2) the physician will bill the patient "separately" for his or her services, and (3) those charges are in addition to the charges and billing for hospital facilities, supplies, and equipment. *Blanche v. United States*, 2015 WL 1396737 (N.D. Ill. 2015) *aff.* 811 F.3d 953 (7th Cir. 2016).

Defendant hospital attempted to rely on a consent form signed by the patient’s son to inform patients its emergency room physicians are independent contractors. Upon arrival to the hospital the patient was in respiratory distress, could not speak and was in urgent need of care. She was already brain dead and hypoxic and the negligent acts had occurred by the time her son signed the consent. The court affirmed the verdict in favor of the plaintiff that the ER physician was an apparent agent of the hospital. *Fragogiannis v. Sisters of St. Francis Health Services, Inc.*, 2015 IL App (1st) 141788, *appeal denied*, 50 N.E.3d 1139 (Ill. 2016).

In a case involving pre-natal care by a physician at an independent clinic, the court determined a hospital may be held liable under an apparent agency theory for the acts of an employee of an independent clinic that is not a party to the litigation. The evidence revealed the hospital promoted itself as a community-oriented hospital that collaborates with neighborhood centers like the clinic and publicized the relationship, on its website that linked to the clinic’s website calling it one of “Our Health Partners,” in annual reports, community service reports and other press releases, had hospital representation on the clinic board, offered financial

and other assistance and the parties were engaged in an affiliation agreement. *Yarbrough v. Northwestern Memorial Hospital*, 2016 IL App (1st) 141585, *appeal allowed* 65 N.E.3d 847 (November 23, 2016).

A native Arabic speaking patient who could not read in any language alleged medical negligence against a hospital for failure to prevent, recognize, and treat an infection he contracted in the hospital following coronary artery bypass surgery. The court affirmed summary judgment for the hospital based on the English-language consent forms signed by the patient to establish he had constructive notice that his physician was not an agent or employee of hospital. The hospital had no duty to determine the patient's education or to ensure his subjective understanding of the English language consent forms. The patient was put on notice by his adult daughter who understood English and acknowledged that she reviewed and encouraged her father to sign multiple consent forms containing the express disclosure that his treating physicians were not agents or employees of the hospital. *Mizyed v. Palos Cmty. Hosp.,* 2016 IL App (1st) 142790 *appeal denied*, (Ill. Sept. 28, 2016).

A widow in a wrongful death action raised a genuine issue of material fact on the elements of "holding out" and "justifiable reliance." The court held it is a question of fact whether the hospital held itself out as the provider of health care without informing patient that care was provided by independent contractors based on the following language that the court deemed ambiguous, "'*some or all* of the physicians who provide medical services" at the hospital "are not employees or agents of the hospital, but rather independent practitioners* *'" and "'[n]on-employed physicians *may* include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties.'" The court also factored in the hospital's website advertisement referring to its excellence and its "team of 1,000+ doctors…" The plaintiffs raised a question of justifiable reliance because they knew nothing of the doctor but sought treatment based on their doctor's recommendation. *Hammer v. Barth*, 2016 IL App (1st) 143066, *appeal denied,* 50 N.E.3d 1139 (Ill. 2016) (emphasis in original).

C. Institutional Negligence

It is most common to name a hospital in a medical malpractice case for the acts of its employees or agents based on vicarious liability. However, the hospital may also be liable for its negligent acts as an institution. Hospitals have an independent duty to assume responsibility for the care of their patients. *Darling v. Charleston Community Memorial Hospital,* 33 Ill.2d 326, 211 N.E.2d 253 (1965) and *Jones v. Chicago HMO Ltd. of Illinois*, 191 Ill. 2d 278, 291-92, 730 N.E.2d 1119 (2000) (extending institutional negligence to HMOs). Ordinarily this duty is administrative or managerial in character. *Id.* Institutional negligence is often

based on the implementation of a policy or procedure that is causally connected to the plaintiff's injuries. This theory may be key to triggering aggregate limits or invoking the hospital's insurance policy when it has successfully insulated itself from liability by maintaining its staff's independent contractor status.

A hospital was not institutionally negligent in credentialing a physician and allowing the physician to perform procedures. The court also failed to find evidence of institutional negligence in the hospital's conduct in obtaining the patient's informed consent or that it has a duty of care to determine all specialized equipment necessary to a procedure. Note the case epilogue wherein the court admonished counsel to seek summary judgment based on admissible evidence and to challenge any inadmissible evidence offered by the opposing party. *Essig v. Advocate BroMenn Medical Center*, 2015 IL App (4th) 140546.

D. Separate Negligent Acts: Multiple Claims vs. Single Occurrence

From the plaintiff's perspective, it is imperative to separately allege each and every act of negligence during the treatment of the plaintiff and ascertain all of the potentially applicable insurance policies available during the course of the negligent treatment, including successive policies. Obviously it is in the best interest of the insurer to maintain that the alleged malpractice constituted a single occurrence in order to limit the amounts available to satisfy the plaintiff's claim. It is up to the plaintiff to establish a succession of acts over a period of time that might expand the amounts available for plaintiff's recovery as arose in *Doe* below. An insured who commits separate negligent acts in the treatment of a single patient is amenable to multiple claims, and the aggregate limits of policies covering each act may be accessed for recovery. *Doe v. Illinois State Medical Inter-Insurance Exchange*, 234 Ill.App.3d 129, 139, 599 N.E.2d 983 (1st Dist. 1992). It is the causative events producing the damage that constitute actionable conduct, not the number of injuries. *Id.*

Whether the events would be characterized as a single or multiple occurrences is a question of causation. *Hartford Cas. Ins. Co. v. Medical Protective Co. of Fort Wayne, IN*, 266 Ill.App.3d 781, 787, 641 N.E.2d 545 (1st Dist. 1994). Where each of a series of related injuries flow from a single cause, it is a single occurrence. *Id.* Where each injury has an independent cause, there is a series of 'occurrences.' *Id.*

E. Policy Limits

The policy limits of the insured parties in a medical malpractice case can factor heavily into case strategy. As suggested above, it is important to ascertain all potential insurance policies as early as possible in the litigation to ensure that your claim has been completely stated in the complaint to invoke all properly applicable policies. This takes on even greater importance with catastrophic injuries for which insurance coverage may be deficient. Individual defendants will seek to limit their exposure as much as possible so no personal assets are at

risk. In Illinois a primary insurer may pay its entire policy limit in settlement of a single claim against a single insured without breaching any duties of good faith, even if, by this act, its other insured entities would be left without a defense or indemnification. *Chicago Hosp. Risk Pooling Program v. Illinois State Medical Inter-Insurance Exchange*, 397 Ill.App.3d 512, 528, 925 N.E.2d 1216 (1st Dist. 2010),

Policy limits also may factor heavily into bad faith claims (see Section II below) in situations where the defendant's insurer rejects a plaintiff's offer to settle within the policy limits thus leaving the insured exposed to liability for an award of damages in excess of the policy limits.

Illinois courts have concluded the provisional acceptance of the underlying insurer's offer to pay policy limits is a clear demonstration that its limits have been exhausted albeit, not formally paid. *Cincinnati Ins. Co. v. Estate of Chee,* 12-3236, 2015 WL 4978711 (C.D. Ill. Aug. 20, 20150.

On appeal, the Seventh Circuit affirmed the federal district court to the extent that it requires the insurer to defend the interests in the suit between the estate and the medical defendants, but reversed the rest of the decision finding that the insurer's duty to defend did not depend on the primary insurer's payment of its applicable policy limits. *Cincinnati Ins. Co. v. Estate of Chee*, 826 F.3d 433 (7th Cir. 2016).

F. Policy Exclusions

If the insurer relies on an exclusionary provision that the policy's exclusion prevents coverage the exclusionary provision must be clear and free from doubt. *Hartford Fire Ins. Co. v. Whitehall Convalescent and Nursing Home, Inc.,* 321 Ill.App.3d 879, 888, 748 N.E.2d 674 (1st Dist. 2001) (fraudulent billing and representations regarding charge for prescription drugs and pharmaceuticals constitutes "medical incident" under policy that provided coverage for the rendering of professional medical treatment to nursing home residents).

Insurers may also succeed in raising policy exclusions for the sexual misconduct of a physician. *See Illinois State Medical Ins. Services, Inc. v. Cichon*, 258 Ill.App.3d 803, 629 N.E.2d 822 (3rd Dist. 1994).

G. Insurer's Duty to Defend

A duty to defend arises from and is limited by the language in the insurance contract. *Chicago Hosp. Risk Pooling Program v. Illinois State Medical Inter-Insurance Exchange*, 397 Ill.App.3d 512, 925 N.E.2d 1216 (1st Dist. 2010).

The duty to defend is broader than the duty to indemnify. *Hartford Fire Ins. Co. v. Whitehall Convalescent and Nursing Home,* 321 Ill.App.3d 879 (1st Dist. 2001).

In a case brought by a patient who was sexually assaulted by the insured's employee during an ultrasound, the court found the insurer had no duty to defend under a professional malpractice policy against claims of negligent hiring, investigation and supervision. *American Family Mutual Ins. Co. v. Enright*, 334 Ill.App.3d 1026, 781 N.E.2d 394 (2d Dist. 2002) The court found the patient's claims did not involve "professional services" but were based on administrative acts that had nothing to do with the insured's professional training, skill, experience or knowledge as a sonographer. *Id.* at 1035.

On the other hand, in *Nat'l Fire Ins. Co. v. Kilfoy*, 375 Ill.App.3d 530 (1st Dist. 2007) a patient injured as a result of eye surgery alleged, among other claims, the facility was "negligent in its hiring, *administrative* supervision, and *business* operation." *Id.* (emphases in original). The court found that the complained-of activities constituted "professional services" for insurance purposes. *Id.* at 536. Unlike *Enright*, the court found the allegations giving rise to the underlying plaintiff's negligent hiring claim did not involve a mere failure to take administrative precautions but instead implicated the facility's failure to employ specialized knowledge and skill to ensure prospective employees were qualified to render medical services. *Id.* at 535–36. These allegations go to the heart of the insured's principal business operation and the way in which the insured exercises business judgment. *Id.* at 536.

See also Rosalind Franklin Univ. of Med. & Sci. v. Lexington Ins. Co., 2014 IL App (1st) 113755, *reh'g denied* (May 7, 2014) (primary focus of underlying complaint consists of activity involving specialized medical knowledge thus bringing it within the ambit of the professional liability policies and the medical malpractice exclusion contained in the institution's directors and officers' liability policy.)

A medical malpractice insurer had no duty to defend a claim until the insured hospital paid the $2.5 million retained limit pursuant to the self-insured retention (SIR) clause. *Geisler v. Everest Nat. Ins. Co.*, 2012 IL App (1st) 103834, 980 N.E.2d 1170. The doctor did not have a right to consent to settlement of the medical malpractice action by the insurer because the policy conferred settlement consent rights only to the general counsel of the named insured. *Id.* The doctor was not a named insured under the policy, and the hospital, which was the named insured, waived its right to consent to settle. *Id.*

H. Insurer in Liquidation − Plaintiff's Rights and Options

If a defendant's insurance carrier becomes insolvent and is in liquidation, the plaintiff's cause is not a total loss. The plaintiff may recover, at least in part, from various entities.

(1) Guaranty Fund.

The Illinois Insurance Guaranty Fund provides a source of partial recovery to claimants who suffer the misfortune of having a covered defendant's insurance company become insolvent during litigation. Once an insurance carrier is placed in liquidation, the Fund assumes responsibility for the obligations of the insurance company to Illinois claimants and named insured entities, subject to the limitations and conditions of the statute. 215 ILCS 5/537.4. The Fund provides substitute coverage when expected coverage ceases to exist subject to the limits of the statute. *Claudy v. Commonwealth Edison Co.,* 255 Ill.App.3d 714, 732, 626 N.E.2d 1088 (1st Dist. 1993) *rev'd on other grounds,* 169 Ill.2d 39 (1995).

The plaintiff must first exhaust his rights under any other available coverage before he or she is entitled to any payments from the Fund. 215 ILCS 5/546(a). Any amount payable by the Fund will be reduced by the amount recoverable under the other insurance coverage. *Id. See also Rogers v. Imeri*, 2013 IL 115860, 999 N.E.2d 340. Failure to timely pursue the claim or to exhaust other available coverage may reduce the amount that otherwise would be payable by the Fund. *Urban v. Loham,* 227 Ill.App.3d 772, 778, 592 N.E.2d 292 (1st Dist. 1992).

The Insurance Guaranty Fund sued a health care clinic's liability insurer for declaratory judgment that its claims-made policy provided coverage for a physician who was no longer employed by the clinic. Reversing summary judgment in favor of the Fund, the Fifth Circuit ruled the physician was not an insured and was not entitled to a defense. The insured was not required to exhaust the clinic's policy prior to payment by the Fund; nor was the insurer estopped from raising a coverage defense. *Illinois Ins. Guar. Fund v. Chicago Ins. Co.*, 2015 IL App (5th) 140033.

(2) Other Entities.

The plaintiff may also proceed against the insolvent impaired carrier. However, if the plaintiff chooses to file a claim with the liquidator, this filing operates as a release of the insured's liability to the plaintiff on the cause of action up to the amount of the applicable policy limits. 215 ILCS 5/537.4.

(3) Individual Defendants.

The plaintiff may also pursue the personal assets of the defendants insured by the insolvent carrier.

(4) Stay of Proceedings

The Insurance Code allows all proceedings arising out of a claim with coverage under an insurance policy written by an insolvent company to be

stayed for 120 days from the date of entry of the order of liquidation. 215 ILCS 5/551.

II. BAD FAITH

Bad faith claims can arise when an insurer wrongly turns down an offer of settlement within the policy limits. 215 ILCS 5/155. The bad faith lies in the insurer's failure to give at least equal consideration to the insured's interests when making the decision on whether to settle. *O'Neill v. Gallant Insurance Co.*, 329 Ill.App.3d 1166, 1172, 769 N.E.2d 100 (5th Dist. 2002). After a jury renders a verdict in excess of the insured medical provider's policy limits, the insured may file a bad faith claim on his own behalf against his insurer. *See Scroggins v. Allstate Insurance Co.,* 74 Ill.App.3d 1027, 393 N.E.2d 718 (1st Dist. 1979)). *See also Leyshon v. Diehl Controls North America, Inc.*, 407 Ill.App.3d 1, 21, 946 N.E.2d 864 (1st Dist. 2010), bad faith finding warranted in *O'Neill* where the court found repeated misconduct by the insurer toward its insured within the confines of one claim and that the insurer had engaged in a pattern of conduct over a five-year period of refusing to settle cases, resulting in excess judgment against the insurer's Illinois customers, other than the plaintiff.

Since the bad faith of an insurance company exposes insurance companies to substantial extra-contractual damages over and above the policy limits, including attorneys' fees, Plaintiff's attorneys should be vigilant about exposing and rooting out insurer bad faith. This includes identifying a policy limits case as early as possible in the process and issuing a policy limits demand letter with a firm deadline for response. Steer clear of imposing an unreasonably short deadline that calls into question plaintiff's good faith. *See Meixell v. Superior Ins. Co.*, 230 F.3d 335 (7th Cir. 2000). While the defense bar calls this a "set-up," when the circumstances warrant it is actually strong advocacy on behalf of the plaintiff that is particularly important in cases where the insurance policy may not provide a sufficient recovery for injured victims. It also gives plaintiffs a stronger bargaining position on such claims.

Discovery of evidence to support a bad faith claim may include the personnel files of claims adjusters. *Surgery Ctr. at 900 N. Michigan Ave., LLC v. Am. Physicians Assurance Corp., Inc.*, 317 F.R.D. 620, 623 (N.D. Ill. 2016).

A. Elements of a Bad Faith Claim

In pleading a claim for bad faith refusal to settle within the policy limits, the plaintiff must allege sufficient facts to establish a reasonable probability of both recovery in excess of the policy limits and a finding of liability against the insured. *Powell v. American Service Insurance Co.*, 2014 IL App (1st) 123643, 7 N.E.3d 11. The mere fact that an insurance company was unsuccessful in the trial of a case does not establish that its defense was made in bad faith. *Id.*

(1) Duty.

Insurance providers have a duty to act in good faith in responding to settlement offers from third party plaintiffs. The basis for bad faith claims is the insurer's failure to put its insured's interests ahead of its own. *Cramer v. Insurance Exchange Agency,* 174 Ill.2d 513, 675 N.E.2d 897. 473 (1996).

(2) Breach.

The insurer breaches its duty through fraud, negligence, or bad faith as assessed according to a reasonable person standard. Illinois courts have identified the following factors relevant to the insurer's breach of duty:

(a) Insurer's refusal to negotiate. *Cernocky v. Indemnity Insurance Company of North America,* 69 Ill.App.2d 196, 216 N.E.2d 198 (2d Dist. 1966)).

(b) Advice of defense counsel. *Olympia Fields Country Club v. Bankers Indemnity Insurance Co.,* 325 Ill.App. 649, 60 N.E.2d 896 (1st Dist. 1945).

(c) Advice from the insurance company's adjusters. *Phelan v. State Farm Mutual Automobile Insurance Co.,* 114 Ill.App.3d 96, 448 N.E.2d 579 (1st Dist. 1983).

(d) Communication with the insured making the insured fully aware of the plaintiff's willingness to settle for the policy limits. *Bailey v. Prudence Mutual Casualty Co.,* 429 F.2d 1388, 1390 (7th Cir. 1970).

(e) An inadequate investigation and defense, *Ballard v. Citizens Casualty Company of New York,* 196 F.2d 96, 102 (7th Cir. 1952).

(f) The significant possibility of an adverse verdict. *Central Illinois Public Service Co. v. Agricultural Ins. Co.,* 378 Ill.App.3d 728, 880 N.E.2d 1172 (5th Dist. 2008).

(g) The potential for damages to exceed the policy limits. *Id.*

(3) Proximate Cause and Damages.

The breach must be a legal cause of the harm to the insured, such as the imposition of personal liability to satisfy the excess verdict. The entry of the excess judgment against the insured constitutes damage sufficient to permit recovery by the insured. *Adduci v. Vigilant Insurance Co.,* 98 Ill.App.3d 472, 424 N.E.2d 645, 648 (1st Dist. 1981) *Cf. Central Illinois Public Service Co. v. Agricultural Ins. Co.*, 378 Ill.App.3d 728, 880 N.E.2d 1172 (5th Dist. 2008).

The plaintiff failed to show how a delay in payment of defense costs pursuant to a medical malpractice policy caused any damages. *Geisler v. Everest Nat. Ins. Co.*, 2012 IL App (1st) 103834, 980 N.E.2d 1170.

B. Insurer's Potential Defenses to a Bad Faith Claim

(1) Bona Fide Coverage Dispute.

To argue that it had a good faith belief that there was no coverage in the case the insurer must have defended the suit under a reservation of rights or sought a declaratory judgment of no coverage. Otherwise, if the insurer is found to have wrongfully denied coverage, it is estopped from raising this defense in a bad faith claim. *Employers Insurance of Wausau v. Ehlco Liquidating Trust,* 186 Ill.2d 127, 147-48, 708 N.E.2d 1022 (1999); *Uhlich Children's Advantage Network v. National Union Fire Co. of Pittsburgh, PA*, 398 Ill.App.3d 710, 929 N.E.2d 531 (1st Dist. 2010). *But see Santa's Best Craft, L.L.C. v. Zurich American Insurance Co.*, 408 Ill.App.3d 173, 941 N.E.2d 291 (1st Dist. 2010) where insurer satisfied its duty to defend plaintiffs under a reservation of rights, despite its belief that the insurance policy did not provide coverage by permitting plaintiffs to choose their own legal counsel to defend them in the underlying action and to reimburse plaintiffs for reasonable defense expenses. The insurer paid half the amount of the invoice submitted immediately while it reviewed the reasonableness of the charges. It did not withhold payment as a way of undermining the defense strategy; rather, the insurer objected to charges for which there was insufficient documentation and to charges that went beyond the scope of coverage for the underlying lawsuit as the circuit court ultimately found.

An insurer is only required to show a bona fide dispute. It does not have to show that every scintilla of evidence pointed against the wrongful conduct, or that the evidence it compiled was overwhelming or conclusive. The question at the summary judgment stage is whether the insurer had a real, genuine basis for disputing the plaintiff's scenario. *Illinois Founders Ins. Co. v. Williams*, 2015 IL App (1st) 122481.

(2) No Action Against Insurer by Insured.

A "no-action provision" contained in ISMIE policies did not defeat a bad faith claim because it is unfair to enforce such a position if ISMIE breached its good faith duty to settle and exposed its insured to personal liability despite the case having not been tried. *SwedishAmerican Hosp. Ass'n of Rockford v. Illinois State Medical Inter-Ins. Exchange,* 395 Ill.App.3d 80, 916 N.E.2d 80 (2nd Dist. 2009).

(3) No Opportunity to Settle Within Policy Limits.

An insurer may raise this defense if the plaintiff has made no demand. Once the plaintiff's attorney has made an assessment of the case and has discovered all available insurance information, the plaintiff should send a written correspondence to the insurer (a.k.a. a "bad faith letter") expressly offering to settle the case within the policy limits. The bad faith letter should include the facts supporting the likelihood of recovery and the damages that will likely exceed the policy limits. It is prudent to give the insurer a reasonable deadline to response. This letter may be sent at any time before the verdict is rendered, but the earlier, the better. A bad faith claim may rise or fall on this communication. Insurers are generally not required to initiate settlement negotiations but such an obligation may arise in special circumstances, particularly when the probability of an adverse finding on liability is great and the amount of probable damages would greatly exceed the coverage limits. *Haddick v. Valor Insurance,* 198 Ill.2d 409, 763 N.E.2d 299 (2001).

Any duty to settle owed by a lower-tiered excess insurer to higher-tiered excess insurers was not implicated where the higher-tiered insurers did not allege that there was a reasonable probability of damages above the lower-tiered insurer's policy limits and dismissal was proper. *W. Bend Mut. Ins. Co. v. Zurich Am. Ins. Co.,* 2016 IL App (1st) 150810-U *appeal denied,* (Ill. Sept. 28, 2016).

(4) Comparative Bad Faith.

This defense to bad faith claims has not been adopted by Illinois courts.

C. Punitive Damages

Punitive damages may be available in bad faith claims. *O'Neill v. Gallant Insurance Co.,* 329 Ill.App.3d 1166, 769 N.E.2d 100 (5th Dist. 2002).

D. Statute of Limitations

The statute of limitations for bad faith claims is five (5) years from the date of the entry of the judgment against the insured under 735 ILCS 5/13-205. *Chandler v. American Fire and Cas. Co.*, 377 Ill.App.3d 253, 879 N.E.2d 396 (4th Dist. 2007).

E. Assignment of Claim to Plaintiff

Medical providers who do not want to risk exposure of their personal assets may enter into an agreement assigning their bad faith claim to the plaintiff in a medical malpractice claim. *See Dienstag v. Margolies*, 396 Ill.App.3d 25, 919 N.E.2d 17 (1st Dist. 2009). This is obviously more beneficial to the insured medical provider as it shifts the risk of recovering the excess amount of the award entirely

to the plaintiff while completely lifting the burden from the medical provider to come up with the money from personal assets. In situations where the insured is insolvent or has limited assets, this may be the only avenue of recovering the entire award. *NOTE: Terms of the assignment, including its timing can be very important to the outcome. This is an area of law that truly requires special expertise. It is highly recommended that novices obtain co-counsel with such expertise.*

III. GOVERNMENTAL DEFENDANTS

An action against a governmental defendant presents certain procedural and substantive obstacles to a plaintiff pursuing a medical malpractice claim. Both the Federal Tort Claims Act and the Illinois Local Governmental and Governmental Employees Tort Immunity Act can be virtual minefields of immunities and bureaucratic frustrations for victims of professional medical negligence.

A. Federal Tort Claims Act (FTCA)

Defendants in FTCA claims for malpractice are generally healthcare providers employed at federally-funded facilities such as Veteran's hospitals, public health services, prisons and various clinics that may not be obviously associated with the federal government. ***BEWARE****: There are a number of clinics that are partially or completely funded by the federal government, thereby subject to the FTCA. They are likely to be staffed by doctors who qualify as employees of the federal government and are also subject to the FTCA. See http:findahealthcenter.hrsa.gov/Search_HCC.aspx for a listing of clinics at which these doctors practice.*

A plaintiff should be cognizant of the following procedural requirements of filing a malpractice action against the U.S. government in federal court. *See generally* 28 U.S.C. §§ 2671-2680.

(1) Statute of Limitations.

The FTCA statute of limitations applies. This is a two-year statute - no tolling for minors or disabled persons. In 2014 the Seventh Circuit recognized a new standard for claim accrual under the FTCA. A plaintiff's medical malpractice claim against the federal government accrues when either, (1) the individual becomes subjectively aware of the government's involvement in the injury, or (2) the individual acquires information that would prompt a reasonable person to inquire further into a potential government-related cause of the injury, whichever happens first. *E.Y. ex rel. Wallace v. United States*, 758 F.3d 861, 866 (7th Cir. 2014).

A plaintiff may invoke the FTCA savings clause to extend the limitations period so long as the plaintiff, (1) filed a civil suit concerning the

underlying tort claim within two years of its accrual, and (2) presented that case to the appropriate federal agency within 60 days of the civil suit's dismissal. *See* 28 U.S.C. § 2679(d)(5). Plaintiff's civil suit was four years prior the filing of her administrative claim and she failed to present any administrative claim to the federal government until five years after she filed her lawsuit indicating she was aware of the government's involvement. *Watkins v. United States*, No. 15-CV-8350, 2016 WL 1435704 (N.D. Ill. Apr. 12, 2016) *aff.* 854 F.3d 947.

A plaintiff's claims do not accrue against *all* doctors involved in her pregnancy when a birth injury occurs and the plaintiff reasonably suspects that it was caused by a doctor either during delivery *or* during her prenatal care, they are distinct in time and place. However, the claims against the prenatal care providers accrued shortly after the birth of the child based on their failure to discover the baby's large size and recommend a C-section where evidence showed the plaintiff consulted with an attorney a few weeks after delivery and gave testimony indicating a subjective belief that the injury to her daughter may have been caused by her prenatal care. *Blanche v. United States*, 811 F.3d 953 (7th Cir. 2016) (emphasis added).

See further detail in Chapter 2, Statute of Limitations.

(2) Other Procedural Requirements.

The following are relevant provisions of the FTCA and FRCP.

The United States shall be liable, respecting the provisions of this title relating to tort claims, in the same manner and to the same extent as a private individual under like circumstances but shall not be liable for interest prior to judgment or for punitive damages. 28 U.S.C. § 2674.

While the FTCA waives the government's sovereign immunity and provides that the federal government is liable to the extent it would be liable under state law, there are some exceptions. For example, no suit can be brought for medical malpractice arising out of injuries that occurred in the military. *Selbe v. United States*, 130 F.3d 1265 (7th Cir. 1997).

An action shall not be instituted upon a claim against the United States for money damages for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, unless the claimant shall have first presented the claim to the appropriate Federal agency and his claim shall have been finally denied by the agency in writing and sent by certified or registered mail. 28 U.S.C. § 2675(a).

A tort claim against the United States shall be forever barred unless it is presented in writing to the appropriate Federal agency within two years after such claim accrues or unless action is begun within six months after the date of mailing, by certified or registered mail, of notice of final denial of the claim by the agency to which it was presented. 28 U.S.C.A. § 2401(b).

The failure of an agency to make final disposition of a claim within six months after it is filed shall, at the option of the claimant any time thereafter, be deemed a final denial of the claim for purposes of this section. The provisions of this subsection shall not apply to such claims as may be asserted under the Federal Rules of Civil Procedure by third party complaint, cross-claim, or counterclaim. 28 U.S.C.A. § 2675(a).

Action under this section shall not be instituted for any sum in excess of the amount of the claim presented to the federal agency, except where the increased amount is based upon newly discovered evidence not reasonably discoverable at the time of presenting the claim to the federal agency, or upon allegation and proof of intervening facts, relating to the amount of the claim. 28 U.S.C.A. § 2675(b).

The district courts . . . shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages, accruing on and after January 1, 1945, for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred. 28 U.S.C.A. § 1346(b)(1).

Any action against the United States under section 1346 shall be tried by the court without a jury . . . 28 U.S.C.A. § 2402.

Upon certification by the Attorney General that the defendant employee was acting within the scope of his office or employment at the time of the incident out of which the claim arose, any civil action or proceeding commenced upon such claim in a United States district court shall be deemed an action against the United States under the provisions of this title and all references thereto, and the United States shall be substituted as the party defendant. 28 U.S.C.A. § 2679(d)(1).

Upon certification by the Attorney General that the defendant employee was acting within the scope of his office or employment at the time of the incident out of which the claim arose, any civil action or proceeding commenced upon such claim in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States for the district and division embracing the place in

which the action or proceeding is pending. Such action or proceeding shall be deemed to be an action or proceeding brought against the United States under the provisions of this title and all references thereto, and the United States shall be substituted as the party defendant. This certification of the Attorney General shall conclusively establish scope of office or employment for purposes of removal. 28 U.S.C.A. § 2679(d)(2).

Whenever an action or proceeding in which the United States is substituted as the party defendant under this subsection is dismissed for failure first to present a claim pursuant to section 2675(a) of this title, such a claim shall be deemed to be timely presented under section 2401(b) of this title if--
(A) the claim would have been timely had it been filed on the date the underlying civil action was commenced, and
(B) the claim is presented to the appropriate Federal agency within 60 days after dismissal of the civil action.
28 U.S.C.A. § 2679(d)(5).

Otherwise state court defendants may be joined in one action as defendants if:
(A) any right to relief is asserted against them jointly, severally, or in the alternative with respect to or arising out of the same transaction, occurrence, or series of transactions or occurrences; and
(B) any question of law or fact common to all defendants will arise in the action.
Fed. R. Civ. P. 20.

Punitive damages are not recoverable. 28 U.S.C. § 2674.

B. State Tort Immunity Act

The Local Governmental and Governmental Employees Tort Immunity Act (the Illinois Tort Immunity Act), 745 ILCS 10/1-101 *et seq.*, addresses the liabilities and immunities of public entities at the state and local level. It was enacted to "protect local public entities and public employees from liability arising from the operation of government." 745 ILCS 10/1-101.1(a). A "local public entity" is an entity formed pursuant to the Illinois Constitution or the Intergovernmental Cooperation Act, as well as any not-for-profit corporation organized to conduct public business. *Carroll v. Paddock*, 199 Ill.2d 16, 764 N.E.2d 1118 (2002). Public business is the business of government and a local public entity must either be owned by or operated and controlled by a local governmental unit. *Id.* Immunity under the Illinois Tort Immunity Act only attaches to liability arising from the operation of government. 745 ILCS 10/1-101.1.

A public "employee" includes a present or former officer, member of a board, commission or committee, agent, volunteer, servant or employee, whether or not

compensated, but does not include an independent contractor. 745 ILCS 10/1-202. *See Wheaton v. Suwana,* 355 Ill.App.3d 506, 511, 823 N.E.2d 993 (5th Dist. 2005) (listing eight factors a court must consider when determining whether a defendant is an independent contractor vs. a public employee); *see also Thede v. Kapsas*, 386 Ill.App.3d 396, 400, 897 N.E.2d 345 (3d Dist. 2008) ("right to control" is the most important of the eight factors).

A plaintiff should consider challenging a defendant's claim to local public entity status under the Illinois Tort Immunity Act where appropriate. To that end, plaintiffs should deny this allegation in answering any affirmative defenses asserting immunity under the Act. Additionally, plaintiffs should conduct discovery to establish whether the defendant receives state funding, whether it is operated or controlled by a local governmental entity, or whether it conducts public business. For a detailed analysis of what constitutes "public business" see *O'Toole v. Chicago Zoological Soc.,* 2014 IL App (1st) 132652.

(1) Parties.

Parties who enjoy the benefits of the Illinois Tort Immunity Act include healthcare professionals employed at state healthcare facilities, such as hospitals or prisons, as well as city and county public health facilities and hospitals, and the entities themselves.

(2) Statute of Limitations.

The Illinois Tort Immunity Act generally prescribes a one year statute of limitations for personal injury claims, but actions for injury or death against any local public entity or employee involving patient care may be brought up to two years "after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of those dates occurs first, but in no event shall such an action be brought more than 4 years after the date on which occurred the act or omission or occurrence alleged in the action to have been the cause of the injury or death. 745 ILCS 10/8-101(b).

The two-year statute of limitations does not begin to run for a minor until the minor reaches the age of eighteen. *See, e.g. Ferguson v. McKenzie,* 202 Ill. 2d 304, 780 N.E.2d 660 (2001) (holding similarly when the Illinois Tort Immunity Act statute of limitations was one year).

Medical negligence claims under the Illinois Tort Immunity Act are subject to a four-year statute of repose. 745 ILCS 10/8-101(b).

A high school student's personal injury action against the school district and the board of education filed after the former student turned 18 years old was subject to the one-year limitations period under the Local Government and Governmental Employees Tort Immunity Act for claims against a local government entity and its employees, rather than the two-year limitations period for filing an action that accrued when the party was under 18 years old when the cause of action accrued. *Lee v. Naperville Cmty. Unit Sch. Dist. 203*, 2015 IL App (2d) 150143, *appeal denied,* 48 N.E.3.

(3) Immunities.

The Illinois Tort Immunity Act provides certain specific (and arguably anomalous) immunities to state or local governmental entities that provide medical care and services to patients.

(a) Failure to Examine or Diagnose.

There is immunity for injury caused by the failure to make a physical or mental examination, or to make an adequate physical or mental examination of any person for the purpose of determining whether such person has a disease or physical or mental condition that would constitute a hazard to the health or safety of himself or others. 745 ILCS 10/6-105. *See Wilkerson v. County of Cook*, 379 Ill.App.3d 838, 884 N.E.2d 808 (1st Dist. 2008); *Mabry v. County of Cook,* 315 Ill.App.3d 42, 733 N.E.2d 737 (1st Dist. 2000).

Section 6-106(a) of the Illinois Tort Immunity Act provides that no public entity or employee is liable for "injury resulting from diagnosing or failing to diagnose that a person is afflicted with mental or physical illness or addiction or from failing to prescribe for mental or physical illness or addiction." 745 ILCS 10/6-106. Thus where a plaintiff essentially alleges that a public entity fails to diagnose an illness, it is immune under Section 6-106(a) of the Illinois Tort Immunity Act. *See Michigan Ave. Nat. Bank v. County of Cook*, 191 Ill. 2d 493, 732 N.E.2d 528 (2000). *See Lipsey v. U.S.*, No. 12-2100, 2013 WL 757652 (C.D. Ill. January 2, 2013) (in denying motion to dismiss the court found that plaintiff's allegations could not be distilled into either a failure to examine or diagnose an

inmate's pregnancy and complications, but rather plaintiff alleges the defendants inadequately responded to and treated plaintiff's pregnancy of which they were aware. Court later granted summary judgment to Kane County, 2016 WL 7209433).

The court found the Local Governmental and Governmental Employees Tort Immunity Act, 745 ILCS 10/6–101 *et seq.,* immunized Stroger (Cook County) Hospital from the plaintiff's medical malpractice claims based on an emergency room visit where the plaintiff's decedent suffered cardiac arrest after being triaged by the staff. The court found triage does not constitute diagnosis and treatment, rather the cardiac monitor is a diagnostic tool and the hospital's failure to place the patient on it is protected. *Lockhart v. County of Cook*, 2015 IL App (1st) 141352-U.

(b) Negligent Treatment.

Section 6-106(d) however, provides that "[n]othing in this section exonerates a public employee from liability for injury proximately caused by his negligent or wrongful act or omission in administering any treatment prescribed for mental or physical illness or addiction or exonerates a local public entity whose employee, while acting in the scope of his employment, so causes such an injury." 745 ILCS 10/6-106. The Illinois Tort Immunity Act does not immunize defendants from liability for the negligent prescription or administration of *treatment*, of a patient, as opposed to the misdiagnosis of a patient. *Mills v. County of Cook*, 338 Ill.App.3d 219, 788 N.E.2d 169 (1st Dist. 2003). *Cf. Willis v. Khatkhate*, 373 Ill.App.3d 495, 505 (1st Dist. 2007) where the court held the failure of the defendant to actually treat the decedent triggered application of the immunity (despite the defendant's failure to accurately diagnose) as distinguished from *Mills* where the court held there is no immunity for a defendant where the plaintiff alleges an employee working for a public entity correctly examines and diagnoses the patient but negligently treats him, causing injury.

Similarly, acts of omission in administering treatment are not afforded immunity under the Illinois Tort Immunity Act. *American National Bank & Trust Co. of Chicago v. County of Cook*, 327 Ill.App.3d 212, 762 N.E.2d 654 (1st

Dist. 2001). Once diagnosis of a medical condition is made and treatment of the condition is prescribed and undertaken, any subsequent prescription or examination required to be made pursuant to that condition is part of the patient's treatment. *Id.*

The limited immunity provision in the Emergency Medical Services (EMS) System Act (EMS Act) (210 ILCS 50/1 *et seq.*) governs over sections 6–105 and 6–106 of the Tort Immunity Act. *Abruzzo v. City of Park Ridge,* 231 Ill.2d 324, 348, 898 N.E.2d 631 (2008) (plaintiff's verdict at trial after remand affirmed in *Abruzzo v. City of Park Ridge*, 2013 IL App (1st) 122360). The EMS Act controls because it is the more specific and more recent statute. *Id.* The provision of emergency medical services includes preparatory actions integral to providing emergency treatment; and assessment and evaluation are integral to providing emergency medical services. *Id.* at 345. The court held the immunity provision of the EMS Act applied to the allegations in plaintiff's complaint because "[t]he failure to assess or examine is an 'omission' in providing emergency medical services under our interpretation of the immunity provision [in the EMS Act]." *Id.*

See also Lockhart v. County of Cook, 2015 IL App (1st) 141352-U above.

In an action against emergency room physicians and Stroger Hospital alleging negligence, negligent infliction of emotional distress, and violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), a patient alleged a physicians' failure to diagnose a spinal cord injury and misdiagnosis and treatment of muscle spasm and back or buttock contusion. The hospital and physicians were found to be immune, the doctors had no duty to believe the patient or accept the sincerity of her complaints and the hospital provided the patient with appropriate medical screening. The EMTALA applied to the hospital but it did not violate the EMTALA when it failed to stabilize the patient's spinal cord injury prior to discharge. *Johnson v. Bishof*, 2015 IL App (1st) 131122, *reh'g denied* (June 22, 2015).

IV. GOVERNMENTAL REGULATION OF HEALTHCARE PROFESSIONALS

Depending on the facts of the case, a medical malpractice settlement or judgment may impact the professional future of a healthcare professional. Once a judgment or settlement has been paid, immediate reporting requirements come into play that may impact the medical practice and/or professional reputation of a physician. Illinois requires reporting of payments to the National Practitioner Data Bank (NPDB) and the Illinois Department of Financial and Professional Regulation (IDFPR).

A physician is also required to disclose the outcome of all malpractice claims to hospitals, professional societies, managed care providers and insurers. These reporting requirements may provide valuable information to plaintiffs in investigating the professional record and reputation of defendants as well as medical expert witnesses. Since this information is integral to the physician credentialing process, it may also be useful in making ancillary claims against hospitals and medical institutions based on their hiring and retention of certain physicians.

A. National Practitioner Data Bank

Congress created the National Practitioner Data Bank (NPDB), 42 U.S.C. § 11101, *et seq.,* a national database operated by the Secretary of the U.S. Department of Health and Human Services. The payment of a settlement in a malpractice claim or satisfaction of a judgment in a cause of action based on malpractice must be reported to the NPDB. 42 U.S.C. §11131(a). The primary purpose of the NPDB is to create and maintain a national database of state medical licensing disciplines and malpractice settlements and judgments to prevent physicians from concealing this information.

By compiling a database with physician-specific information, this system makes each malpractice award, settlement, or disciplinary action by a hospital or state licensing agency readily available to state medical licensing agencies and hospitals regardless of where in the country the physician might attempt to relocate his practice. This information is not readily available to the public.

B. Illinois Dept. of Financial and Professional Regulation (IDFPR)

The IDFPR is the state agency that issues medical licenses to professionals and has the authority to discipline physicians and affect their medical licensure in Illinois. Under the Illinois Medical Practice Act (IMPA) insurers must report a settlement or judgment in a medical malpractice case to IDFPR. 225 ILCS 60/23(A)(3). A physician is also required to file a mandatory report when he or she settles a medical liability case that is not covered by an insurance company. 225 ILCS 60/22(A)(36).

PLEASE NOTE: The Illinois Medical Practice Act of 1987 is set for repeal on December 31, 2019.

C. Medical Disciplinary Board

Under the IMPA, the Medical Disciplinary Board (MDB) is responsible for evaluating qualifying reports and submitting the results of its findings to the IDFPR. *See* 225 ILCS 60/1 *et seq.* The following institutions must report to the MDB when certain events have occurred.

(1) Healthcare institutions.

A healthcare institution must report the termination or restriction of any provider's clinical privileges based on a final determination that the practitioner has either committed an act(s) that may directly threaten patient care or such a provider may be mentally or physically disabled in such a manner as to endanger patients under the provider's care. If the provider accepts voluntary termination or restriction of clinical privileges when formal proceedings have been initiated, this must also be reported. 225 ILCS 60/23(A)(1).

(a) Clinical training programs.

Effective December 30, 2013, the program director of any post-graduate clinical training program shall report to the Disciplinary Board if a person engaged in a post-graduate clinical training program at the institution, including, but not limited to, a residency or fellowship, separates from the program for any reason prior to its conclusion. The program director shall provide all documentation relating to the separation if, after review of the report, the Disciplinary Board determines that a review of those documents is necessary to determine whether a violation of this Act occurred. 225 ILCS 60/23(A)(1.5).

(2) Professional Associations.

The president or CEO of a professional association or society must report to the MDB when it renders a final determination that a person has committed unprofessional conduct related directly to patient care or that a person may be mentally or physically disabled in such a manner as to endanger patients under that provider's care. 225 ILCS 60/23(A)(2).

(3) Professional liability insurers.

Every insurance company that offers policies of professional liability insurance to a practitioner licensed under the MPA must report to the

MDB the settlement of any claim or cause of action, or final judgment rendered in any cause of action, that alleged negligence in the furnishing of medical care by the licensed person when the settlement or final judgment is in favor of the plaintiff. 225 ILCS 60/23(A)(3).

(4) Prosecutors.

The State's Attorney must report to the MDB all instances in which a practitioner is convicted or otherwise found guilty of the commission of any felony. 225 ILCS 60/23(A)(4).

(5) State agencies.

All agencies, boards, commissions, departments, or other branches of the State government must report to the MDB any instance in which a practitioner has either committed an act or acts that may be a violation of the MPA or that may constitute unprofessional conduct related directly to patient care or that indicates that a practitioner licensed under the MPA may be mentally or physically disabled in such a manner as to endanger patients under that practitioner's care. 225 ILCS 60/23(A)(5).

D. Public Access to Reported Information

The public has access to some of the information garnered in the reporting and disciplinary process. Information reported to the National Practitioner Data Bank is not freely available to the public. On the other hand, after a determination is made by the Illinois MDB, the information is placed in the IDFPR newsletter and made available to the public. The database that lets Illinois consumers check the malpractice history of thousands of Illinois doctors and chiropractors can be found at https://www.idfpr.com/applications/professionprofile/default.aspx. This searchable database includes about 46,000 doctors and 4,500 chiropractors, along with malpractice judgments and settlements going back ten years.

The Illinois Department of Professional Regulation website also lists disciplinary action in its licensing database and provides a summary report of the action to anyone who inquires about that practitioner with the payment of a fee. 225 ILCS 60/23(F). Additionally, this information may be available through various media outlets that collect and store such information like jury verdict and settlement reporters or through Westlaw or LEXIS/NEXIS services.

E. Use of Public Reports in Litigation

The professional record of a healthcare professional may prove useful in prosecuting a medical malpractice case. For instance, a party was able to elicit the fact that a physician expert cannot practice medicine without supervision as it is "highly relevant" to the expert's credibility on the issue of whether other

physicians exercised the appropriate standard of medical care. *Creighton v. Thompson*, 266 Ill.App.3d 61, 639 N.E.2d 234 (1st Dist. 1994).

Conversely, disciplinary information may also prove detrimental to a plaintiff. Thus licensing information should be gathered for all practitioners involved in the litigation including parties, treating healthcare practitioners and medical experts on both sides of the case.

Evidence of a physician expert's letter of reprimand from the IDPR for a failure to diagnose was admissible as relevant to his qualifications and credibility as an expert and physician. *Cetera v. DiFilippo*, 404 Ill.App.3d 20, 934 N.E.2d 506 (1st Dist. 2010).

The Medical Practice Act provides that its reporting requirements will not act in any way, to waive or modify the confidentiality of medical reports and committee reports to the extent provided by law. 225 ILCS 60/23(B). Any information reported or disclosed shall be kept for the confidential use of the MDB, the coordinators and MDB attorneys, the medical investigative staff, and authorized clerical staff. *Id. See* 735 ILCS 5/8-2101 *et seq*.