Medical Litigation Newsletter

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In This Issue

Hospital Peer Review and Quality Improvement Privileges: A Multistate Survey

Hospital medical staff departments, and quality assurance departments and committees, often collect and maintain information and documents relevant to pending medical malpractice litigation. An occurrence which becomes the subject matter of litigation often has been reviewed by quality or peer review committees. Also, medical staff members or other personnel are subject to a credentialing process during the appointment or reappointment of privileges at a facility. This process generates a collection of information and documents that may also be relevant in litigation. Counsel representing plaintiffs are becoming more aggressive in seeking out credentialing, peer review and quality assurance materials. Defense counsel must consequently be familiar with the protections provided under state law for information and documents related to critical quality improvement processes.

This article includes a short summary of some protections provided for peer review and quality assurance materials in a sampling of jurisdictions across the United States. Of course, each circumstance is factually specific and counsel should be consulted before the production of any information or documents that may be protected under state law. This article addresses current law in Arizona, Florida, Illinois, Indiana, Missouri and Wisconsin. Hinshaw & Culbertson LLP maintains offices in these and other jurisdictions and our experienced practitioners are often called upon to advise clients on these issues and, if necessary, to present arguments to a court. Counsel must presume that the presiding court is unfamiliar with the privilege and must stress the policy reasons behind the protection where it exists. With limited exceptions, state legislatures have encouraged a full and frank peer review and credentialing process by protecting certain documents and information collected and used in those processes.

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Hinshaw Representative Matters

We are pleased to report the following:

Michael P. Russart of Hinshaw's Milwaukee, Wisconsin office represented a health care provider in a Medicare audit and obtained a partially favorable verdict from the administrative law judge (ALJ). Medicare claimed that based upon the inadequacy of the provider's records, the provider was overpaid by more than $103,000. Medicare had instituted collection actions to recover the overpayments. The health care provider appealed, and the collections were stayed. After a hearing, the ALJ ruled that the health care provider was entitled to payment of nearly $37,000. During the appeal, the health care provider submitted to record reviews and audits by a Medicare contractor. Now, the health care provider has a fully compliant electronic record keeping system which will guard against future audits and overpayment liabilities.

Gregory T. Snyder and ***Jennifer L. Johnson*** of Hinshaw's Rockford, Illinois office secured summary judgment for a hospital system client that operates a health club. Plaintiff, one of the health club's members, slipped and fell on water near the pool's edge, sustaining several fractures. She consequently sued the health system. The health club member had signed an exculpatory agreement that barred her from bringing a claim for injury due to accidents at the facility, but she claimed the water on the pool deck was a condition beyond the parameters of the exculpatory

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Arizona

By: Darrell S. Dudzik, Phoenix

The Arizona health care quality assurance and immunity statutes can be found in the Arizona Revised Statutes under "Public Health and Safety," Chapter 25, Article 1. In Arizona, written standards and criteria are to be made available to all health care providers who are subject to, or otherwise involved in, a quality assurance process. If a health care provider furnishes records or information as a part of the process and does so *without malice,* such provider is not subject to legal action or civil damages. "Malice" is defined as "evil intent and outrageous, oppressive, or intolerable conduct that creates a substantial risk of tremendous harm to others." Malice is to be determined by the court and must be based on a finding from "clear and convincing" evidence.

All information considered in the review process is confidential and not subject to subpoena or order to produce. Further, a provider may not be called to testify concerning information provided or testimony given as part of a quality assurance process. The confidentiality provisions do not apply when an "aggrieved" health care provider brings a claim against a health care entity. The provisions further will not be found to affect a patient's right to claim privilege or privacy or prevent disclosure of records if they are otherwise subject to discovery.

Florida

By: Paul J. Gamm, Ft. Lauderdale

In Florida, post-occurrence peer review or quality review performed by a hospital or other health care provider is no longer privileged from production in a civil suit. In November 2004, Florida voters amended the Florida Constitution, providing an inherent right to know about adverse medical incidents. Many viewed this amendment to be a significant change from existing case law and Florida statutes with regard to quality assurance review and privilege regarding medical incidents. After much debate as to the application of the amendment to past and current cases, the Florida Supreme Court issued a series of opinions addressing these concerns.

Florida Hospital Watermen, Inc. v. Buster, 984 So. 2d 478 (Fla. 2008), was the first such opinion addressing the constitutional amendment repealing peer review quality assurance privilege. Prior to November 2004, Florida statutes specifically provided a privilege for hospital medical review committees pertaining to staff membership as well as incident reporting. These statutes specifically stated that the investigations, proceedings and records "*shall not*" be subject to discovery or introduction into evidence in any civil action against the provider, administrator or health services professional. Notwithstanding the privilege regarding the investigations, proceedings and records, both statutes indicated that the information was not immune from discovery, and that no person who helped compile the information should be prevented from testifying. As such, while the documents, proceedings and records of the investigations were privileged, the witness' fact knowledge regarding the incident was not. Notwithstanding the distinction, the statutes were used to prevent discovery of the entire process and, more often than not, prevented some fact witness testimony.

In *Buster*, the Supreme Court of Florida found that the constitutional amendment abrogated the statutory protections afforded the documents, records and proceedings for peer review quality assurance investigation.

While *Buster* appeared to implement by opinion the full force and effect of the November 2004 constitutional amendment, the Supreme Court's reasoning included that the information was essentially readily available all along. However, until the amendment's implementation, no court was willing to compromise what it perceived the legislative intent in protection of quality assurance and peer review investigation in medical privileges or hospital administrative matters. As such, from that point forward, quality assurance and peer review was no longer privileged, and instead became completely and fully discoverable during a civil suit.

There have been several attempts to limit the unfettered access provided by amendment—some successful, some not. First, the Supreme Court of Florida in 2008 clarified the scope of the constitutional amendment and to whom it applies. Specifically, in *Benjamin v. Tandem Health Care, Inc*., 998 So. 2d 566 (Fla. 2008), the Court found that the constitutional amendment providing access to adverse medical incidents and previously privileged quality assurance information did not apply to nursing homes or skilled nursing facilities as it did not fall within the definition of health care facility or health care provider. Specifically, the constitutional amendment defined "health care facility" and "health care provider" as having meaning given in general law related to a patient's rights and responsibilities. The Supreme Court of Florida found that the phrase "patient's rights and responsibilities" was consistent with Fla. Stat. § 381.026, which provided a definition for "health care facility" and "health care provider." Under those definitions, "health care facility" was defined as a facility licensed under Fla. Stat. ch. 395, pertaining to hospitals and outpatient surgery centers, and "health care provider" was defined as physicians licensed under Fla. Stat. ch. 458-459 or podiatrists licensed under Fla. Stat. ch. 461. As such, because nursing homes were not contained within the definition of "health care facility" or "health care provider," they were exempt from the constitutional amendment's repeal of privilege. This opinion is particularly important as many potential medical malpractice defendants may be not only hospitals or surgery centers, but nursing homes, home health care facilities or other medical centers that do not fall within the definition granted in this constitutional exercise and abrogation of privilege. It also appears that based on *Benjamin*, retail pharmacies would likewise receive the benefit of that interpretation and be excluded.

Most recently, the Supreme Court of Florida found that the federal Health Care Quality Improvement Act of 1986 (HCQIA) does not preempt Florida's constitutional right to know of adverse medical incidents. *West Florida Regional Medical Center, Inc. v. See*, 2012 WL 87282 (Fla. Jan. 12, 2012). Specifically, the Court found that the HCQIA provided immunity from damages to any peer body and those reporting to it. The HCQIA was meant to encourage physicians to participate in professional peer review and protect those who participated from liability. The Court found that the HCQIA does not provide for confidentiality of any of the peer review records or communication. The HCQIA provides immunity from civil

clause. Finding that water on a pool deck was a condition well within the scope of dangers that ordinarily accompany pool usage, the court entered summary judgment in favor of the health care system.

Dawn A. Sallerson and ***Jason K. Winslow*** of Hinshaw's Belleville, Illinois office obtained dismissal, in part, of a complaint alleging medical malpractice against defendant doctor in a case pending in Wabash County, Illinois. The original complaint alleged that the doctor transected the patient's spinal accessory nerve during a surgical procedure. After expiration of the statute of limitations and the statute of repose periods, plaintiff, the patient, filed an amended complaint adding a claim regarding the doctor's alleged failure to obtain the informed consent of the patient before the surgical procedure. Defense counsel successfully argued that the amended set of facts, which involved what the doctor purportedly said or did not say in the pre-surgical consultation phase of treatment, was a separate transaction or occurrence for purposes of the relation back doctrine than that set forth in the original complaint, which related to the doctor's alleged surgical acts or omissions. The court ruled that the relation back doctrine did not save the otherwise time-barred amended claim, focusing specifically on the patient's failure to establish that, either through the allegations in the original complaint or other evidence in the record, the doctor was put on notice that his alleged failure to obtain the informed consent of the patient was at issue in the case. As a result, the court granted the doctor's motion to dismiss as to the informed consent claim.

action to those who participate, but it does not provide for confidentiality. Additionally, the HCQIA specifically states that it will not preempt or override any state law, nor shall the Act be construed as effecting any rights and remedies afforded patients under state law. Finally, the HCQIA is silent with regard to a confidentiality privilege, which reflects the intent of Congress not to provide the same. As such, the HCQIA does not provide any additional remedy or ability for health care facilities or providers in keeping the quality assurance and peer review investigations privileged from production in a civil suit.

Illinois

By: Charles A. Egner, Joliet

In Illinois, protection of peer review and quality assurance materials is provided under the Illinois Medical Studies Act (IMSA), found at 735 ILCS 5/8-2101 and 735 ILCS 5/8-2102 of the Illinois Code of Civil Procedure.

The IMSA provides protection for any materials initiated, created, prepared or generated by a peer review committee. The entity asserting the privilege has the burden of proof in the argument concerning its application. If counsel for a patient or claimant presses for the documents or information at issue, it becomes appropriate for a court to make a determination as a matter of law after *in camera* inspection of the materials.

Analyzing the IMSA's purpose provides some guidance as to what will be protected. The act's purpose is to ensure that members of the medical profession effectively engage in self evaluation in the interest of advancing the quality of health care. It is founded upon the concern that without such protection, physicians and other care providers would be reluctant to sit on review committees and engage in frank and honest evaluations of their colleagues. To encourage full and frank consideration of the quality of care provided by a peer, courts have focused on that "consideration" itself. In general, the protection extends to the materials that are used in the course of the review process, but not those documents or the information collected or generated before the process begins or after it ends.

In addition to analyzing the time of creation of the document or collection of the information, courts will also analyze the nature and content of the materials that a facility contends should be protected. The Appellate Court for the First District of Illinois, in *Webb v. Mount Sinai Hospital and Medical Center*, 347 Ill. App. 3d 817, 807 N.E.2d 1026 (1st Dist. 2004), decided that the lower court's decision to order the production of multiple memoranda from a director of risk management to a risk management committee was based in part upon the labeling of those documents as prepared "in anticipation of litigation and identification of issues of liability." While the documents at issue also included references to peer review and quality improvement, the court held that they were not generated solely for quality assurance and peer review and therefore were not protected under the IMSA.

The reason for the generation of the materials at issue is therefore a critical factor in the determination as to whether the privilege applies. In general, peer review of a specific case should be protected from discovery. In *Ardisana v. Northwest Community Hospital*, 342 Ill. App. 3d 741, 795 N.E.2d 964 (1st Dist. 2003), the First District Appellate Court reviewed the lower court's decision to order the production of a quality management worksheet prepared for the surgical quality audit committee and minutes of the committee meetings during which the patient's care was discussed. Also at issue was a letter from the chairman of the audit committee to a physician requesting additional information about plaintiff's care. The appellate court protected those materials generated during the course of the case review, including the peer review committee minutes, the quality management worksheets and the letter to the physician requesting additional information. The *Ardisana* court also held that the recommendations made by the audit committee were protected from discovery. The court carefully distinguished recommendations of a review committee from "ultimate decisions" taken at the facility. Recommendations by a committee will be protected, but "ultimate decisions" made, or actions taken by the entity (including revocation, modification, a restriction of privileges, letters of resignation, or revision of rules, regulations, policies and procedures), will not be.

These timing and content issues are also analyzed in the credentialing context. For example, transcripts, applications and other documents voluntarily submitted for the purpose of obtaining privileges at a facility are generally not protected. The same is true concerning the list of privileges granted, modifications of privileges, and restrictions or revocations. Such materials are prepared before, or generated after, the protected process.

Application of the privilege is fact-specific. A determination as to whether protection exists is made only after analysis of: the purpose for which the document was created or reviewed; the intended audience for the document or collected information; and whether the review process had been initiated or completed at the time that the document was generated or the information collected and reviewed.

Indiana

By: Scott B. Cockrum and Nathan D. Hansen, Northwest Indiana

All proceedings of a peer review committee are confidential in Indiana. Moreover, all communications to a peer review committee are considered privileged communications. However, the governing board of a hospital may disclose the final action taken with regard to a health care provider without violating the provisions of the peer review statute.

Under Ind. Code § 34-30-15-2, any person attending a peer review committee proceeding shall not be permitted to disclose any: (1) information acquired in connection with or in the course of the proceeding; (2) opinion, recommendation or evaluation of the committee; or (3) opinion, recommendation or evaluation of any committee member. However, any information that would otherwise be discoverable (such as medical records) does not become confidential merely by its use in the committee proceeding.

No records, determinations of, or communications to a peer review committee shall be subject to subpoena or discovery, or admissible in evidence, in any judicial or administrative proceeding. A limited waiver of the peer review privilege can occur during investigations of a health care provider by the Indiana Attorney General; however, this waiver must be executed in writing. The statute also provides broad immunities to participants in the peer review process and to the decisions made by the peer review committee.

For decades, Indiana courts have strictly applied the peer review statute in protecting the confidentiality of peer review proceedings. As discussed in *Terre Haute Reg'l Hosp., Inc. v. Basden*, 524 N.E.2d 1306, 1311 (Ind. Ct. App. 1988), the purpose of the peer review privilege is to foster an effective review of medical care, which requires that all participants in the peer review proceedings "communicate candidly, objectively, and conscientiously." The *Basden* court reasoned that absent the peer review privilege, the effectiveness of the peer review process would be hindered.

Since 2001, two Indiana Court of Appeals decisions have discussed what is and what is not admissible with regard to peer review proceedings, specifically in the context of impeachment of a physician. *Fridono v. Chuman*, 747 N.E.2d 610 (Ind. Ct. App. 2001); *Linton v. Davis*, 887 N.E.2d 960 (Ind. Ct. App. 2008).

In *Fridono*, plaintiff presented expert testimony of a physician at trial and questioned the expert regarding his qualifications and credentials. On cross-examination, the expert denied that his privileges at a specified medical school had ever been restricted or modified. To impeach plaintiff's expert, defendant presented a letter that imposed restrictions on his privileges as a result of a peer review process. While references to the peer review committee and process were redacted, the specific restrictions placed on the expert were not. The trial court denied plaintiff's motion *in limine* to preclude defendant from using the letter at trial. The court of appeals discussed the conflict in the peer review statute at Ind. Code § 34-30-15-1 and Ind. Code § 34-30-15-9, and whether final actions of peer review proceedings can be used in judicial proceedings. The court concluded that "determinations of" a peer review committee are distinct from the "final action taken" by a hospital as a result of peer review proceedings. Further, the court found that the results of a peer review process (including modification, restriction and termination of privileges) are outside the scope of the privilege, reasoning that disclosure of the results of a peer review proceeding is consistent with the purpose of the privilege: "to encourage candor by the medical personnel on the committee."

The court of appeals in *Linton* applied *Fridono* in allowing a physician who provided an expert opinion to be impeached with the physician's licensure status. The issue in *Linton* revolved around whether the trial court erred in admitting into evidence testimony regarding the proceedings and rulings of the Indiana Medical Licensing Board in its investigation of defendant physician. The court concluded that the board's specific findings regarding the care of a particular patient are not admissible in a judicial proceeding.

Missouri

By: Terese A. Drew, St. Louis

In Missouri, the protection of documents and information related to review of care provided to a patient is governed by Mo. Rev. Stat. § 537.035. That section indicates that "interviews, memoranda, proceedings, findings, deliberations, reports, and minutes of peer review committees" are not subject to discovery. It prevents discovery of any of the proceedings of review, but specifically provides that information otherwise discoverable—for example the testimony of a treating physician regarding the treatment—is not immune simply because it was presented in the course of a peer review process.

In *Faith Hospital v. Enright*, 706 S.W.2d 852, 654 SW2d 889 (Mo. 1983) the Supreme Court of Missouri held that the protection extends to credentials committees if the findings and deliberations of the committee are

specifically in regard to health care provided patients. However, in recent cases, such as *Kirksville Missouri Hospital Company, LLC v. Jaynes*, 328 S.W.3d 418 (Western District 2010), Missouri courts have found that a report requested by a peer review committee and reviewed by that committee and prepared by a third party is not protected from discovery. The *Jaynes* court focused on the language of the statute requiring that the findings and deliberations specifically concern the health care provided a patient. The underlying matter involved allegations of negligent credentialing of a physician. As with the other jurisdictions addressed in this article, Missouri law therefore requires a close examination of the factual situation in conjunction with the state's law in determining whether a privilege can be successfully claimed.

Wisconsin

By: Michael P. Russart, Milwaukee

In Wisconsin, the protections afforded health care providers for peer reviews are codified in Wis. Stat. §§ 146.37 - .38.

Wis. Stat. § 146.37 provides civil immunity for individuals acting in good faith participating in the review or evaluation of health care providers' services or facilities, as long as the review is conducted in connection with any program organized or operated to help improve the quality of health care or to avoid improper utilization of health care providers' services or facilities. In other words, individuals who participate in peer review or utilization review for health care providers and act in good faith are not liable for damages resulting from any act or omission occurring during the course of the review or evaluation.

Wis. Stat. § 146.38 provides confidentiality to information acquired in connection with formal peer reviews or evaluations. However, individuals are required under Wisconsin law to testify or provide information about facts known to them from events in which they participated or witnessed separate from any knowledge learned solely from a formal peer review or evaluation. For example, a treating physician is required to testify about his or her care and treatment even if the care was the subject of peer review. The treating physician should not testify about anything he or she learned solely through the peer review process.

Recent amendments strengthened the scope of Wis. Stat. § 146.38 for health care providers. After February 1, 2011, incident and occurrence reports may no longer be used in any civil or criminal action against a health care provider. Wis. Stat. § 146.38 (2m). Previously, an incident or occurrence report not written for the express purpose of a peer review or evaluation was not protected by the peer review privilege. Merely presenting a previously drafted incident or occurrence report during a peer review or evaluation did not cause the document to become protected by operation of the peer review confidentiality provision.

The Wisconsin legislature has defined incident or occurrence report as "a written or oral statement that is made to notify a person, organization, or an evaluator who reviews or evaluates the services of health care providers or charges for such services of an incident, practice or other situation that becomes the subject of such a review or evaluation." Whether any such document will be considered an incident or occurrence report will depend on the circumstances under which it was created and the manner in which the document is used. Wisconsin health care providers should be cognizant of the definition provided by the legislature and revise or create policies or procedures to reduce the likelihood that such reports are admissible in future court actions against health care providers.

The recent legislative changes also introduced protection for health care providers from the use of certain reports in civil or criminal actions against them. These include reports required by the Wisconsin Department or its divisions responsible for regulation and licensing or quality assurance activities related to health care providers or statements of, or records of interviews with, employees of a health care provider related to the regulation of the health care provider and obtained by the regulatory agency. Those reports and statements gathered by the regulatory agency may still be used in any administrative proceeding conducted by a regulatory agency.

Conclusions

Counsel should be consulted regarding any specific information or documents and whether such are protected under a peer review or quality assurance privilege. Our offices are aggressive in protecting such materials when requested in the course of civil litigation. However, protection of the materials begins long before the materials are sought by opposing counsel. The relationship between the materials that are claimed privileged and a committee functioning in a peer review or quality assurance capacity is critical to protection under the law. Peer review and quality improvement meetings should be clearly identified as such. Individuals involved in the process should be made aware of the protections claimed under the applicable state law. Documents created or requested or reviewed by the functioning

committee should be marked as confidential. The process itself should be focused on quality improvement or peer review and every attempt should be made not to mix the purposes of the meetings with other nonprivileged business of the facility or committee. All of the involved individuals should be made aware that the documents and information protected consist of the materials generated or collected from the initiation of the process and up to the point of action after the process is completed. Of course, the facility must also restrict access to the materials so that there can be no confusion regarding whether or not the entity intends the materials to be protected and confidential.

Illinois Health Care Providers See Conflict Between New State Law and HIPAA Privacy Rule

In November 2011, the Illinois General Assembly passed Public Act 097-0623 (the Act). The Act amended the Code of Civil Procedure to mandate the release by health care providers of a deceased person's medical records upon the written request of his or her surviving spouse, adult children, parents, or siblings, in descending order of priority, if the decedent did not appoint an agent under a power of attorney for health care or the decedent's estate is not represented by an executor or administrator, and the decedent did not specifically object to such disclosure. The Act has led to conflict between relatives of decedents and health care providers, because the Health Insurance Portability & Accountability Act (HIPAA), a federal law, permits only executors, administrators and others who have the legal authority to act on behalf of the deceased individual or his or her estate to gain access to the medical records. The Act does not give the relatives listed in the law the authority to act "on behalf of" the decedent.

The public policy underlying HIPAA is that a person's medical records must be kept confidential unless another person or entity has a legitimate need for them. Specifically, HIPAA prohibits any use or disclosure of medical records unless the use or disclosure is permitted by HIPAA or its regulations. With respect to deceased individuals, HIPAA requires health care providers to treat as "personal representatives" of the decedent the executor or administrator of his or her estate, or any other person who under state law has the legal authority to act "on behalf of" the person. In other words, health care providers must treat these people as they would the patient him or herself, and give to such people all the rights that the patient would have with regard to the medical records. Some health care providers have concluded that HIPAA does not contemplate the disclosure of a deceased patient's medical records to multiple relatives for any reason or no reason at all.

The Act does not make the relatives of the deceased patient "personal representatives" for purposes of HIPAA. In Illinois, the Probate Act sets out who qualifies as a "representative" of a deceased person's estate: an executor, an administrator or a guardian. The hallmarks of these offices are that the person is appointed by a court, is granted authority to cause others to take steps with regard to the decedent's estate or his or her property, and is held responsible by the court for his or her actions. In other words, a person must be legally recognized as a fiduciary of the deceased individual or his or her estate to quality as a "representative" under Illinois law. The relatives named in the Act bear no fiduciary duties to the decedent. Rather, they could use the requested medical records for their own purposes, for no purpose, or for purposes that would have been objectionable to the deceased person. Therefore, some health care providers have concluded that the relatives listed in the Act do not qualify as "personal representatives" and cannot be given access to the deceased patient's medical records.

HIPAA allows states to enact laws that are more protective of an individual's health information than those set forth in the HIPAA regulations, but does not permit state law to diminish the privacy protections afforded to patients under HIPAA. Therefore, to the extent a law diminishes the degree to which a decedent's health information is protected, it is preempted by the more restrictive HIPAA rules. Because the Act purports to expand access to decedents' medical records to individuals beyond those who stand as fiduciary "representatives" of a deceased person, it may be preempted, requiring health care providers to abide by the HIPAA privacy regulations rather than the Act.

The U.S. District Court for the Northern District of Florida recently found that HIPAA preempted a Florida law similar to the Act because a relative not appointed by a court does not have a fiduciary relationship to the decedent and therefore cannot qualify as a personal representative for HIPAA purposes. *Opis Management Resources, LLC v. Dudek,* (Dec. 3, 2011). Until a federal court analyzes the interplay between HIPAA and the Act, there is no binding authority on this issue and health care providers must decide whether to comply with the more restrictive HIPAA rules or the more permissive disclosures contemplated by the Act.

Health care providers are advised to consider the relative severity of penalties arising out of violations of these two laws. Under the Act, a health care provider that denies a relative's request for records is required to pay expenses and reasonable attorneys' fees incurred by a relative if a court finds that the Act is not preempted and orders enforcement of the relative's request. Under HIPAA, a health care provider that unlawfully discloses medical records can be assessed civil monetary penalties of between $100 and $50,000 for each violation, depending on the level of culpability, up to a maximum of $1.5 million for all violations of an identical provision in a calendar year, and can also be subject to criminal fines of up to $250,000 and up to 10 years' imprisonment.

Download to read: **Public Act 097-0623**

For further information, please contact **Jerrod L. Barenbaum**, **Michael P. Davidson** or your regular Hinshaw attorney.

No Physician-Patient Relationship Created by Telephone Call from Mother to Emergency Room

The Third District Appellate Court of Illinois recently examined whether a single telephone call by a mother to her local emergency room was sufficient to create a physician-patient relationship. In *Estate of Kameryn L. Kundert v. Illinois Valley Community Hospital*, 2012 IL App (3d) 110007, the parents of a six-week-old newborn filed a wrongful death action against the hospital after the mother relied upon advice she received from an unknown person in the emergency room. The mother claimed that in response to a telephone call where she reported symptoms of a high fever, fussiness and an inability to eat or sleep, she was told that her child did not require immediate medical attention and to give the child Tylenol and tepid baths. The case was dismissed by the trial court in response to a motion brought by the hospital pursuant to Section 2-615 of the Illinois Code of Civil Procedure. The hospital argued that the facts alleged did not constitute the existence of a physician-patient relationship, and that thus, there was no duty of care. In construing the allegations of the complaint in a light most favorable to plaintiff, the Third District Appellate Court determined that the actions described in the complaint did not constitute a knowing acceptance of the child as a patient. In the complaint, the parents alleged that the person on the telephone told the mother that the hospital did not have the equipment or medical personnel to provide services to infants. The court reasoned that the alleged statements constituted a refusal of services, and thus, that the legal duty imposed by a physician-patient relationship did not exist. Addressing public policy issues, the court pointed to the effect imposing tort liability under these circumstances would have on health care providers. The court stated "[w]e would expect that the result of finding that this phone call created a physician-patient relationship would be that anytime a parent called and reported a child with a fever, the response would be the same: 'hang up and call 911 or drive your child to an emergency room.' We believe that this would benefit neither the providers nor consumers of medical care." Thus, the court found that public policy also supported the trial court's decision to dismiss the case.

Download to read: ***Estate of Kameryn L. Kundert v. Illinois Valley Community Hospital*, 2012 IL App (3d) 110007**

For further information, please contact **Gregory Snyder** or your regular Hinshaw attorney.