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Lebron v. Gottlieb Memorial Hospital: Capping Medical Practice Reform in Illinois

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I. INTRODUCTION

In 2005, P.A. 94-677, entitled “An Act Concerning Insurance” (Act), became law in Illinois.¹ While the title of the Act was underwhelming, its content promised to address the high cost of medical liability insurance in Illinois that burdened both physicians and the general public. The Illinois General Assembly believed that medical liability insurance reform was necessary to “preserve the public health, safety, and welfare of the people of Illinois.”² Moreover, the Act operated in several areas to widen the availability of hospitals and physicians, and improve numerous aspects of health care.

The Act implemented a series of trade-offs in order to reduce medical liability insurance costs while encouraging better healthcare services in the state. It also contained an inseverability provision, stating that if any of its provisions were held invalid, the entire law would fall.³ The provision that caught the most attention, and was ultimately tested in the Illinois Supreme Court, was the imposition of a cap on non-economic damages in medical liability suits.

Non-economic damages compensate for, among other things, pain and suffering, disability, disfigurement, loss of consortium, and loss of society.⁴ The Illinois General Assembly found that imposing a limit on these

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1. An Act Concerning Insurance, 2005 Ill. Laws 4964, *invalidated by* Lebron v. Gottlieb Mem'l Hosp., 930 N.E.2d 895, 914 (Ill. 2010).

2. *Id.* § 101 at 4965.

3. *Id.* § 995 at 5005.

4. *See, e.g.*, Civil Justice Reform Amendments of 1995, 1995 Ill. Laws 284, *enacting* 735 ILL. COMP. STAT. 5/2-1115.2 (1995) (held unconstitutional by *Best v. Taylor Mach. Works*, 689 N.E.2d 1057 (Ill. 1997)). Surprisingly, An Act Concerning Insurance, 2005 Ill. Laws 4964, does not itself define the key term “non-economic damages.”

damages would help to preserve the public health, welfare, and safety of Illinois residents⁵ by substantially reducing medical malpractice insurance premiums.⁶ The Legislature felt the reduction was necessary to keep physicians, particularly those in high-risk specialties and underserved areas, from leaving Illinois to practice elsewhere.⁷ Thus, the Act amended the Illinois Code of Civil Procedure to impose a cap on non-economic damage awards of \$500,000 for physicians and \$1 million for hospitals.⁸

Fast forward to February 4, 2010 – the day the Illinois Supreme Court struck down the Act when it decided *Lebron v. Gottlieb Memorial Hospital*.⁹ *Lebron* was a medical malpractice action arising from the caesarean delivery of a child who allegedly sustained severe permanent injuries.¹⁰ The plaintiffs sought a declaration that the cap on non-economic damages set forth in the Act violated the Illinois Constitution’s separation of powers clause.¹¹ The Illinois Supreme Court agreed and held that the cap was unconstitutional as it infringed upon the judiciary’s prerogative to reduce jury-awarded damages under the doctrine of remittitur.¹² As a result of the *Lebron* decision and the inseverability provision, the court declared the Act invalid in its entirety.

The inseverability provision was likely included in the Act to “up the ante with respect to the Illinois Supreme Court’s decision whether to invalidate the caps”¹³ and in the hopes that the court would look favorably upon the beneficial purpose of the legislation as a whole.¹⁴ Regardless, the

5. § 101(5), 2005 Ill. Laws at 4965.

6. *Id.*

7. Compare Congressman Kirk Launches Campaign to Keep Doctors in Illinois, WAUKEGAN NEWS SUN, (Jan. 25, 2005), http://www.house.gov/apps/list/hearing/il10_kirk/newssunwristbands.html (“Illinois is especially vulnerable to losing doctors because it borders three ‘reform state[s],’ Wisconsin, Indiana and Missouri The average neurosurgeon in Illinois pays more than four times the amount for malpractice insurance than a neurosurgeon in Wisconsin.”), with NORTHWESTERN UNIV. FEINBERG SCHOOL OF MED. ET AL., 2010 ILL. NEW PHYSICIAN WORKFORCE STUDY 21 (Nov. 2010), <http://www.familymedicine.northwestern.edu/RESLI/FINAL%20REPORT%2011%2011%2010.pdf> (A survey of 561 medical residents and fellows trained in Illinois found that roughly half plan to practice outside the state, with the medical liability climate weighing heavily in that decision).

8. Edward J. Kionka, *Things To Do (or Not) To Address The Medical Malpractice Insurance Problem*, 26 N. ILL. U. L. REV. 469, 498 (2006).

9. See *Lebron v. Gottlieb Mem’l Hosp.*, 930 N.E.2d 895, 917 (Ill. 2010).

10. *Id.* at 899–900.

11. *Id.* at 900.

12. *Id.* at 908.

13. Kionka, *supra* note 8, at 504.

14. *Id.* The inseverability provision was likely intended to avoid issues raised in *Best*, in which the plaintiffs argued that “the legislative ‘findings’ listed in the preamble do not provide a rational justification for the limitation of compensatory damages for noneconomic injuries.” *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1068 (Ill. 1997). The inclusion of an inseverability provision may have been in hopes that the Illinois Supreme Court would

court was undeterred from striking down the law.¹⁵ The court, however, did emphasize that it was not passing judgment on the constitutionality of the other provisions in the Act and that the Legislature would be free to reenact them as it saw fit.¹⁶ This article surveys the often overlooked provisions, beyond the cap on non-economic damages, which became invalid as a result of the *Lebron* holding. Such a review will demonstrate the far-reaching effects of the decision in light of the goals of the Illinois General Assembly when passing the Act. First, the changes regarding oversight of the medical liability insurance industry will be examined. Next, the article will look at the changes to the Medical Practice Act of 1987, which increased the State's oversight of and ability to discipline physicians and required the dissemination of physician qualifications to the public. Finally, the article will conclude with a discussion of the changes to the Illinois Code of Civil Procedure that concerned medical liability suits.

II. OVERSIGHT OF THE MEDICAL LIABILITY INSURANCE INDUSTRY

In order to make medical malpractice insurance more affordable, the General Assembly increased the State's oversight of medical liability insurance carriers by amending several sections of the Illinois Insurance Code and enacting some entirely new provisions.¹⁷ A key amendment to the Insurance Code would have required companies writing medical liability insurance to file insurance rates with the Illinois Department of Financial and Professional Regulation (IDFPR) whenever the rates changed.¹⁸ The IDFPR would publish the data on a company-by-company basis, and the IDFPR could fine companies for violating the reporting requirements.¹⁹ Upon obtaining the information and receiving a request from a threshold number of insureds, the IDFPR had discretion to hold a public hearing.²⁰ Further, the IDFPR was required to hold a hearing if the insurance rate increase would be greater than six percent.²¹ At the hearings, the burden was to be on the insurance company to justify the increase.²²

justify the caps on damages in the context of "the entire legislative solution package." Kionka, *supra* note 8, at 504.

15. *Lebron*, 930 N.E.2d at 914.

16. *Id.*

17. §§ 101, 103, 2005 Ill. Laws at 4964–65, *invalidated by Lebron*, 930 N.E.2d at 914.

18. § 310, 2005 Ill. Laws at 4966 (amending 215 ILL. COMP. STAT. 5/155.18(c)(1), (c)(3) (2004)).

19. *Id.* (amending 215 ILL. COMP. STAT. 5/155.18(c)(5), 155.18(d)(2)).

20. *Id.* (amending 215 ILL. COMP. STAT. 5/155.18(c)(2)).

21. *Id.* (amending 215 ILL. COMP. STAT. 5/155.18(c)(2)). A hearing may be held if the greater of one percent of the company's insured with a specialty of twenty-five of the company's insureds request a hearing. *Id.* At the hearings, the burden is on the company to justify the rate or proposed rate. *Id.*

22. *Id.* (amending 215 ILL. COMP. STAT. 5/155.18(c)(3)).

Interestingly, the first hearings under the new provisions resulted in a directive prohibiting the State's largest medical liability insurer, ISMIE Mutual Insurance Company, from increasing its average rate for 2006–2007, and instead setting a target to reduce the average rate by 3.5 percent for that policy year.²³ On July 1, 2006, ISMIE cut rates by an average of 5.2 percent for individual doctors.²⁴

In addition to the rate-reporting requirement, the Act imposed numerous conditions to increase transparency in the medical liability insurance business, while providing mandatory plan provisions to benefit insureds. For instance, the Act required medical liability insurers to offer insureds the right to make quarterly premium payments and to give 180-days notice before an insurer could discontinue the writing of medical liability insurance in Illinois.²⁵ Moreover, the Legislature encouraged companies to offer plans with deductibles and to provide premium discounts for participation in risk-management activities.²⁶ As an example, ISMIE policyholders were given the opportunity to reduce their premiums further by attending seminars on implementing risk-management techniques in their medical practices.²⁷

The Act also established the Professional Liability Insurance Resource Center, available on the website of the IDFPR.²⁸ The Resource Center made contact information and base rates of medical liability insurers available.²⁹ Moreover, the Act required insurers to report all court claims alleging liability on the part of a physician, hospital, or healthcare provider for medically related injuries³⁰ so that this information could be published.³¹ Finally, while insurers were already required to submit reports to the

23. DEP'T OF FIN. AND PROF'L REGULATION, STATE OF ILL., ORDER: IN RE MEDICAL MALPRACTICE RATE INCREASE OF ISMIE MUTUAL INSURANCE COMPANY 3 (2006); see Press Release, Ill. Dep't of Fin. and Prof'l Regulation, IDFPR Orders ISMIE to Make Changes to Reduce Rates Paid by Illinois Doctors (Mar. 14, 2006), available at <http://www.idfpr.com/NEWSRSL/03142006ISMIEDecision.asp>; Kionka, *supra* note 8, at 505–06.

24. Mike Colias, *ISMIE to Pay Dividends, Lift Freeze*, CRAINS CHICAGO BUS., Jan. 15, 2007, available at <http://www.chicagobusiness.com/article/20070115/NEWS/200023484/ismie-to-pay-dividends-lift-freeze>.

25. § 310, 2005 Ill. Laws at 4968 (amending 215 ILL. COMP. STAT. 5/155.18(d)(2)(E), 155.18(d)(2)(H)).

26. *Id.* (amending 215 ILL. COMP. STAT. 5/155.18(d)(2)(F)–(G)).

27. See Press Release, ISMIE Mutual Cuts Average Premiums by 5.2 Percent for 2006–2007 (Apr. 5, 2006) (on file with author); ISMIE Now Offers Evening and Weekend Fellowship Seminars! (Apr. 6, 2010), available at http://www.ismie.com/pubs/ismie-news/Documents/2010/2010_0406.pdf.

28. 215 ILL. COMP. STAT. 5/155.18(a) (2004) (enacted by 2005 Ill. Laws 4968).

29. *Id.*

30. § 310, 2005 Ill. Laws at 4968–69 (amending 215 ILL. COMP. STAT. 5/155.19).

31. *Id.* Each clerk of the circuit court should provide the information requested by the IDFPR. 705 ILL. COMP. STAT. 105/27.10 (2004) (enacted by 2005 Ill. Laws 4969).

IDFPR summarizing their direct writings in the State, the Act required additional information, such as paid and incurred losses by county for the past ten policy years, to be made available to the General Assembly and the public.³²

The reporting requirements of the Act made it easier for smaller insurance companies to compete for business.³³ A year after passage of the amendments, the insurer Medical Protective reduced its medical malpractice insurance premiums by thirty-two percent statewide.³⁴ The Office of the Illinois Governor attributed this reduction to the reforms in the Act, citing the publication of rate information and claims data among the reforms that encouraged insurance companies to set competitive premium rates.³⁵

Reaction of the insurance industry to the *Lebron* decision has been strong. According to one study, Illinois medical malpractice insurers will probably face an eighteen percent increase in costs after *Lebron*.³⁶ Furthermore, the *Lebron* ruling was not unanticipated by the insurance industry, and thus there might have been further rate reductions had the *Lebron* court gone against expectations and upheld the cap on non-economic damages.³⁷ While premium rates for physicians in Illinois have remained steady thus far, the impact of the *Lebron* decision on the insurance industry may take time to materialize.³⁸ As the number of malpractice claims rise, doctors may face higher premium costs in the future, and leave Illinois to practice in states offering lower premiums.³⁹

Despite *Lebron*, the Department of Insurance (DOI) is encouraging medical insurers to comply with the rate reporting provisions in the Act

32. § 310, 2005 Ill. Laws at 4968 (amending 215 ILL. COMP. STAT. 5/1204). All the provisions requiring publication of the information by the IDFPR supersede any other state law provisions that may protect such information from public disclosure as confidential. *Id.* at § 1204(C-5)(3).

33. Mike Colias, *Illinois Supreme Court Strikes Down Medical Malpractice Caps*, CRAINS CHICAGO BUS., Feb. 4, 2010, available at <http://www.chicagobusiness.com/cgi-bin/news.pl?id=36984>.

34. Press Release, Office of the Gov., Gov. Blagojevich Announces Major Reduction in Medical Malpractice Insurance Rates in Illinois (Oct. 13, 2006) available at <http://www.illinois.gov/pressreleases/ShowPressRelease.cfm?SubjectID=2&RecNum=5414>.

35. *Id.*

36. Mike Colias, *Illinois Med-mal Ruling to Boost Insurers' Costs 18%: Study*, CRAINS CHICAGO BUS., Feb. 22, 2010, available at <http://www.chicagobusiness.com/cgi-bin/news.pl?id=37194>.

37. *Id.*

38. *A Disaster Delayed*, CHI. TRIB., July 8, 2010, at 16, available at http://articles.chicagotribune.com/2010-07-08/news/ct-edit-cap-20100708_1_tort-reform-illinois-supreme-court-states-with-lower-premiums.

39. *Id.*

voluntarily.⁴⁰ The DOI has noted some benefits that have resulted from the reforms, such as increased competition among companies offering medical liability insurance, including the entry of five new companies offering medical liability insurance in the State over three years.⁴¹ The DOI also maintains that it “retains authority to conduct public hearings on rates that are unfairly discriminatory, excessive, or inadequate.”⁴²

III. PHYSICIAN DISCIPLINE AND PUBLIC ACCESS TO DISCIPLINARY INFORMATION

The Act modified the Medical Practice Act of 1987 by increasing the State’s oversight of the medical profession. To accomplish this, the Act increased both the size and scope of authority of the Medical Disciplinary Board and expanded the immunity from liability available for participants in peer review committees. The Act also required the dissemination of physician qualifications to the public.⁴³

A. Changes to the Medical Disciplinary Board

The Act doubled the number of Medical Disciplinary Board members who are members of the public and not working as healthcare providers.⁴⁴ The Act also doubled the number of required Disciplinary Board investigators.⁴⁵ Additionally, the Act increased the number of medical coordinators – licensed physicians who serve as the chief enforcement officers of the Medical Practice Act under the Disciplinary Board.⁴⁶ Finally, the Act broadened the obligations of other physicians and medical professionals who serve as advisors to the Disciplinary Board.⁴⁷

The Act enlarged the scope of disciplinary actions available to the Medical Disciplinary Board⁴⁸ and extended the time period for the commencement of such actions (within five years after receipt of a complaint and within ten years of the underlying incident).⁴⁹ In addition,

40. Press Release, Ill. Dep’t. of Ins., Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms (Feb. 20, 2010), *available at* <http://www.insurance.illinois.gov/newsrsls/2010/MedMal02202010.pdf>.

41. *Id.* In 2008, there were nineteen companies offering medical malpractice insurance in Illinois, compared to fourteen in 2005. *Id.*

42. *Id.*

43. §§ 101(5), 315, 2005 Ill. Laws at 4965, 4974, *invalidated by* *Lebron v. Gottlieb Mem’l Hosp.*, 930 N.E.2d 895, 914 (Ill. 2010).

44. § 315, 2005 Ill. Laws at 4974 (amending 225 ILL. COMP. STAT. 60/7(A) (2004)).

45. *Id.* (amending 225 ILL. COMP. STAT. 60/7(G)).

46. *Id.*

47. *Id.* (amending 225 ILL. COMP. STAT. 60/7(J)).

48. *Id.* (amending 225 ILL. COMP. STAT. 60/22(A)).

49. *Id.*

the Act doubled the maximum authorized fine in a medical disciplinary action to \$10,000.⁵⁰ These fines are applied to the Medical Disciplinary Fund, and thus this increase could have enhanced the effectiveness of the Medical Disciplinary Board and its investigations.⁵¹

The Act also expanded the immunity from criminal prosecution or civil damages to individuals and organizations providing any report or information of medical errors to Peer Review Committees. Peer Review Committees are professional review bodies tasked with conducting a review based on the competence or professional conduct of a physician, the results of which may adversely affect the clinical privileges of that physician if the review shows he did not follow the required standard of care.⁵² This provision would have encouraged physicians and other healthcare professionals to identify and fix medical system problems before they caused manifest injury to patients.⁵³

The Act would also have facilitated the disciplinary investigations of physicians reported for Medical Practice Act violations. If a physician is a defendant in a medical malpractice lawsuit, the IDFPR could have required the plaintiff's attorney to provide it with the relevant patient records.⁵⁴ The Act would have immunized attorneys who turned over such medical records, even without their clients' consent, from lawsuits premised on a violation of the attorney-client relationship.⁵⁵

B. The Patients' Right to Know Law

A "Patient's Right to Know Law," established by the Act, required the IDFPR to make a profile of each physician available to the public. Each profile was to contain such basic information as the physician's name, medical schools attended, any specialty board certifications, number of years in practice and locations of practice, names of hospitals where the physician has medical staff privileges, location of the physician's primary practice setting, any translating services available at the primary practice setting, and whether the physician participates in the Medicaid program.⁵⁶

50. § 315, 2005 Ill. Laws at 4974 (amending 225 ILL. COMP. STAT. 60/22(A) (2004)).

51. *Id.*

52. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11151 (2006); AM. MED. ASS'N (AMA), CODE OF MEDICAL ETHICS Op. E-9.10 (last updated June, 1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion910.shtml>.

53. *See* OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 5 (2002) [hereinafter HHS REPORT].

54. §315, 2005 Ill. Laws at 4991 (amending 225 ILL. COMP. STAT. 60/24).

55. *Id.*

56. *Id.* (enacting 225 ILL. COMP. STAT. 60/24.1(B)).

These profiles would also contain information regarding any criminal convictions, disciplinary actions, adverse medical malpractice judgments (or settlements of medical malpractice lawsuits) during the past five years, and any restrictions on hospital privileges imposed for competence or character-related reasons.⁵⁷ Physicians would have the right to review their profiles before release to the public to check for any errors,⁵⁸ ensuring that the information published about them was indeed accurate – an opportunity not available on some physician rating websites.⁵⁹

After *Lebron*, however, the Patient's Right to Know Law, which involved cooperation between the IDFP and physicians, is no longer valid. It remains to be seen whether the Illinois Legislature will reenact the law. But in the meantime Illinois consumers are losing out on access to valuable data that would encourage informed decision making in the choice of medical care.

IV. REFORMING THE LEGAL PROCESS

The Act also made a number of changes to the Illinois Code of Civil Procedure that concerned medical liability suits beyond the caps in non-economic damages. These changes included a tightening of the affidavit of merit and expert witness requirements, a provision providing for payment of plaintiffs' future medical expenses and life care costs through the purchase of annuities, and an evidentiary privilege against admissions of liability made by a healthcare provider to a patient. In addition, the medical liability exemptions in the Good Samaritan Act were expanded to encourage healthcare providers to offer their services in free clinics.

A. New Requirements for the Health Professional Affidavit

The Act expanded the affidavit of merit requirements to include mandatory disclosure of the consulting physician's name and an assertion that the physician met the new expert witness standards of the expert witness qualifications statute, 735 Ill. Comp. Stat. 5/8-2501.⁶⁰ These changes were instituted in an effort to ban anonymous reports, thereby

57. *Id.*

58. *Id.* (enacting 225 ILL. COMP. STAT. 60/24.1(C)).

59. See, e.g., Shaili Jain, *Goodling Ourselves – What Physicians Can Learn From Online Rating Sites*, 362 NEW ENG. J. MED. 1, 6 (Jan. 7, 2010) (noting that if a physician disagrees with a comment posted on an online rating site, there is no opportunity for rebuttal because the physicians are bound both by privacy laws and a duty to maintain patient confidentiality); JoNel Aleccia, *Docs Seek to Stifle Patients' Rants on Web Sites*, MSNBC.COM, Jan. 13, 2010, http://www.msnbc.msn.com/id/34794632/ns/health-health_care/print/1/displaymode/1098/ (explaining that doctors cannot respond to patient online comments because doing so violates federal privacy laws).

60. See *infra* Part IV.D. (discussing expert witness standards).

ensuring accountability and discouraging obviously unmeritorious claims.⁶¹ The affidavit of merit provision required that, contemporaneously with the initiation of a medical malpractice action, the plaintiff must file an affidavit stating that he or she had consulted and reviewed the facts of the case with a health professional who confirmed there was a meritorious basis for the action.⁶² Further, the affidavit was to state that, to the reasonable belief of the affiant, the professional had practiced or taught within the last five years in the same area of medicine that was at issue in the suit. The affidavit was also to provide a statement demonstrating that this professional met the Section 8-2501 expert witness standards.⁶³ In addition, the new requirements specified that a written report be filed with the complaint for each defendant in the action and that the written reports be from a health professional licensed in the same profession and with the same licensure class as the individual defendant.⁶⁴ In the case of corporate defendants, the reviewing professional was not only required to be a licensed physician, but also qualified by experience with the standard of care, methods, procedures and treatments relevant to the allegations of the claim.⁶⁵

Aside from adding new requirements, the Act also reenacted and amended requirements for the affidavit of merit that had been part of an earlier tort reform statute struck down by the Illinois Supreme Court in 1997.⁶⁶ One such provision required a copy of the written report to be attached to the affidavit and to include the reviewing health professional's name, address, state of licensure, and current license number.⁶⁷ The Act also provided that a professional organization or insurer could not use the information regarding the preparation of a written report to discriminate against the preparer of the report. Now that the Act has been struck down, the identity of the reviewing health professional need no longer be disclosed.

61. *Lebron v. Gottlieb Mem'l Hosp.*, 930 N.E.2d 895, 914 (Ill. 2010).

62. 735 ILL. COMP. STAT. 5/2-622(a)(1) (2004).

63. §330, 2005 Ill. Laws at 4996 (amending 735 ILL. COMP. STAT. 5/2-622(a)(1)); *see infra* Part IV.D. (discussing expert witness standards).

64. §330, 2005 Ill. Laws at 4996 (amending 735 ILL. COMP. STAT. 5/2-622(a)(1)).

65. *Id.*

66. *Id.* This provision was originally part of P.A. 89-7, which was struck down by the Illinois Supreme Court's holding in *Best*. The court, after finding that numerous provisions of P.A. 89-7 were unconstitutional, determined that what remained of the Act did not reflect the intent of the legislature in enacting P.A. 89-7, and consequently held the unconstitutional provisions were inseverable and struck down the entire Act. *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1104 (Ill. 1997). The court did not pass upon the constitutionality of the affidavit of merit requirement reenacted in P.A. 94-677.

67. § 330, 2005 Ill. Laws at 4996 (amending 735 ILL. COMP. STAT. 5/2-622(a)(1)).

B. Guaranteed Payment of Future Medical Expenses and Costs of Life Care

The Act added a new section to the Illinois Code of Civil Procedure, which provided for payment of the plaintiffs' future medical expenses and life care costs through the purchase of annuities. At any time up to five days after a verdict for the plaintiff, either party in a medical malpractice action could elect (or the court could order) payment under this option.⁶⁸ Deferred payments would reduce the likelihood that a severely injured plaintiff might exhaust a lump sum payment and later become a public burden.

The annuity option provided that the plaintiff receive annual annuity payments equal to eighty percent of the anticipated expenses, as adjusted for expected inflation over the life of the plaintiff. To determine the annuity payments, the trier of fact was required to make findings of (1) the present cash value of the plaintiff's future expenses for medical treatment and care, (2) the current annual cost of these expenses, and (3) the rate of inflation to be applied to these expenses.⁶⁹ After a defendant would make an election under this provision (within five days of the verdict), the court would enter a judgment ordering the defendant to pay twenty percent of the present cash value of these future expenses and order the remainder to be paid through an annuity.⁷⁰

If the judgment was insufficient to pay the estimated costs, for example, in situations involving plaintiff's contributory negligence, the Act provided that the plaintiff could seek leave of court to assign or transfer his right to receive payments from the annuity in exchange for a lump sum.⁷¹ Such a request would be granted if the court found the plaintiff suffered from a financial hardship that required such action.⁷² While this would understandably have jeopardized the plaintiff's ability to pay future medical expenses, a lump sum payment could assist in meeting current exigencies.

C. Exclusion of Admissions of Liability from Evidence

The Act added an entirely new provision, which provided that within seventy-two hours of learning of the potential cause of an inadequate or unanticipated treatment or care outcome, any expression of grief, apology or explanation given by a healthcare provider to a patient, the patient's family, or the patient's legal representative would be inadmissible as evidence in any subsequent lawsuit.⁷³ The purpose of this provision was to

68. *Id.* (amending 735 ILL. COMP. STAT. 5/2-1704.5).

69. *Id.* (amending 735 ILL. COMP. STAT. 5/2-1704.5(B-C)).

70. *Id.*

71. §330, 2005 Ill. Laws at 4995 (amending 735 ILL. COMP. STAT. 5/2-1704.5 (2004)).

72. *Id.*

73. *Id.* (amending 735 ILL. COMP. STAT. 5/8-1901(b)).

encourage healthcare providers to acknowledge their mistakes promptly and offer fair settlements, thus possibly obviating litigation.⁷⁴

After an unanticipated medical outcome, both parties are interested in seeking honest answers to open questions.⁷⁵ Enabling a physician to provide answers without fear that his honest discourse could be used against him later might decrease the likelihood that the patient will file a claim in the first place. Studies have found that patients are more likely to bring suit when they feel their questions have not been adequately answered, when they sense a lack of accountability, and when they fear the same mistake could occur in another patient's care.⁷⁶ In one study, thirty-seven percent of those medical malpractice plaintiffs who responded said an explanation and an apology would have changed their mind as to whether to file suit.⁷⁷

It is not surprising that patients are more likely to sue when they perceive that their physicians are less than forthcoming about the medical treatment provided. As Opinion E-10.015 of the American Medical Association *Code of Medical Ethics* points out, "[t]he relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups."⁷⁸ Thus, a patient may justly feel that a physician who attempts to hide a medical error through silence, even if it is the physician's own error, is acting unethically and is violating the obligations owed the patient. Enabling discussions between physicians and patients before a claim is filed could lessen the animosity that might develop between the parties and consequently facilitate more earnest and helpful discussions for both parties, which would in turn lead to settlements.⁷⁹

Furthermore, this provision had a significant public health benefit. Physicians may refuse to talk about negative medical outcomes out of fear of prejudicing their legal position. Moreover, liability insurance policies commonly prohibit or penalize honest discussions with patients and their

74. *Lebron v. Gottlieb Mem'l Hosp.*, No. 2006 L 12109 (Cir. Ct. Cook County, Nov. 13, 2007). See, e.g., Richard C. Boothman et. al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 142 (2009) ("If it appears that compensation is owed, the discussion shifts from the typical approach, in which both sides take equally unreasonable financial positions and work towards a middle ground, [to] evidence-based discussions about what is truly owed because of the medical error.").

75. Boothman, *supra* note 74, at 141.

76. *Id.* at 133.

77. *Id.*

78. AMA, *supra* note 52, Op. 10.015 (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.shtml>.

79. Boothman, *supra* note 74, at 142.

families if such discussions are deemed a failure to cooperate in the defense of a potential claim.⁸⁰ On the other hand, disclosures of medical mistakes would be likely to assist in the patients' subsequent medical treatment and improve their health outcomes. This candor can enable physicians and medical staff to deliver safer and better care while allowing a healthcare provider who may have caused an injury to help mitigate its consequences.⁸¹

D. Revised Standards for Expert Witness

The Act revised the standards for expert qualifications in medical malpractice suits.⁸² Under the revisions, the court was required to consider whether a proposed expert witness on the issue of standard of care had been board certified or completed a residency "in the same or substantially similar medical specialties as the defendant" and had "significant experience" with the standard of care relevant to the allegations against the defendant.⁸³ In addition, the court was to consider whether the proposed expert had devoted a substantial portion of his or her work to the practice of medicine, teaching, or research related to the type of treatment that gave rise to the suit and whether the witness was licensed in the same profession and class as the defendant.⁸⁴ The expert would also have to provide evidence of current or recent experience in the active practice of medicine, teaching, or relevant participation in university-based research.⁸⁵

E. Expanding the Good Samaritan Act

The Good Samaritan Act recognizes that healthcare professionals are deterred from volunteering their services in free clinics if doing so could subject them to liability for medical malpractice.⁸⁶ This makes it difficult for clinics to provide care to patients in need, as the clinic must expend limited resources on insurance coverage for volunteering healthcare workers.⁸⁷ Accordingly, the 1987 Good Samaritan Act exempts healthcare professionals from liability arising from medical treatment provided at a free clinic, so long as the professional acted in good faith.⁸⁸ The Act added retired physicians to those healthcare providers exempted from liability for

80. *Id.* at 149.

81. *See id.*

82. §330, 2005 Ill. Laws at 5001 (amending 735 ILL. COMP. STAT. 5/8-2501 (2005)).

83. *Id.* (amending 735 ILL. COMP. STAT. 5/8-2501(a)).

84. *Id.* (amending 735 ILL. COMP. STAT. 5/8-2501(b)-(c)).

85. *Id.* (amending 735 ILL. COMP. STAT. 5/8-2501(d)).

86. HHS REPORT, *supra* note 53, at 4.

87. *Id.*

88. § 340, 2005 Ill. Laws at 5002-03 (amending 745 ILL. COMP. STAT. 49/30 (2004)).

such services and included hospitalization, office visits, and home visits in the categories of qualifying medical services.⁸⁹ Free medical clinics could also apply to receive reimbursements from the Illinois Department of Public Aid for their overhead expenses.⁹⁰

V. CONCLUSION

The Act did not just cap non-economic damages in medical liability suits – the other provisions of the Act were far more comprehensive and in many ways more significant. These other provisions aimed to improve the quality of health care in Illinois by introducing reforms in the liability insurance industry, increasing medical board oversight of physicians, publishing basic information about physicians' qualifications, including prior disciplinary action taken against them, and modifying the legal process. All such reforms are now invalid as a result of *Lebron*. Whether the General Assembly will take further action remains to be seen, but it is clear that the *Lebron* holding has undercut a wide range of legislative measures intended to improve the delivery of health care in Illinois.

89. *Id.* (amending 745 ILL. COMP. STAT. 49/30(a), (d)).

90. *Id.* § 340 at 5003 (amending 745 ILL. COMP. STAT. 49/30).