Claims & Litigation Update

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Claims and Litigation Update

2024 Review

- IPT/MAIC/IRMS claims – settlements, frequency and severity
- Verdicts and trial results in Illinois
- Case law quick hits

IPT Top Cause Codes

Top Five Cause Codes by Count					
Claims Set Up in 2024		**Claims Set Up in 2023**		**Claims Set Up in 2022**	
Falls	31	Falls	38	Negligence in Patient Care	35
Negligence in Patient Care	18	Negligence in Patient Care	33	Falls	32
Emergency Medicine Other	15	Surgical/Postoperative Care	15	PL – COVID-19	15
Obstetrical Cause Other	14	Failure to Diagnose Emergency	14	Failure to Diagnose Emergency	12
Failure to Diagnose Emergency	10	Failure to Diagnose	10	Deposition Assist	11

MAIC Top Cause Codes

Top Four Cause Codes by Count					
Claims Set Up in 2024		**Claims Set Up in 2023**		**Claims Set Up in 2022**	
Postoperative Complication	19	Failure to Diagnose Emergency	18	Failure to Diagnose Emergency	21
Failure to Diagnose Emergency	19	Postoperative Complication	12	Negligence in Patient Care	15
Delay in Treatment Emergency	7	Failure to Diagnose	7	Delay in Treatment Emergency	7
Lack of Proper Surgical Technique	6	Negligence in Patient Care	7	Postoperative Complication	6

IRMS Top 5 Cause Codes

Top Five Cause Codes by Count		
2024	**2023**	**2022**
OB Cause Other 115	OB Cause Other 118	OB Cause Other 86
Falls 113	Falls 79	Postoperative Complication 65
Surgery Cause Other 110	Postoperative Complication 72	Negligence in Patient Care 61
Postoperative Complication 96	Surgery Cause Other 72	Surgery Cause Other 47
Failure to Diagnose (ED/General) 97	Failure to Diagnose/Delay Treatment – ED 68	Falls 44

Large Settlements – IPT 2024

- **Top Ten Claims for 2024 – $9,650,000**
- **Top Ten in 2023 was $24.3M**
- **2 claims settled at or above $1 million**
- **Top 5 Claim Payments:**
  - Birth Injury Case $4.5M
  - Fall/Bleed/Treatment and Transfer Delays $2M
  - Postoperative Complication $750,000
  - Death following cardiac arrest in ED $500,000
  - Pressure Sores/Amputation $400,000
- **Birth Injury also largest settlement amount in 2023**

Large Settlements

- **MAIC – 2024 Claims that settled at or above $1M**
  - Failure to Diagnose Emergency $2M
  - Failure to Diagnose Emergency and Delay in Treatment $1.2M
  - Fall and Failure to Timely Treat and Transfer $1M
  - Delay in Emergency Treatment $1M
- **IRMS - 38 claims settled above $1 million**

12 Surgery Related	8 ED – Failure to Diagnose
4 Obstetrics/Delivery	4 Failure to Diagnose

- **Largest IRMS Settlements –** Failure to Diagnose Emergency, Surgery Related and Sexual Misconduct

Claim Frequency and Severity Analysis

- Claim counts by four assertions – unasserted event, patient complaint, attorney lien and lawsuit
- Emergency Department and Operating Room are the most consistent area of claims across all three programs and consistently generate high settlements
- Hospital falls consistently high generator of claims
- Obstetrics/Birth Injuries – large settlements and events are frequently reported
- Permanent injuries (amputations, brain injury, paralysis) and wrongful deaths often generate the largest settlements
- Failure to Diagnose is the most common specific cause code in both frequency and severity

Trials & Verdicts

- 90 medical malpractice verdicts in Illinois reported to Jury Verdict Reporter between January 2024 and present
- Illinois Jury Verdicts – Medical Malpractice
  - 48 Not Guilty Verdicts
  - 34 Guilty Verdicts against all Defendants
  - 8 Split Verdicts (Guilty against some but not all defendants)
  - 1 Hung Jury
- Cook County Verdicts
  - 34 Not Guilty
  - 27 Guilty
  - 6 Split Verdicts
  - 1 Hung Jury

Trials & Verdicts

- IPT Trial (Cook County, September 2024)
  - Wrongful death case – alleged failure to timely treat sepsis
  - Guilty Verdict for $3M (plaintiff asked for $47M)
  - Very large co-defendant settlement and set-off, $0 paid by IPT

- Verdicts outside of Cook County
  - 23 Verdicts
  - 14 Not Guilty Verdicts
  - 7 Guilty Verdicts against all Defendants
  - 2 Split Verdicts

Trials & Verdicts

- 13 verdicts above $10M including 11 in Cook County
- Severity and large requests continue in many cases
- Defendants are still winning more than Plaintiffs
- Some very large verdicts in recent years outside of Cook County, but most verdicts are reasonable in six figures or low to mid seven figures

Defense Considerations

- High-Low Agreements
- Damages Defense Plan – discuss early and often
- Damages Experts
- Consider alternative amount as soon as jury selection at trial

Case Law Update – Quick Hits

James v. Geneva Nursing & Rehabilitation Center, LLC, 2024 IL 130042

- **Background:** Plaintiff alleged the nursing home caused the deaths of several residents in April and May 2020 by failing to have implemented effective procedures for maintaining hygiene and personal protective equipment. Specifically alleged that failure to properly quarantine staff and residents contributed to the deaths due to covid.
- Geneva filed a Motion to Dismiss asserting immunity under the governor's executive orders. Interlocutory appeal allowed, ruling by Appellate Court for the 2nd District and IL Supreme Court accepted leave to appeal.

- **Certified Question:** Does Executive Order No. 2020-19, which triggered the immunity provided in 20 ILCS 3305/21 grant immunity for ordinary negligence claims to healthcare facilities that rendered assistance to the State during the COVID-19 pandemic?

- **Statute:** No civil liability for assisting state during an actual or impending disaster.

Case Law Update

James v. Geneva Nursing & Rehabilitation Center, LLC, 2024 IL 130042

- **Executive Orders:** During pendency of disaster proclamation, immunity from civil liability for any injury or death when a health care facility was rendering assistance to the State by providing services during the COVID-19 outbreak unless injury or death was caused by gross negligence.

- **Central Arguments:** Plaintiff argued that the alleged acts of negligence were not specifically tied to the rendering of assistance. Defendant argued that the executive order was clear and unambiguous and bestowed immunity.

- **Holding:** Plain language of the executive orders was not ambiguous. Immunity from ordinary negligence claims during governor's disaster declaration if the health care facility was rendering assistance to the State during this time.

Case Law Update

Williams v. McAllister Nursing and Rehab, LLC (Elevate Care Country Club Hills named as a Respondent in Discovery), 2024 IL App (1st) 231805

- **Background:** Pressure injury case filed against McAllister with Elevate named as a respondent in discovery (RID) under 2-402 of the Code of Civil Procedure. Elevated filed a Motion to Terminate as it could not be converted to a defendant. Denied by trial court. RID appealed.

- **Statute:** The plaintiff in any civil action may designate as respondents in discovery an entity believed to have information essential to the determination of who should be defendants in the action.

- **Issue on Appeal:** When a plaintiff names an entity as an RID, does plaintiff need probable cause against the entity or an intent to convert it to a defendant?

- **Ruling:** Plaintiff does not need probable cause or intent to convert an RID to a defendant. Court upheld the trial court's ruling and compelled Elevate to answer the production requests.

Case Law Update

Brayboy v. Advocate Health, 2024 IL App (1st) 221846

- **Background:** Wrongful death suit alleging negligence against Advocate including apparent agency for the conduct of the emergency room physician. Mother presented with a three year old with fever, vomiting and various other symptoms. Health Care Consent form with independent contractor provisions presented to the mother two hours after arrival. The child passed away after discharge a few days later as a result of a bacterial infection.

- **Procedural:** Trial Court granted Advocate's Motion for Partial Summary Judgment. Plaintiff appealed.

- **Specific Issue:** When does a notice or consent form have to be provided by a hospital to be effective?

- **Ruling:** Partial summary judgment reversed by appellate court. Genuine issue of material fact on the holding out and reliance elements of apparent agency analysis.

Case Law Update

Brayboy v. Advocate Health, 2024 IL App (1st) 221846

- **Notable Statements/Analysis by Court:** The timing of the notice or consent form must be sufficient such that it can be a realistic factor in a patient's choice to obtain treatment at the hospital.
- The notice or consent form should be presented in a meaningful way, at a meaningful time, in order to sufficiently disclaim reliance by the patient.
- Presentation of the form two hours after arrival did not present plaintiff with a real choice on whether or not to stay given the condition of her son.
- Plaintiff presented evidence that Advocate marketed itself in such an extensive way that a reasonable person could conclude that the hospital accepted responsibility for the doctors in the hospital.
- Plaintiff's discharge instructions largely contradicted the consent form
  - We examined and treated you today on an emergency basis only.
  - We cannot recognize and treat all injuries or illnesses in on ED visit.
  - Our physicians and clinical staff are committed to quality and service.

Case Law Update

Galich v. Advocate Health, 2024 IL App (1st) 230134

- **Background:** Cook County trial involving alleged inadequate oxygenation whereby the jury found against Advocate and for plaintiff. Advocate appealed the verdict based on the handling of jury questions received during jury deliberations.
- Jury sent a note during deliberations questioning the judge whether or not there needed to be a unanimous decision on a single issue of negligence within the issues jury instruction (IPI 20.01).

- **IPI 20.01:** Sets forth specific allegations of negligence against the defendants that has been supported by expert testimony at trial.

- **Specific Issue:** Does a jury need a unanimous decision on a single issue of negligence or a unanimous conclusion that the defendant was negligent?

- **Ruling:** A jury must unanimously agree that the evidence supports the conclusion that the defendant was negligent. The jury need not unanimously agree as to which of the several listed alleged negligent acts of the defendant constituted negligence.

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Pitfalls and Best Practices When Dealing with Aging and/or Impaired Physicians

ILLINOIS RISK MANAGEMENT SERVICES

MARCH 20, 2025

Presented by:
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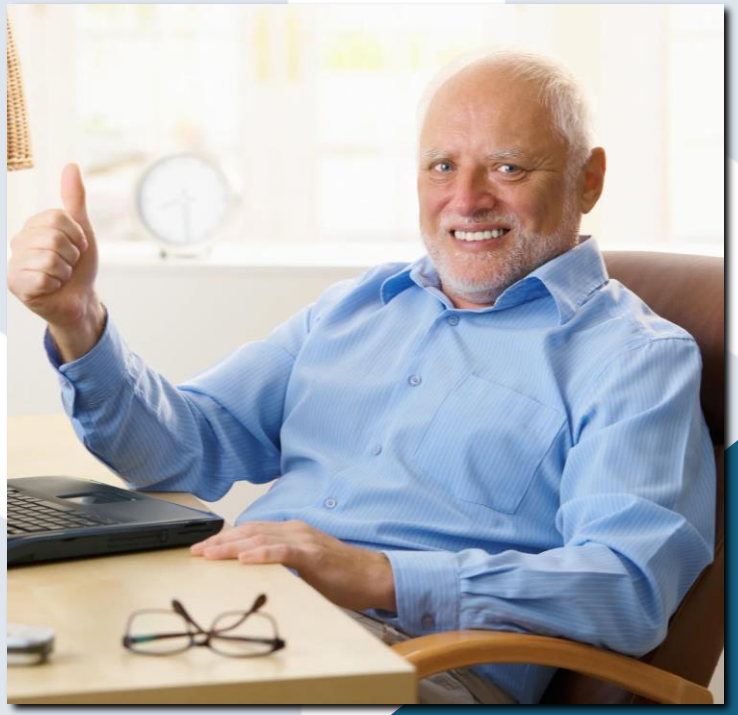
Objectives

1. Review aspects of normal aging
2. Discuss the impact of an aging physician population
3. Identify warning signs of cognitive impairment
4. Discuss cognitive screening controversies
5. Discuss controversies about age-based physician screening

The Late Career Physician

Do any of these scenarios sound familiar?

- A late-career primary care physician still wants to manage ICU patients but fails to utilize the resources of critical care physicians and underestimates the severity of his patient's illness — and an avoidable poor outcome follows.
- An older urologist with waning dexterity perforates a patient's bladder during a routine cystoscopy – maybe more than once!
- A general surgeon with a pristine 40-year track record nicks a patient's common bile duct in 50% of his most recent laparoscopic cholecystectomies.



The Late Career Physician

Too early to retire? Too late?


The New York Times

THE NEW OLD AGE

When Is the Surgeon Too Old to Operate?

A handful of hospitals have instituted mandatory screening procedures for medical professionals over 70. Many have been unenthusiastic about the idea.

In the fall of 2015, Dr. Herbert Dardik, chief of vascular surgery at Englewood Hospital and Medical Center in New Jersey, nodded off in the operating room.

Dr. Dardik, then 80, was not performing the operation. He'd undergone a minor medical procedure himself a few days earlier, so he'd told his patient that another surgeon would handle her carotid endarterectomy.

But when she begged Dr. Dardik at least to be present during the operation, he agreed to sit in. ***"I was really an accessory," he recalled. "It was so boring, I kind of dozed off"*** — whereupon an alarmed nurse-anesthetist reported the incident to administrators.

The Late Career Physician

Too early to retire? Too late?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THE NEW OLD AGE

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A handful of hospitals have instituted mandatory screening procedures for medical professionals over 70. Many have been unenthusiastic about the idea.

Within days, the hospital's chief of anesthesiology and CMO were in Dr. Dardik's office, praising his surgical skill while urging him to reduce his workload.

"I got so annoyed, I stood up and opened the door and said,'Get out,'" Dr. Dardik said. "Who knows better what I can do but myself?"

He also resisted the suggestion that he undergo testing at Sinai Hospital in Baltimore, which had established a two-day program to evaluate whether older surgeons could safely continue practicing.

Not long afterward, Dr. Dardik was on a plane when its older-looking captain came aboard (FAA regulations mandate a retirement age of 65).

"I hope this guy's still ok," Dr. Dardik remembered thinking. At which point, "it hit me like a hammer – **this is what other people think when they look at me."**

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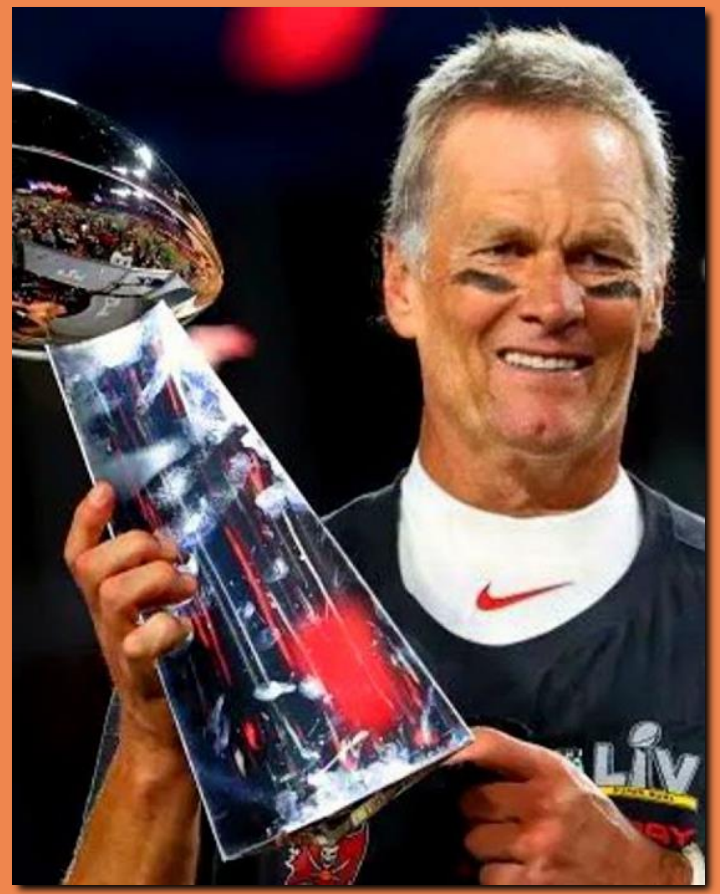
The Late Career Physician

Consideration of Competency Testing

Competency testing of late career physicians – *mandatory or voluntary* – is being considered in the larger context of:

- Rising life expectancies
- Delayed retirement for financial reasons
- Changing societal norms regarding contributions that late-career professionals can make to their professions



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Ensuring Clinician Competency

A Medical Staff Responsibility

- ***All*** Medical Staff applicants should be asked to document their ability to exercise the privileges requested safely with or without reasonable accommodation.
- The Joint Commission standards require that the hospital evaluate the health status of physicians who exercise or seek to exercise clinical privileges or other health care services.
- The Americans with Disabilities Act (ADA) prohibits discrimination based on disability and bars discrimination against a qualified individual due to the disability.
- When discussing the issue of the aging provider, it is essential to maintain compliance with state and federal law related to age discrimination.

Ensuring Clinician Competency

A Medical Staff Responsibility

A Review of Current Processes

- Bi- or Tri-annual recredentialing
- Primary source verification
- Peer references
- OPPE / FPPE data and ongoing internal Peer Review
- Patient satisfaction surveys
- Maintenance of Board Certification
- NPDB entries / continuous query
- State Licensing Board sanction & citations
- Criminal background checks

Ensuring Clinician Competency

A Medical Staff Responsibility

Negligent Credentialing

- Knew or should have known about a provider's lack of competency
- Ignored series of unexpected adverse outcomes
- Lack of follow through on reports of health concerns raised by staff
- Growing body of evidence that late-career practitioners can be a potential problem
  - Clinical care
  - Behavioral concerns

EFFECTIVE AND UNIFORMLY APPLIED STANDARDS FOR GRANTING OF PRIVILEGES HELPS AVOID CLAIMS FOR NEGLIGENT CREDENTIALING

Safety Sensitive Employment

The underlying principle for fitness-for-duty assessment is the protection of the public

- Health professions
- Legal profession
- Transportation industry
- Law enforcement

The Late Career Physician

Disincentives for Retirement

- Baby boomers face financial pressures & may wish to work past traditional retirement age
- In some specialties, the financial reward for working longer will be boosted due to shortages
  - Physician supply < Demand
- Generation X, Generation Y, and Millennials prefer a work-life balance --- will tend to decrease overall physician workforce productivity

Normal Aging – Neuropsychological Changes

- Decision making
  - Differences in how decisions are reached
  - More reliance on prior knowledge
- Changes in memory
  - Recall worse than recognition
  - Slower pace of learning
  - Increased need for repetition
- Decreased speed
  - Processing speed
  - Reaction time
  - Psychomotor speed
  - Fine motor skills/dexterity

The Effects of Aging on Cognitive Function

- Diminished memory
  - Episodic memory (personally experienced events)
  - Semantic memory (acquired knowledge)
  - Working memory (ability to maintain, manipulate, and reorganize information in short-term memory)
- Diminished complex attention (processing 2 or more sources of information at the same time; ability to disregard less relevant stimuli in order to focus on a specific task)
- Crystallized intelligence, the ability to problem-solve based on *prior* learning and experience, is better preserved with aging than fluid intelligence, which is problem-solving requiring *novel* information or approaches.

Normal Aging Risks for Impairment

These are often treatable conditions

Exacerbated By On Call Burden

Sleep deprivation

- Earlier waking time
- Difficulty initiating sleep
- More nighttime awakenings
- Lighter sleep
- More difficulty adjusting to shift changes

Sensory loss

- Vision
- Hearing

Identifying Cognitive Impairment

Potential clues to cognitive deficits

- Poor business decisions
- Loss of skill (bad outcomes, medical errors, prescription errors)
- A failure to remediate skills following competency assessment
- Clinic staff concerns (or turnover)
- Lawsuits or complaints to regulatory agencies
- Dissatisfied patients
- Professional boundary problems (judgement)
- Irritability, impatience, mood swings
- ***Skill deficit vs Knowledge deficit vs Cognitive deficit?***

Identifying Cognitive Impairment

Who can, or will, help?

Family members, institutions, and colleagues may contribute to hiding problems with an impaired physician

- Power differential
- Fear of loss
  - Practice
  - License
  - Prestige
- Hesitancy to “betray” a colleague
- Social stigma of dementia / other illness

The Impaired Physician

Not my brother's keeper?

- **A 2005 STUDY** found physicians would be more likely to report a colleague impaired due to substance abuse rather than cognitive decline or psychological impairment

- **A 2010 STUDY** showed 20% of physicians had encountered an impaired colleague in their previous three years of practice but more than 30% had taken no action

Cui malo?

Farber NJ, et al. Physicians' willingness to report impaired colleagues. Soc Sci Med. 2005 Oct;61(8):1772-5.

DesRoches CM, et al. Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues. JAMA. 2010;304(2):187–193.

Assessing/Maintaining Physician Current Competency

- Medical professionals can – ***and do*** -- experience physical/cognitive decline with aging
- Existing credentialing/peer review/privileging may not identify decline timely enough to ensure patient safety
- *Mandatory retirement age is not a fair or reasonable solution*
- Mandatory, practical screening at a specific age strikes a fair balance between patient safety, organizational liability, and provider autonomy and dignity….but is it legal ?

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Background

- 1 in 4 US physicians is over 65
  - Represent 15% of the active workforce
- Those aged 55 – 64 make up 27% of the workforce
- Life expectancies increasing
- Financial disincentives to retirement
- Looming physician shortages

Mandatory Retirement Ages

- 56 – Air Traffic Controller
- 57 – Federal Firefighter
- 57 – Federal Law Enforcement
- 65 – Airline Pilot
- Judiciary, Military, Foreign Service, etc.

Is Mandatory Screening of Aging Providers Legal?

?

EEOC Sues Yale New Haven Hospital for Age and Disability Discrimination

Hospital Unlawfully Subjected Only Physicians Over 70 to Neuropsychological and Eye Exams, Federal Agency Charges

NEW HAVEN - Yale New Haven Hospital, the teaching hospital of the Yale School of Medicine, violated federal law by adopting and implementing a discriminatory "Late Career Practitioner Policy," the U.S. Equal Employment Opportunity Commission (EEOC) charged in a lawsuit filed today.

According to the EEOC's lawsuit, the policy requires any individual aged 70 and older who applies for or seeks to renew staff privileges at the hospital to take both neuropsychological and eye medical examinations. Individuals and employees younger than age 70 are not subject to these requirements.

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Cognitive Impairment Concerns

It's not just an age issue

If the organization knew or ***should have known*** that a practitioner is not qualified (due to training, quality, *or* cognitive deficits) and the practitioner injures a patient through an act of negligence, the organization can be found separately liable for the ***negligent credentialing*** of this practitioner.

522 lawsuits filed against retired orthopedic surgeon, Ascension St. Vincent's

Dr. David Heekin is accused of operating on patients while impaired by a progressive neurological condition

2022

Between 2016 and 2020, patients noticed Dr. Richard David Heekin slurring his words and having "difficulty with balance, inability to concentrate, angry outbursts, erratic behavior, gait disturbances and impaired judgment and mood," according to court documents.

License surrendered 2021

The suits claim the hospital allowed Dr. David Heekin to operate on patients for years even as he was allegedly suffering a progressive neurological condition that caused him to lose his balance and slur his speech. The suits allege he caused devastating injuries and even the death of one patient.

I-TEAM: Appeals court rules more than 2,700 texts and images regarding doctor at the center of malpractice lawsuits be released in discovery

St. Vincent's employees whose communications are at issue planning to ask for a rehearing, court filing shows

The text messages and images in question are from 2014 to 2021.

litigated has been disclosed by the plaintiffs in public legal filings. It says, we "are going to both report him to the state I think. He is out of his mind today. He's so confused... "not making any sense," and "can't form a full sentence."

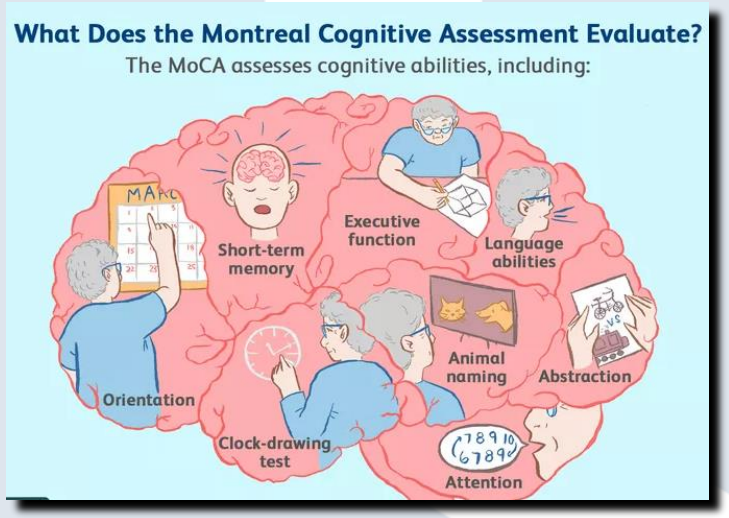
I-TEAM: Former Ascension CEO compelled to testify at deposition in negligence lawsuits

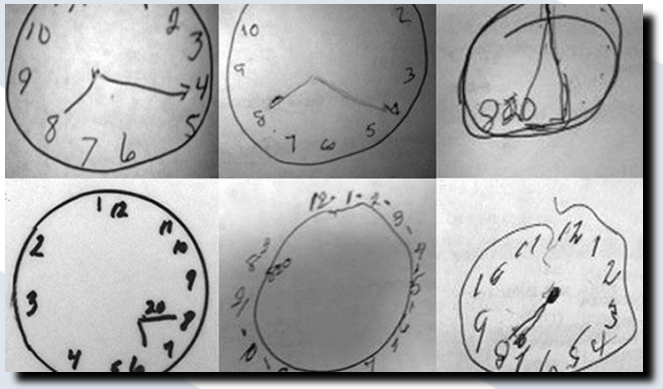
A former orthopedic surgeon at Ascension St. Vincent's accused of operating while impaired in hundreds of lawsuits

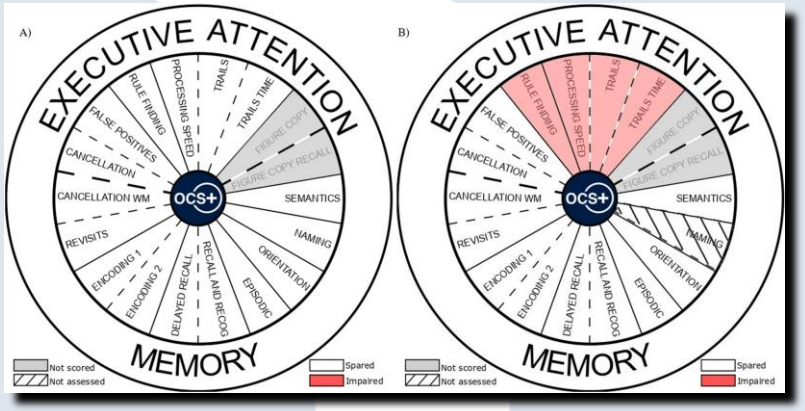
Cognitive Screening

The Challenges

- There is no single universally accepted screen that satisfies all requirements in the detection of cognitive impairment
- There are many screening tests, but few have been well validated
- Many have low accuracy for mild levels of impairment
- Many have demographic biases in score distribution
- Many over-emphasize memory dysfunction
- Cannot be used to create a differential diagnosis because they are designed to identify specific dementia subtypes







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Cognitive Impairment Concerns

What to do?

Relying upon complaints or "referral for cause" after concerns have already arisen may sacrifice opportunities to detect a physician's impaired performance at a stage when remediation might be more successful and future errors more effectively prevented.

Self Referral For Cognitive Evaluation

- *Self referral for evaluation requires self-awareness.* Even cognitively normal adults have been shown to be poor judges of their own cognitive performance
  - Maintenance of certification process
  - The Post-Licensure Assessment System (PLAS) - joint activity of the National Board of Medical Examiners and the Federation of State Medical Boards.
  - UCSD's Physician Assessment and Clinical Education Program (PACE)
  - Colorado's CPEP (Center for Personalized Education for Professionals)
  - Pennsylvania Medical Society's LifeGuard Assessment
  - Texas A&M University Rural and Community Health Institute KSTAR Program (Knowledge, Skills Training, Assessment, & Research)

https://www.fsmb.org/spex-plas/plas-information/
https://www.paceprogram.ucsd.edu/
https://www.cpepdoc.org/
https://architexas.org/programs/kstar-physician/index.html

Existing and Alternative Age Neutral Policies

- **Physician Wellness Committees**
  - Physician Wellness committees are designed to accept the referrals from medical staff leadership or committees when there is a reasonable suspicion that a physician may suffer from some form of physical, psychiatric or other impairment which could result in adverse patient consequences
  - This committee typically is multidisciplinary in nature, including a psychiatrist, which will then either conduct an initial evaluation which can take many forms or which may refer the physician to an outside agency for a more thorough evaluation including physicals, fitness for duty evaluation, or neuropsychological testing

Existing and Alternative Age Neutral Policies

- All of these policies are age neutral but rely on either self-reporting or the reporting of by peers and other individuals at the Hospital
  - Studies have demonstrated that there is significant under reporting even when suspected impairment, disruptive behavior and other forms of unacceptable conduct is observed.
- Factors Associated with Cognitive Decline
  - The various studies and publications which have observed certain quality of care, physical, psychological, cognitive and other deficits associated with aging have identified the following factors, some of which may already be tracked within an organization through one of the existing programs and policies identified above. These include but are not limited to the following:

Existing and Alternative Age Neutral Policies

- ✓ Disruptive behavior
- ✓ Fatigue, stress and burnout
- ✓ Decline in clinical performance
- ✓ Longer length of stays
- ✓ Incomplete medical records, inappropriate comments contained in medical records and documentation errors
- ✓ Prescription errors
- ✓ Billing mistakes
- ✓ Irrational business/patient care decisions
- ✓ Skill defects
- ✓ Patient complaints

Existing and Alternative Age Neutral Policies

- ✓ Office staff/peer observations of deficits
- ✓ Patient injuries
- ✓ Lawsuits
- ✓ Unsatisfactory peer review evaluations
- ✓ Failure to keep up with continuing medical education requirements
- ✓ Recertification failures
- ✓ Decreased processing speed
- ✓ Increased difficulty inhibiting irrelevant information
- ✓ Decreased hearing and visual acuity
- ✓ Decreased manual dexterity

Existing and Alternative Age Neutral Policies

- ✓ Decreased visuospatial ability
- ✓ Higher mortality rates
- ✓ Diagnostic errors
- ✓ Use of outdated medications and treatment forms and modalities

- **Alternative Approaches and Policies**
  - ➢ Incorporate all or some of the factors listed above into the routine appointment and reappointment application process in which these factors are investigated, identified and reflected in reports being sent to the Department Chair, the Credentials Committee, the MEC and eventually the Board of Directors

Existing and Alternative Age Neutral Policies

- Incorporate some or all of these factors into existing FPPE/OPPE policies which are then monitored on a continuous basis and reviewed, as appropriate, as part of collegial intervention and routine peer review processes
- Strongly recommend that physicians who reach a particular age or a certain number of years in practice that they voluntarily agree to take a physical, ophthalmologic, neuropsych evaluation or other evaluative process as deemed acceptable by the medical staff and Hospital
  - decision would be voluntary and refusal to do so should not result in any disciplinary action, reduction in staff category or other similar adverse outcome

Existing and Alternative Age Neutral Policies

- in the event that deficits are identified, the physician will be required to disclose the report so that it can be further reviewed and appropriate next steps taken
- If the practitioner does not agree to be voluntarily assessed, to the extent that the Hospital has not already incorporated the factors above into an FPPE/OPPE Policy, the Hospital could then do a concurrent or retrospective review of the practitioner's cases and other practices to determine whether there are any red flag factors which could result in further reviews or a requirement to undergo identified evaluations

Non-Disciplinary Remedial Measures

- As should be true with existing policies, the identification and confirmation of any problems relating to impairment or any form of deficit should not, absent extreme danger to patients, result in the imposition of disciplinary action.
- Hospitals and medical staffs should instead implement and apply its existing peer review policies and collegial intervention methods in order to identify the cause of any identified issues in order to allow the physician to address these issues and to attempt to identify other remedial steps short of disciplinary action

Non-Disciplinary Remedial Measures

- Depending on the results of this review, it may be appropriate to then work with a Physician Wellness Committee which would serve as an advocate for the physician but also require a physical examination, ophthalmological test as well as neuropsych evaluations in order to identify whether the physician suffers from such defects that require that some form of support or alternative practice options should be considered.
- These other remedial measures can include the following:
  - Changing/limiting practice
  - External support
  - Retraining/reeducation
  - Eliminate or reduce procedural work

Non-Disciplinary Remedial Measures

- Allow more time in taking care of and treating patients
- Provide memory aides
- Provide or require consultations with other physicians for second opinions
- Reduced or removal from ED on call schedule
- Mandatory consultations
- Proctoring

Questions & Answers

Michael R. Callahan
Senior Consultant

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Michael R. Callahan brings an unparalleled level of healthcare consulting experience. Formerly a healthcare attorney for over 40 years, he provides consultative services, educational programs and thought leadership in his role as Senior Consultant.

His areas of focus include hospital/physician relations, medical staff bylaws and policies, peer review policies and investigations, privileging and credentialing issues, National Practitioner Data Bank guidelines and reporting standards, EMTALA standards, accreditation compliance, medical staff integration and hospital/medical staff disputes.

In addition, he is recognized as a national expert involving all aspects of the federal Patient Safety and Quality Improvement Act of 2005.

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Thank You!

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Appendix
Physician Late Career Policies Under EEOC Attack

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Yale’s Late Career Practitioner Policy

- **Overview**
  - Since March 2016, as a condition of appointment, continued appointment and reappointment, MDs, DOs, dentists, podiatrists and certain advanced practice providers who require medical staff clinical privileges and who are 70 years or older must undergo a neuropsychological screening evaluation and a basic ophthalmologic exam.
  - The evaluation and exam are conducted thereafter at the time of reappointment.

Yale's Late Career Practitioner Policy

- The cognitive function evaluation includes 16 tests which are administered by a neuropsychologist and focus on the following areas:
  - information processing
  - visual scanning and psychomotor efficiency
  - processing speed and accuracy
  - working memory
  - concentration
  - verbal fluency
  - executive function

Yale's Late Career Practitioner Policy

- Results are reviewed by a medical staff committee which then makes recommendations to the Credentials Committee.
- The medical staff physicians at the Hospital are not Hospital employees.

- **Results**
  - As of April, 2019, the Policy was applied to 145 individuals.
  - The age range was 70 to 84 – average age was 74.
  - 86% were men and 89% were physicians.
  - 14 were listed as "Borderline deficient"
  - 1 was listed as "Deficient"
  - 7 "Failed"

Yale's Late Career Practitioner Policy

- 5 were "N/A" because they refused testing and either resigned or changed their status.
- 80 "Passed"
- 38 "Qualified Passed"
  - 21 have been retested a second time and all "Passed" or "Qualified Passed"
- 18 demonstrated cognitive deficits that were likely to impair their ability to practice medicine independently
  - None were independently identified as having performance problems
  - All opted to voluntarily discontinue their practice or move to a closely proctored setting

Interrelationship between Hospital and Yale Medical School (“YMS”)

- Hospital and YMS operate under a 100-page Affiliation Agreement.
- Agreement fully integrates the operations of both.
- YMS has a large say on who heads each clinical department.
- All YMS faculty with appointments in clinical departments must obtain and maintain medical staff privileges at the Hospital.
- Hospital has a comprehensive appointment/reappointment process and ongoing monitoring and peer review procedures including the imposition of an FPPE or similar plan when warranted.

EEOC Complaint

- Plaintiff is a pathologist who filed a charge with the EEOC 30 days prior to filing of the lawsuit alleging violations of the Age Discrimination in Employment Act, 29 USC Section 621, et. seq. (“ADEA”) and the Americans with Disabilities Act, 42 USC Section 12101, et. seq., as amended by the Americans with Disabilities Act Amendment Act of 2008 (“ADA”).

- EEOC issued a Letter of Determination finding reasonable cause that the Hospital violated the ADEA and ADA with respect to the Plaintiff and other aggrieved individuals because the Policy only applied to practitioners who were 70 or older rather than to all practitioners irrespective of age.

EEOC Complaint

- EEOC issued a Notice of Failure of Conciliation on October 11, 2019 when efforts to reach an acceptable agreement failed.
- The EEOC Complaint was filed on February 9, 2020, in the U.S. District Court in the District of Connecticut.

- **ADEA Claim**
  - ➢ The ADEA makes it unlawful, among other things, for an employer:
    - ✓ to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age;

EEOC Complaint

- ✓ To limit, segregate, or classify his employees in any way which would deprive or intend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's age;

➢ Because the Policy applied only to those age 70 or above, the Plaintiff, who passed the examinations, and other employees were subjected to the stigma of being singled out because of their age and to unlawful discrimination and classification of applicants and employees in violation of the ADEA

EEOC Complaint

- The effect of the practices has been to deprive the Plaintiff and a class of applicants and employees age 70 and above of equal employment opportunities and otherwise to affect adversely their status as applicants or employees because of their age

- The unlawful employment practices complained of were willful within the meaning of the ADEA

EEOC Complaint

- **ADA Claims**
  - The ADA states that an employer “shall not require a medical examination and shall not make inquiries of an employee as to whether such employee in an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity” (42 USC Section 12112(d)(4)(A))
  - The Policy’s ophthalmologic and neuropsychological exam are medical examinations under the ADA and their use on the Plaintiff and other employees solely on the basis of their age violates the ADA
- The unlawful employment practices complained of were intentional and done with malice or with reckless indifference to the federally protected rights of the Plaintiff

EEOC Complaint

- **Interference with Rights Protected by the ADA**
  - The ADA makes it unlawful to “interfere with any individual in the exercise or enjoyment of any right granted or protected by [the ADA].”
  - Under the ADA, an employee has a right to enjoy employment free from unlawful medical examinations
  - By subjecting the Plaintiff and other YSM employees (and employees of other employers) whose employment with YSM (and other employers) requires the receipt and maintenance of medical staff privileges at the Hospital to medical examinations under the Policy, the Hospital has unlawfully interfered with these employer’s rights under the ADA

EEOC Complaint

- **Comment**
  - The EEOC in its EEOC Compliance Manual, Section 2 – Threshold Issues, has a Section entitled “Third-Party Interference with Employment Opportunities.” This Section provides as follows:
    - ✓ In addition to prohibiting employers from discriminating against their employees, Title VII, the ADEA, and the ADA prohibit a covered third-party employer from discriminatorily interfering with an individual’s employment opportunities with another employer.
    - ✓ While the third-party employer might, in some cases, be a joint employer, the principle described here applies even where an employment relationship has never existed between a third-party employer and the individual. This kind of liability is commonly known as “third-party interference.”

EEOC Complaint

- ✓ The ADA specifically prohibits interference with rights protected under the statute. While Title VII and the ADEA do not include comparable provisions, they prohibit discrimination against “individuals”. Therefore, a charging party need not necessarily be an employee of the employer that is accused of discriminatory interference.

- ➢ The EEOC gives an example of how this third-party interference principle applies in the context of a hospital/physician relationship very similar to its arguments against Hospital.

EEOC Complaint

- ✓ Respondent is a hospital that receives emergency room services from ABC Medical Corp. CP is employed by ABC as the director of Respondent's emergency room. CP files a charge alleging that Respondent discriminated against her on the basis of age and sex by asking ABC to replace her with a younger male director. Respondent is a covered employer under Title VII and the ADEA. Under these circumstances, CP has a Title VII and ADEA claim against Respondent for interfering with her employment relationship with ABC. If Respondent exercises sufficient control over CP, it may also be a joint employer.

EEOC Complaint

- ✓ See Enforcement Guidance On Control By Third Parties Over The Employment Relationship Between An Individual And His/Her Direct Employer, EEOC Compliance Manual, Volume II, Appendix 605-F.
- ✓ See Sibley Memorial Hospital v. Wilson, 488 F.2d 1338, 1341 (D.C. Cir. ✓ 1973).

EEOC Complaint

- **But**
  - Plaintiff and most of the physicians are not employed by the Hospital – they are employed by the University
  - EEOC has alleged in its their complaint that all Physicians affected by the Policy are employees
  - EEOC, at this stage at the pleadings, is not required to set forth the basis of it's claim that the independent physicians are employees.
  - Independent contractors cannot seek protection under the ADEA or ADA

EEOC Complaint

- Absent a direct to employment relationship, a claimant must establish that, in this case, the Hospital has sufficient and direct control over the individual. Some factors include:
  - ✓ When, where, and how the individual performs the job
  - ✓ Does job require a high level of skill or expertise
  - ✓ Does the Hospital furnish the the tools, materials and equipment
  - ✓ Does the Hospital have a right to assign additional projects to the worker
  - ✓ Does the Hospital set the hours of work and duration of the job
  - ✓ Is the individual paid by the hour, week, or month rather than the agreed cost of performing a particular job

EEOC Complaint

- ✓ Does the individual hire and pay assistants
- ✓ Can the Hospital discharge the individual

- ➢ A Hospital which has an existing late career policy or which is considering such a policy should consult with legal counsel to determine whether there have been court decisions within its jurisdiction which have addressed these direct control factors to determine whether independent physicians will be treated as employees for purposes of Title VII, the ADEA or the ADA

Hardenbergh Group

Working with Hospital-Based Practice Groups to Monitor and Enforce Quality and Peer Review Standards

Illinois Risk Management Services

March 20, 2025

Presented by:
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Hardenbergh Group

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Background

- Most hospitals and health systems have physicians and physician groups provide hospital-based services usually through some form of contractual arrangement
- Example services include ED, radiology, pathology and anesthesia
- More recently, hospitals have entered into similar arrangements, usually exclusive, for other specialty services such as ICU, cardiology, and call-coverage

Background

- When the relationship is with an independent physician group, hospitals have expressed concern about whether the groups are totally transparent when adverse patient events occur either within their group practice, in the hospital, or at other practice sites in which they have a contractual arrangement.

Background

- The failure of the group or the hospital to identify and address these events, as well as to determine whether the group has complied with quality standards as well as applicable legal and accreditation standards as well as hospital policies can lead to increased liability exposure to the hospital, loss of reimbursement as well as running afoul with regulatory and accreditation agencies.

Legal Liability Theories

- Respondeat Superior
  - When the physician or physician group is employed by the hospital as the employer, the hospital will be directly liable for any of the provider's negligent conduct which results in a patient's compensable injury.

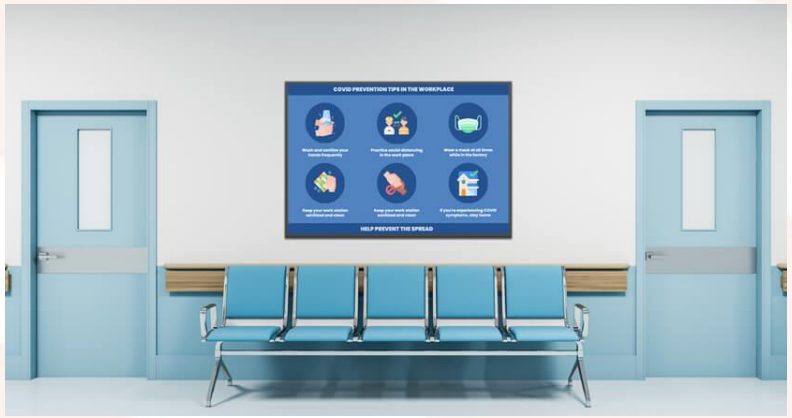
- Negligent Credentialing/Corporate Negligence
  - If the hospital gave clinical privileges to an unqualified practitioner, or if it knew or should have known that the practitioner was unqualified, it can be held liable under this theory if it caused a patient's compensable injury. This liability theory applies to independent, non-employed practitioners.

Legal Liability Theories

- Apparent/Ostensible Agency
  - ➢ The apparent agency standard in Illinois was articulated in the Supreme Court of Illinois decision in Gilbert v. Sycamore in 1993:
    - ✓ The hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital; 2) where the actions of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of or acquiesced in them and; 3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary are and prudence."

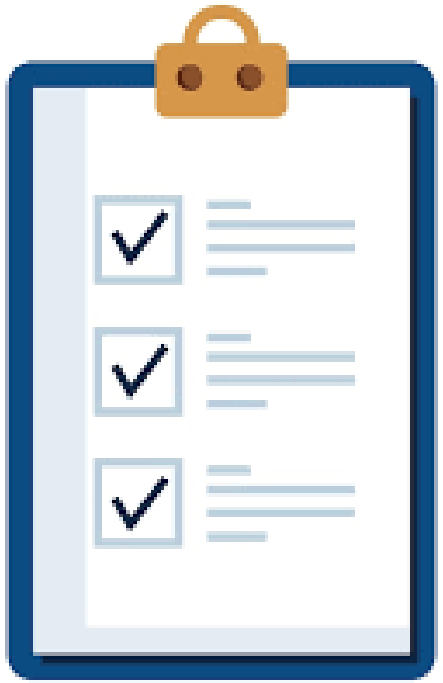
Legal Liability Theories

- To defend against apparent agency arguments, hospitals have informed patients through signage, language in the informed consent form and in verbal communications that the hospital-based practitioners are not employed by the hospital and are instead independent contractors responsible for their own actions.



Regulatory/Accreditation Standards

- CMS Conditions of Participation
- EMTALA
- Hospital Licensing Act
- Joint Commission



Available Privilege Protections From Discovery

- Illinois Medical Studies Act
  - Privilege protections apply to hospital and employees but not independent physicians or physician groups
- Medical Practice Act
  - Privilege protections apply to physicians and physician groups
- Patient Safety and Quality Improvement Act of 2005
  - Broader privilege protections apply to hospital and to physicians or physician groups if "affiliated" with the hospital
  - Protections contingent on whether the hospital in a member of a PSO and employs, owns, controls or manages the group or if group is in a PSO

Methods Used to Monitor Quality and Peer Standards

- Development and enforcement of applicable quality indicators, metrics and quality improvement initiatives
- Development and enforcement of process and outcome measures
- Development and tracking of compliance with OPPE and FPPE standards
- Data collection and patient satisfaction surveys
- Compensation/bonus/sharing arrangements tied to compliance with quality improvement goals

Methods Used to Monitor Quality and Peer Standards

- Contract includes key requirements
  - ➢Must comply with all legal, regulatory and accreditation standards as well as the medical staff and hospital bylaws, rules, regulations and policies.
  - ➢Hospital has the right to audit compliance
  - ➢Group required to disclose any and all instances of patient complaints, adverse events, threatened or actual litigation, termination from Medicare/Medicaid/Managed care programs, etc., emanating from any practice site.
  - ➢ Failure to comply, with opportunity to cure, is grounds for terminating a particular physician or the group as a whole

Methods Used to Enforce Quality and Peer Standards

- Hospital has the right access group policies and procedures to determine compliance
- Hospital has the right to membership on key physician group committees
- Clean sweep provisions - if physician/group contract is terminated, hearing and appeal rights are waived - no Data Bank reporting is required
- Bylaws and provider agreement state that in the event there is a conflict between the bylaws and the agreement, the agreement prevails

Other Related Issues and Considerations

- Make sure that all quality related information is collected and shared from all practice sites where group is treating patients within hospital/health care system
- For independent groups, review insurance coverages to make sure that required limits apply to each group practice site
- Request list of exclusions including the COI
- Strive for uniform contracts, and quality standards and clinical privilege eligibility criteria

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Questions?

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Michael R. Callahan brings an unparalleled level of healthcare consulting experience. Formerly a healthcare attorney for over 40 years, he provides consultative services, educational programs and thought leadership in his role as Senior Consultant.

His areas of focus include hospital/physician relations, medical staff bylaws and policies, peer review policies and investigations, privileging and credentialing issues, National Practitioner Data Bank guidelines and reporting standards, EMTALA standards, accreditation compliance, medical staff integration and hospital/medical staff disputes.

In addition, he is recognized as a national expert involving all aspects of the federal Patient Safety and Quality Improvement Act of 2005.

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Thank You!

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