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ILLINOIS STATE BAR ASSOCIATION

HEALTH CARE LAWYER

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

All the latest developments in health care law

By W. Eugene Basanta and Nicholas Schroer

Cases

Federal decisions

ERISA does not preclude change to benefit plan

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001 et seq., was enacted by Congress in 1974 with the objective of ensuring that "disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee pension and benefit] plans" including addressing the problem that "many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans." 29 U.S.C. §1001(a). A recent decision from the Seventh Circuit however illustrates that, with respect to health benefit plans, ERISA offers little in the way of real protections for retired employees.

The defendant-employer established a health care plan for its employees, including retirees, in 1982. Among its provisions, the plan provided that retirees were responsible for paying half the cost of the benefit plan, while the defendant-

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How does a violation of the Nursing Home Care Act affect a facility's right to recover unpaid amounts?

By Laura A. Elkayam and Lawrence J. Stark

Introduction

The Illinois Nursing Home Care Act (the "Act") states that: "[b]efore a person is admitted to a facility…a written contract shall be executed between a licensee and [a patient or patient's representative]." Though observance of this provision may not seem terribly burdensome, many nursing homes have loosely complied. Sometimes signatures cannot practically be obtained prior to admittance; sometimes patients withhold signature despite otherwise agreeing to and accepting the terms of their care; and sometimes signatures are never obtained due to simple administrative carelessness.

After rendering care for months or even years to a patient who fails to pay the tab, a nursing home that wishes to sue may find itself haunted by its technical non-compliance with the Act. Surely there are consequences for failing to "execute" a "written contract" as required by the Act, but what are they? Is a nursing home barred from seeking recovery of unpaid amounts on the contract? Can it, at the very least, maintain an equitable action in quantum meruit and try to prove the reasonable value of its services? Or are the sanctions for violating the Act limited to those specified in the Act itself?[2]

Thirty years after the Act's passage, we now have a partial answer. In May of 2010, the First District of the Illinois Appellate Court, in *Carlton at the Lake, Inc. v. Barber*, held that nursing homes seeking to recover amounts due on unsigned contracts could seek equitable relief under a theory of quantum meruit, but that public policy, as expressed by the Act, required dismissal of breach of contract claims predicated on these

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All the latest developments in health care law

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employer paid the other half. Additionally, under the plan, retired employees could pay their share of the costs of the health benefit plan out of any unused sick leave pay balance they had at retirement. The plan also contained a standard reservation of rights provisions specifying that the defendant, " must necessarily and does hereby reserve the right to amend, modify or terminate the plan . . . at any time by action of its Board." Relying on this provision, and in light of the fact that by 2008, the amount of accumulated retiree sick leave pay owed by the defendant had reached $121 million, it decided to stop paying any part of retirees' health plan costs, including using sick leave accounts to pay those costs. A class action was then brought by a group of retirees under ERISA. The trial court dismissed the suit on the pleadings and the plaintiff-retirees appealed.

In an opinion by Judge Easterbrook, a split panel of the Seventh Circuit upheld the trial court's decision. In doing so, the court explained that, under ERISA, there is no vesting of an employee's interest in a health benefit plan, absent a contract creating vested rights. Here, as Judge Easterbrook observed, the plan included a reservation of rights provision permitting the defendant to amend or end the plan at any time. See *Vallone v. CAN Financial Corp*. 375 F.3d 623 (7th Cir. 2004). Additionally, Judge Easterbrook noted that, while an employer has certain fiduciary duties under ERISA, those duties encompass how the plan is administered, and not whether to establish, amend, or even terminate the plan. Thus, when the defendant decided in 2008 to stop paying for health benefits for retirees, including their sick leave accounts, the defendant had the right to do so, "even though this dashed retirees' expectations."

In upholding the trial court's decision, the court's majority rejected the argument that the defendant had diverted plan assets, namely the sick leave account balance, from the plan to its own benefit in violation of 29 U.S.C. §1106(a)(1)(D). In the court's analysis, the sick leave account balance of $121 million was an unfunded liability of the defendant and not a plan asset. "Any given retiree might have deemed the balance a personal asset, in the sense that it represented [defendant's] promise not to ask the retiree to pay for health care until the balance had been exhausted. But §1106(a)(1)(D) deals with assets *of the Plan*, not with employers' unfunded promises." (Emphasis in original). The court also rejected any argument that somehow the defendant had created vested rights for the retirees in the plan. While the court acknowledged that, at times, documents distributed by the company, such as summary plan descriptions, made no mention of any right to change or end the plan, the fact remained, the court said, that the defendant had consistently retained that right. That the retirees had a reliance interest in use of their sick leave accounts to pay for their health care in retirement provided no basis to limit the defendant's choices regarding changing or discontinuing the plan.

In his dissent, Judge Hamilton was of the view that the retirees' reliance on the promise of the defendant to use their sick leave balance to help pay for their health benefits provided a basis to challenge the plan change regardless of the defendant's reservation of rights. Looking to the concept of promissory estoppel and to the language of the plan documents as a whole, Judge Hamilton found a basis for the retirees' claim. In part he urged the court to reconsider its absolute deference to the reservation of rights clause in order, "to pursue ERISA's fundamental purposes of protecting employee benefits from abusive practices of employers and to use the equitable doctrine of promissory estoppel when its elements are proven." *Sullivan v. CUNA Mutual Insurance Society,* No. 10-1558 (7th Cir., Aug. 10, 2011).

Seventh Circuit follows *Greber*

In 1985, when the Third Circuit U.S. Circuit Court of Appeals decided *United States v. Greber,* 760 F.2d 68 (3d Cir. 1985) dealing with the scope and meaning of the federal Medicare and Medicaid anti-kickback statute, 42 U.S.C. §1320a-7b(b), it sent shockwaves through the health care business and legal communities. The anti-kickback statute in relevant part provides that if a party, "knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) . . . in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program. . ." that person is guilty of a felony. §1320a-7b(b)(1). In *Greber*, the court ruled that if, in part, any payments to a physician were intended to induce patient referrals, the statute was violated, "even if the payments were also intended to compensate for professional services." In a May 2011 decision, the Seventh Circuit joined the Third Circuit, as well as other federal circuits, by adopting *Greber's* position regarding intent under the anti-kickback statute.

The case involved criminal charges against several parties, including the defendant-physician, arising from a plan under which the physician and others were paid substantial sums of money to refer patients to an inpatient psychiatric facility for Medicare-reimbursed services. To disguise these payments, the physician and his colleagues were placed on the facility's payroll, given false job descriptions, and filed false timesheets. Following his conviction, the physician appealed, arguing in part that the trial court had erred by applying the *Greber* intent standard, rather than a "primary motivation" standard. Under this alternative standard, a defendant can avoid violating the federal law, "if the primary motivation behind the remuneration was to compensate for bona fide services provided."

In an opinion by Judge Kanne, the appeals court rejected the physician's argument. "Nothing in the Medicare fraud statute implies that only the primary motivation of remuneration is to be considered in assessing [the defendant's] conduct. We join our sister circuits in holding that if part of the payment compensated past referrals or induced future referrals, that portion of the payment violates 42 U.S.C. § 1320a-7b(b)(1)." *United States v. Borrasi,* 639 F.3d 774 (7th Cir. 2011).

Illinois decisions

Siemieniec's application of the zone-of-danger rule overruled

A recent decision from the Illinois Supreme Court, held that the "zone-of-danger rule" only applies in certain cases where a plaintiff's main theory of liability is negligent infliction of emotional distress. In doing so, the Illinois Supreme Court overruled *Siemieniec v. Lutheran General Hosp.*, 117 Ill. 2d 230, 512 N.E.2d 691 (1987).

In *Siemieniec*, the court recognized that the parents of a child born with a congenital or genetic disorder have a cause of action in

tort if, but for the defendant's negligence in testing as to the risk of giving birth to a child with the condition, the parents would have avoided conceiving or ultimately terminated the pregnancy. Under *Siemieniec,* the remedies sought by the parents of a child born with hemophilia included the extraordinary medical costs and other expenses in caring for the child during their minority, as well as damages for emotional anguish and suffering. The court also held that the parents could not recover damages for emotional distress as an "element in the calculation of damages" for wrongful birth since they could not state a claim for negligent infliction of emotional distress under the "zone of danger rule."

In the instant case, the plaintiffs brought suit against a group of defendants, including a hospital, physicians, and several other medical professionals, seeking damages for wrongful birth and negligent infliction of emotional distress after their second child was born with Angelman Syndrome. The plaintiff-parents gave birth to their first child in 1997. After this child began displaying prolonged developmental delays, the plaintiffs sought genetic testing in 2000 from one of the defendant-physicians in an attempt to determine if their child had Angelman Syndrome. The defendant-physician ordered a genetic sequencing test, which was performed by several other defendants. Soon thereafter, the defendant-physician reported to the plaintiffs that their son's condition was not caused by a genetic abnormality.

Prior to planning another pregnancy, the plaintiffs sought a second opinion from a different defendant-physician to determine if their son suffered from Angelman Syndrome due to a UBE3A gene mutation. In 2001, this defendant-physician expressed to the plaintiffs that all of the genetic mechanisms that could have caused Angelman Syndrome were ruled out. Unfortunately, both this communication and the previous communication to the plaintiffs regarding the test results were incorrect. The sequencing analysis of the DNA indicated that the plaintiff's son actually suffered from Angelman Syndrome due to the mutation of the UBE3A gene.

Relying on the faulty information they were given by the defendants, the plaintiffs decided to have another child. In March 2002, the plaintiff-wife gave birth to another son. In July of the same year, the plaintiffs began noticing that their newborn son was also displaying the same developmental issues that their older son displayed. Thereafter, in September, the plaintiffs requested a copy of one of the previously conducted UBE3A sequencing tests. The plaintiffs were told that the test results could only be released to the physician who conducted the examination, but were also told that the results of the test were "abnormal." After counsel for the plaintiffs eventually obtained the sequencing results, it was evident that the son's UBE3A gene was truncated and further testing was needed to determine if the mother was the carrier of this abnormal gene. Later tests showed that this gene mutation was inherited from the mother. Plaintiffs argued that had they been given this information after the tests were conducted, they would not have conceived another child.

In September of 2003, the plaintiffs filed a wrongful-birth complaint that was then amended several times. The first amended complaint added a physician and a hospital. Soon thereafter, the plaintiffs voluntarily dismissed a research facility as a defendant and then reached settlements with a physician and two health care professionals. In 2006, the remaining defendants, the hospital and physician, moved for summary judgment on the ground that the plaintiffs had failed to bring suit against them within the two year limitation set forth in 735 ILCS 5/13-212. The trial court stated that there was "a question of fact" as to when the limitation period began to run on the plaintiffs and ultimately dismissed the motion.

The plaintiffs' third amended complaint was filed in 2008, seeking damages for wrongful birth. These damages included extraordinary costs of caring for their child during his minority, the extraordinary costs of caring for him after reaching the age of majority, and costs for their lost wages. Plaintiffs also sought damages for the separate tort of negligent infliction of emotional distress. The circuit court ruled that the plaintiffs were allowed to recover damages for the extraordinary costs of caring for their son during his minority, but were unable to recover damages for the extraordinary costs of caring for their son after reaching the age of majority. The court then dismissed the portions of the plaintiff's complaint concerning negligent infliction of emotional distress, damages for their son's lost wages, and the expenses of caring for their son during his majority pursuant to 735 ILCS 5/2-615. The court concluded that the only remaining claim, which sought damages for the extraordinary expenses of caring for their son during his minority, was completely offset by the settlement with the

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previous defendants. Therefore, the circuit court dismissed the case with prejudice, stating that there was no just reason to delay enforcement or appeal.

On appeal, the appellate court affirmed in part and reversed in part, and then remanded for further proceedings. *Clark v. Children's Mem. Hosp.,* 391 Ill. App. 3d 321, 907 N.E.2d 49 (1st Dist. 2009). The circuit court's dismissal of the counts seeking damages for the costs of care after the son reached the age of majority as well as the counts alleging negligent infliction of emotional distress were reversed. However, the circuit court's dismissal of the counts seeking damages for lost wages was affirmed. The appellate court reasoned that any recovery for lost wages would duplicate any damages awarded for the extraordinary costs of caring for the son as an adult. The appellate court declined to consider the defendants' argument for dismissal due to the statute of limitations.

The Illinois Supreme Court cited the Illinois Marriage and Dissolution of Marriage Act, 750 ILCS 5/513 in stating that the General Assembly had expressly adopted only two exceptions to the general rule of no parental obligation for the support of children upon reaching majority. According to the court, if the legislature had wanted to place the burden of support of a disabled child on the tortfeasor rather than on the parents, it would have done so explicitly. Absent this, the court concluded that under Illinois law, parents are not obligated to support a child after the child reaches majority, even for the children unable to support themselves, unless ordered to do so under §5/513 of the Marriage and Dissolution of Marriage Act.

The court next turned to the defendants' argument that the appellate court's decision was contrary to *Siemieniec*, which rejected a plaintiff's claim for emotional distress damages in similar circumstances to the instant case. In this context, the court examined the "zone-of-danger rule." Under this rule, recovery for the negligent infliction of emotional distress by bystanders is limited to those who were in the zone of physical danger and who, because of the defendant's negligence, feared for their own safety. See *Rickey v. Chicago Transit Authority*, 98 Ill. 2d 546, 555, 457 N.E. 2d 1 (1983). *Siemieniec* applied this rule to a claim by parents under facts similar to those of the present case and concluded that the plaintiffs had not satisfied the rule because there were no allegations that the negligent acts of the defendant had endangered the parents of the disabled child.

From this perspective, the supreme court noted that the zone-of-danger rule was specifically designed for cases where the plaintiff's theory of liability for negligent infliction of emotional distress is freestanding and not linked to another tort. Furthermore, the court stated that it had erred in applying the zone-of-danger rule in *Siemieniec* to wrongful-birth claims for emotional distress. The court therefore overruled *Siemieniec* on this issue and held that the zone-of-danger rule applies only in cases where the plaintiff's only basis of liability is for negligent infliction of emotional distress, rather than in cases where the defendant's acts give rise to a separate tort claim by a plaintiff, who then also asserts emotional distress as an element of damages. In those cases where emotional distress is anchored with another tort, the court said, the zone-of-danger rule has no application.

Based on its analysis, the court affirmed the appellate court's reversal of the trial court's dismissal of the plaintiffs' claim for negligent infliction of emotional distress and reversed the ruling of the appellate court regarding the plaintiffs' ability to recover damages for post-majority expenses. The court also affirmed the trial court's ruling that denied the defendants' motion seeking summary judgment. The case was then remanded for further proceedings. *Clark v. Children's Memorial Hospital*, No. 108656 (Ill. Sup., May 6, 2011).

Court recognizes basis for medical battery claim

The family of a deceased cancer patient filed suit against the physicians and hospital caring for him at the time of his death. Among the plaintiff-administrator's claims were allegations of medical negligence and battery. The trial court granted a directed verdict for all of the defendants on the medical battery claim, as well as on the negligence claim against one of the defendant-physicians. Following a trial on other of the plaintiff's claims, the trial court entered judgment for the defendants following the jury's verdict. Finding several errors by the trial court, the First District Appellate Court reversed and ordered a new trial.

Initially, the appeals court looked at the trial court's directed verdict for the defendants on the battery counts. As the court explained, "The elements of a medical battery claim are: (1) an intentional act on the part of the defendant; (2) a resulting offensive contact with the plaintiff's person; and (3) a lack of consent." Further, the court stated that, "the gist of an action for battery is the absence of consent on the plaintiff's part." The court then observed that, "a patient is entitled to refuse medical treatment . . . even where the patient's life is in jeopardy."

In the instant case, the facts showed that the deceased patient had never signed the hospital's standard consent form. Additionally, the deceased had expressly refused the blood thinning drugs administered by the defendants. Despite this, the deceased received multiple doses of Lovenox, a blood thinner.

The appellate court rejected several arguments raised by the defendants in response to the battery claims. Specifically, the court disallowed the claim that consent to the administration of Lovenox was not required under the hospital's policies. The hospital's consent form specified that written consent was required for "any treatment or procedure which poses a risk to the patient . . . ." Finding that the administration of a drug such as Lovenox poses risks to patients and that it is a "treatment," the court held that entry of a directed verdict for the defendants on this claim was in error.

The appeals court went on to consider whether the need for consent here could be dispensed with on the basis of the so-called "emergency exception." This exception to the need for patient consent to treatment requires that (1) a medical emergency exists; (2) treatment is required to protect the patient's health; (3) it is impossible or impractical to obtain consent from either the patient or someone authorized to consent for the patient; and (4) there is no reason to believe that the patient would decline the treatment, given the opportunity to consent."

The court found this exception inapplicable in this case. "[T]he record indicates that the decedent had clearly refused Lovenox at an earlier time, and there was no evidence that any later consent was sought from decedent or his family prior to the administering of Lovenox. We find that this evidence does not establish that a medical emergency existed which would excuse any lack of consent by the decedent, so the emergency exception does not apply."

As to the directed verdict for one of the physician-defendants on the plaintiff's medical negligence claim, the appellate court found, based on the testimony of the plaintiff's expert, the evidence was sufficient to preclude a directed verdict. Finally, the court held that the trial court had made several evidentiary errors that had prejudiced the plain-

tiff. As a result, the case was remanded and a new trial was ordered. *Sekerez v. Rush University Medical Center*, No. 1-09-0889 (Ill. App. 1st Dist., June 30, 2011).

Judgment in fentanyl products liability suit upheld

Following a trial, an $18 million judgment was entered against a drug company in connection with the death of a patient who had been using the company's prescription transdermal drug skin patch to receive the pain medication fentanyl for chronic neck pain. The patient died when the patch, which was part of a lot recalled by the defendant-drug company due to a risk of leakage, allegedly malfunctioned, resulting in an overdose of fentanyl. On appeal, the First District Appellate Court upheld the judgment in the face of several claimed errors by the trial court.

A major area of dispute on appeal involved whether the plaintiff-administrator, the deceased's husband, had presented a sufficient products liability claim to overcome the defendant's motion for judgment notwithstanding the verdict. The appeals court began its analysis noting that, in a products liability suit, the plaintiff "must prove three elements: (1) the injury resulted from a condition of the product; (2) the condition was an unreasonably dangerous one; and (3) the condition existed at the time it left the defendant's control." Quoting *Tweedy v. Wright Ford Sales, Inc*., 64 Ill. 2d 570, 357 N.E.2d 449 (1976) from the Illinois Supreme Court, the court stated that "[a] *prima facie* case that a product was defective and that the defect existed when it left the manufacturer's control is made by proof that in the absence of abnormal use or reasonable secondary causes the product failed 'to perform in the manner reasonably to be expected in light of [its] nature and intended function.'" The drug company argued that the *Tweedy* doctrine should not be applied to the facts of the instant case because the plaintiff had not presented sufficient evidence of a product "malfunction," namely, that the drug patch did not perform in the manner reasonably expected in light of its nature and intended function. While not addressing the specific argument that he failed to present the required evidence of a "malfunction," the plaintiff asserted that he had presented sufficient evidence of a "nonspecific defect" to sustain the jury's verdict.

Part of the problem here was that the patch in question, which was the second to last patch worn by the deceased, had been removed from the deceased's back the day before her death and discarded by her husband, the plaintiff. At the time that he removed the patch and applied a new one, the plaintiff explained, the removed patch "slid from her skin, and almost fell off, almost as if all the adhesive material from the patch and large adhesive overlay bandage was gone, leaving a slick film behind. . . ." An autopsy showed that the deceased's blood had a fentanyl level of 28.2 nanograms per milliliter, while a proper dosage would have been 1.7 nanograms per milliliter. While the deceased was also taking other medications her physician had prescribed at the time of her death, the medical examiner concluded that she had died from an overdose of fentanyl.

Plaintiff's theory was that that the overdose was the result of the defective patch. In response, the defendant argued that a defect in a product cannot be established merely because of an injury and that there was no evidence here to show that the patch in question, which had been discarded before any inspection, had malfunctioned. Looking to *Weedon v. Pfizer, Inc*., 332 Ill. App. 3d 17, 773 N.E.2d 720 (1st Dist. 2002) the appeals court held that *Weedon* "stands for the principle that a plaintiff need not show a malfunction such as an 'exploding coffee pot, collapsed ladder, or brake pedal that goes all the way to the floor' in order to prove a products liability claim involving a nonspecific defect." As the court explained,

> We believe *Weedon* recognizes the difference between a defect in a medical device residing in, or on, a patient as compared to those defects in products that are actively used and whose operation or performance is clearly observable . . . Given the nature of the product at issue here, . . . and the way it functions, the patch's "operation" or "performance" is not observable. Thus, it is difficult to envision how a "malfunction" in a patch could ever be observable. Arguably, an observable malfunction might be excessive gel on the skin, and we note that plaintiff testified that he did observe a slick film on [the deceased's] skin when he changed the penultimate patch. Another observable malfunction might be a markedly elevated blood fentanyl level such as 28.2 ng/mL when the only source of fentanyl is the patch that is designed to deliver a level of 1.7 ng/mL.

Based on this analysis, the appeals court ruled that evidence of an obvious malfunction is one, but only one, way for a plaintiff to show that a product failed to perform properly and that here, the plaintiff had presented sufficient evidence to show that the drug patch was defective. The appellate court also considered a variety of evidentiary issues, including whether the trial court had properly allowed in evidence of the drug patch recall. The court rejected each of the defendant's evidentiary arguments and upheld the trial court's judgment for the plaintiff. *DiCosolo v. Janssen Pharmaceuticals, Inc.* No. 1-09-3562 (Ill. App. 1st Dist., June 30, 2011).

Trial court's battery instruction proper

Another recent First District Appellate Court opinion involves a plaintiff-patient filing battery charges against a hospital where he received care based on the alleged actions of two defendant-security guards who worked for the hospital. Following a verdict and judgment for the defendants, the plaintiff appealed claiming error in the jury instructions, including the instructions regarding civil battery.

The incident giving rise to this suit began shortly after the plaintiff's knee surgery at the hospital. Post-surgery, the plaintiff complained of severe leg pain and refused to participate in any physical therapy. Soon thereafter, the plaintiff was required to use crutches to ambulate. Approximately four days after surgery, a nurse notified the plaintiff that he would soon be discharged. The plaintiff became upset, claiming that he was being discharged too soon. In an agitated state, the plaintiff allegedly threatened the nurse, attempted to walk on his own while placing weight on his leg, and fell as he attempted to use the restroom. The plaintiff then got to his feet and fled the room on his crutches making his way toward the elevator in an attempt to leave the hospital against medical advice.

The plaintiff contended that while exiting the doors on the first floor, he was approached by the two defendant-security guards. According to the plaintiff, the guards positioned themselves so as to prevent him from leaving. The plaintiff claimed that one of the guards slammed the exit door on his bandaged foot. Subsequently, the plaintiff's spouse arrived, and was able to take the plaintiff home after he was properly discharged. In the weeks after the surgery, plaintiff claimed he was unable to walk and that his leg pain continued. Later surgery relieved the extreme pain in plaintiff's foot but did not help with the hypersensitivity which persisted at the time of the trial.

The defendant-security guards recalled

the events somewhat differently. They testified that they had received a call requesting assistance with a combative patient who was not allowed to leave the hospital. According to the guards, the exit door used by the plaintiff was operated by a push button and would remain open for a period of time. They explained that when they were trying to step in front of the fleeing plaintiff, his bandaged foot was accidently stepped on. The guards claimed the plaintiff was combative and struck them with his crutch.

A defense medical expert testified that the persistent nerve condition in the plaintiff's foot was the result of the knee injury and not the incident involving the defendant-security guards. The expert went on to state that based on an electromyography examination, the plaintiff's nerve injury could not have been caused by someone simply stepping on his foot. According to the expert, there was no evidence that a physical impact with the plaintiff's foot caused any nerve damage. Rather, the expert explained, it could have been the result of walking on it during the recovery period after surgery.

On appeal, the plaintiff contended that the trial court's jury instruction regarding the battery claim misstated the law. The appellate court referred to *Bulger v. Chicago Transit Authority,* 345 Ill.App.3d 103, 801 N.E.2d 1127 (1st Dist.2003), stating that it is within the trial court's discretion whether to give a jury instruction. In determining if the trial court abused its discretion, the court must consider the instructions in their entirety and determine if the jury was "fairly, fully, and comprehensively informed as to the relevant legal principles." Even if the trial court gave faulty instructions, the reviewing court usually will not reverse unless the instructions clearly mislead the jury and the result was a serious prejudice to the appellant.

The appellate court noted there are no Illinois Pattern Jury Instructions on battery and that, as a result, parties must offer their own instructions regarding Illinois battery law. The trial judge, over the plaintiff's objection, accepted the defendants' instructions which in part stated that the plaintiff in a battery action must show that, "the defendant had the intent to cause a harmful or offensive contact with plaintiff." The plaintiff took issue with this phrasing, arguing that to make out a civil battery claim all that was required was proof of an intentional touching.

The appeals court began its analysis by explaining that in U.S. jurisdictions, "there exists a dichotomy within the intent requirement for the tort of battery, *i.e.*, whether intent equates to an intent to harm or offend, or merely an intent to touch." The court further noted that Illinois courts have been inconsistent on this issue. With this in mind, the court examined relevant portions of the Restatement (Second) of Torts.

The Restatement provides that battery is committed if an individual: "(a) acts intending to cause a harmful or offensive contact with the person of the other or a third person, or an imminent apprehension of such a contact, and (b) a harmful contact with the person of the other directly or indirectly results." Restatement (Second) of Torts §13. The court then noted its own prior decisions which state that battery requires more than an intent to touch, and that a defendant must intend to actually cause a harmful or offensive contact. *Happel v. Wal-Mart Stores, Inc.,* 316 Ill.App.3d 621, 737 N.E.2d 650 (2d Dist. 2000); *Welch v. Ro-Mark, Inc.,* 79 Ill.App.3d 652, 398 N.E.2d 901 (1st Dist. 1979). Because the appeals court found legal support for the instruction used by the trial court, it opined that on this basis the instructions were proper.

The appellate court went on, however, to consider whether under the facts of the instant case, the instructions properly framed the issues for the jury. The court suggested that battery cases holding that one need not prove intent to harm or offend typically are so-called medical battery or "helpful intent" cases. In such cases, the court observed, it is obvious that the defendant lacked any intent to harm or offend, yet the actions are nonetheless considered batteries. Accordingly, the court noted, medical battery cases focus on the issue of whether the touching was intended, yet still unauthorized due to a lack of consent. The court went on to state that if the intent element in cases such as the instant one was simply framed to require proof of the intent to touch, the result would be detrimental to public policy. Any type of intentional contact that occurs through daily activity, no matter how minimal could, the court stated, be considered a battery should the contact be inadvertently offensive. The court concluded that under the factual circumstances of the case at bar, the instructions given could not have resulted in any prejudice to the plaintiff that would have deprived him of a fair trial. *Bakes v. St. Alexius Medical Center*, No. 1-10-1646 (Ill. App. 1st Dist. June 23, 2011).

MRSA infection information not privileged

Two medical malpractice actions arose from injury to one patient and the death of another who had contracted methicillin-resistant staphylococcus aureas (MRSA) while under the care at the defendant-hospital in 2005. The trial court dismissed the suits when the plaintiffs failed to attach to their complaints the attorney affidavit and health care professional report required by 735 ILCS 5/2-622. The plaintiffs contended on appeal that their expert was unable to decide whether there was a meritorious cause of action as required by §2-622 because the trial court had improperly ruled that the information needed for the expert's opinion was privileged and not discoverable under the Medical Studies Act, 735 ILCS 5/8-2101. The cases were consolidated on appeal and the Fifth District Appellate Court reversed and remanded.

In relevant part, §8-2101 of Medical Studies Act provides that, "All information . . . reports . . . , or other data of . . . committees of licensed or accredited hospitals or their medical staffs . . . (but not the medical records pertaining to the patient), used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care . . . shall be privileged [and] strictly confidential . . . ." The privilege created by this Act has been considered in an array of court decisions over the years. In the instant case, the appeals court examined these earlier decisions and the purposes for and policies behind the Act, to ascertain its applicability to MRSA infection information.

In 2007, before filing suit, one of the plaintiffs filed a petition under Illinois Supreme Court Rule 224 for discovery against the defendant-hospital, requesting infection-control data and statistics, policies and procedures for controlling and treating infectious diseases, and a list of any and all of the hospital's patients who had contracted MRSA within 90 days prior to admission of plaintiff to the hospital. Later in 2007, the plaintiffs filed their suits against the hospital and several physicians, alleging negligence and medical malpractice. Although the plaintiffs' complaints did not include a §2-622 report, their counsel did attach affidavits under §2-622(a)(3) stating that they were not able to obtain consultations with a licensed physician required by §2-622 because the defendants had not complied their requests for hospital infection records.

After filing suit, the plaintiffs continued to request the production of MRSA infection-related documents from the hospital, but it did

not reply. In March 2008, the court entered an order entitling the plaintiffs "to all discovery requests regarding any MRSA cases" at the defendant-medical center's facility pursuant to the original petition. Soon thereafter, defendants filed motions to dismiss the plaintiffs' complaints under 735 ILCS 5/2-619 for failure to file a certificate of merit written by a healthcare professional in accordance with §2-622. The defendants argued that the hospital had sent the plaintiffs their own personal medical records in late 2007, but did not comply with the other requests for discovery because they fell outside the scope of §2-622(a)(3) and §8-2001.

At a hearing, plaintiffs' counsel explained to the trial court that in order for their expert to render an opinion under §2-622 as to whether the defendants were negligent for failing to notify the public of the MRSA outbreak, they would need to know the number of MRSA infections at the hospital. In response, the defendants stated that the hospital used an infectious disease committee to investigate any infectious disease outbreaks within the facility and that such investigations are privileged under the Medical Studies Act. At this time, the trial court ruled that plaintiffs were entitled to know the number of MRSA outbreaks within the medical facility and that the defendant's records regarding the outbreaks could not be considered privileged simply because they were mentioned in a peer review committee meeting.

The defendants filed an affidavit of a nurse that was the manager of infection control at the hospital. This affidavit was accompanied by 27 pages of documents submitted to the court for *in camera* inspection. The nurse stated that these documents were created exclusively for the infection committee and for improving patient care. The plaintiffs contended that the Medical Studies Act did not apply to protect the documents listing the number of cases involving MRSA during the requested period.

During a later hearing, the trial court apparently changed course and made a "definite ruling" that the documents produced by the defendants were in fact privileged under the Medical Studies Act. The plaintiffs argued that the information regarding MRSA infections was critical to being able to create a §2-622 report and that without this information they could not obtain the report. The court denied the plaintiffs' motion to compel and gave plaintiffs 30 days to furnish the §2-622 report. When the plaintiffs' expert stated that without access to the information requested by the plaintiffs, he could not provide the necessary report, the court granted the defendants' motion to dismiss.

On appeal, plaintiffs argued that the lower court's ruling that the MRSA information was privileged under the Medical Studies Act was erroneous. The plaintiffs noted that statistical information that can be found by reviewing patient files without reference to the patient's identity is not protected or even privileged under the Act. Defendants maintained however that prior to submitting a §2-622 report, discovery is limited to the plaintiffs' personal medical records. Therefore, the defendants contended, the plaintiffs' complaints were properly dismissed since the information they requested was privileged and undiscoverable.

Initially, the appeals court disagreed with the defendants that discovery prior to filing a §2-622 is limited to the information within the plaintiffs' personal medical records. As the court explained, under §2-622 a plaintiff must file one of three types of affidavits accompanying their complaint. In the instant case, the relevant affidavit is one stating that counsel has requested records under §2-8001, but that the opposing party has failed to comply within a 60 day period. 735 ILCS 5/2-622(a)(3). In the case at bar, plaintiffs' counsel had attached an affidavit in compliance with this section. The court held that the language of §§2-622 and 2-8001(b) supported the argument that prior to filing a §2-622 affidavit, discovery is not restricted to the personal records of the plaintiff.

The appellate court then turned to the issue of whether the trial court had erred in finding that the defendant-hospital's MRSA infection rates were privileged under the Medical Studies Act. The court began by explaining the purpose and scope of the of the Medical Studies Act's privilege. Its purpose, the court said, is to ensure that members of the medical profession efficiently engage in the peer review process in order to improve the quality of health care and to encourage voluntary studies and programs to improve patient care and reduce rates of death and disease. A party seeking to invoke this evidentiary privilege has the burden of establishing its applicability. The court noted that the Act is not intended to shield hospitals from potential liability, and that the only documents which the Act applies to are those generated specifically for the use by peer review committees. Furthermore, documents created during the ordinary course of a hospital's business are not privileged by the Act, even if they are later used by a committee for peer review purposes.

In the case at bar, the trial court had first ruled that the plaintiffs were entitled to know how many MRSA outbreaks occurred during the time period in question at the hospital and that the hospital's records could not be considered privileged just because they were mentioned during peer review meetings. The appellate court firmly supported this reasoning and stated that the MRSA rates were not privileged under the Act. The court found that disclosing the number of people infected by MRSA at the hospital within the nine-month request period would not conflict with public policy or with the Medical Studies Act's purpose. In the court's view, the defendant should not be entitled to use the Medical Studies Act to avoid potential liability by claiming that the MRSA information was privileged simply because it was later reviewed during a committee meeting. The plaintiffs only sought to determine the number of MRSA infections at the hospital during a given time period and not any other documents specifically created for the use of the committee. Furthermore, defense counsel had admitted that the documents were in fact generated during the course of regular hospital business and the record showed that the information on MRSA infections was available outside of the committee. Therefore, the court ruled that the number of MRSA infections was a "mere incident of fact" and ordered the hospital to disclose the number of MRSA infections on remand. *Zangara v. Advocate Christ Medical Center*, Nos. 1-09-1911 & 1-09-1914 (Ill. App. 5th Dist., June 10, 2011).

Chiropractors' class action rejected by appellate court

A Fifth District Appellate Court decision stems from an order of the circuit court granting the plaintiffs' motion for class certification. The plaintiff-chiropractors originally entered into contracts with a health care network in which they agreed to participate in the network's preferred provider organization (PPO). According to their preferred provider agreements, the plaintiffs were bound to accept discounted reimbursements from insurance companies, health care plans, and claims administrators under contract with the PPO network. On appeal, the appellate court rejected the class certification and ruled that the plaintiffs had failed to state a claim.

The plaintiffs first claimed that the defendant-insurers discounted workers compensation related bills that came from the plaintiffs without "steering" patients directly

to them by offering financial incentives to the insureds for using the plaintiffs as their health care providers. Counsel for plaintiffs claimed that the defendants were not entitled to take these PPO discounts on bills submitted for workers' compensation patients. According to the plaintiffs, doing so without providing financial incentives to steer patients to the plaintiffs violated the Illinois Consumer Fraud and Deceptive Business Practice Act, 815 ILCS 505/1 et seq. since the defendants misrepresented to plaintiffs that they were authorized to take the PPO discounts. In separate counts, plaintiffs alleged other related causes of action, such as unjust enrichment and breach of contract.

In the agreements signed by the plaintiffs, they not only agreed to participate in the PPO plan and accept a list of all payors eligible to use the plaintiffs' services, but they also agreed to cooperate with payors when treating participating patients under the worker's compensation program to expedite their return to work. Plaintiffs further agreed to refer participating patients only to other providers within the PPO plan. The preferred provider agreements set out the reimbursement discount rates for all types of services, including reimbursement from workers' compensation payors for services rendered to injured employees. No provision in these agreements promised the plaintiffs that payors would utilize any type of financial steerage or incentives.

The defendant-insurers had an agreement with the network under which the defendants were given access to the provider network and medical cost management services for its workers' compensation claims. Similar to the plaintiffs' agreements, this agreement did not include any provision that the defendants promised to provide financial incentives to any patient to use a network provider. Defendants did, however, promise to distribute materials to customers, educate employers on how to use and access the PPO network, and direct claimants to contract providers in a manner permitted by law.

The appeals court began by dissecting the numerous claims that the plaintiffs brought, starting with the breach of contract claim. As the court observed, the record indicated that the parties had not entered into contracts directly with one another. Furthermore, the court noted, the preferred provider agreements signed by plaintiffs contained no provisions promising any financial or other incentives to steer patients to the plaintiffs. The court expressly stated that even if the plaintiffs were third-party beneficiaries to the payor agreement, that agreement did not contain any language whatsoever stating that the defendants must provide financial incentives to patients in order to obtain the PPO discount.

The court then discussed the impact of the defendants' agreement to "steer claimants to network providers 'as permitted by applicable law.'" The plaintiffs initially argued that, assuming this provision could be understood to require financial incentives, because the Illinois workers' compensation law makes it impossible to give financial incentives to workers to utilize certain providers, the taking of discounts by the defendant-insurers in the context of workers' compensation claims was unlawful. However, as the court stated, "This theory is belied by the provision in the payor agreement that [defendants] must only direct patients to network providers 'as permitted by applicable law.'"

In their petition for a rehearing, the plaintiffs referred to the Workers' Compensation Act, 820 ILCS 305/8(a) contending that the defendants were in fact permitted by under Illinois law to provide financial incentives to patients to choose a certain provider amongst those listed in the network under some circumstances. This section states that employees may elect to choose their own physician at their employer's expense, but in making an alternative choice, the employee may have to choose from a posted panel of alternate providers. Further, the employee is limited to two choices of providers. Thereafter, the employer has the right to choose and pay for the necessary medical expenses while the employee cannot select a provider to be paid at the employer's expense. The plaintiffs argued that in the case at bar, if an employee had exhausted the two choices, the defendants had the ability to provide financial incentives to that employee because if the employee were to choose, on their own, a different provider, the employee would have to incur all of the cost. The court found that the possibility of limited situations where steerage might have been feasible did not make the breach of contract claim viable. The plaintiffs had failed to allege that these types of situations applied in their case. The court went on to reiterate that the provider agreements provided that the plaintiffs were to treat workers' compensation beneficiaries at a discounted rate. These agreements did not indicate that plaintiffs only needed to accept the discounted rate in situations where there has been some form of steerage. Moreover, the defendants' agreement only required them to provide steerage as permitted under applicable Illinois law. Therefore, the court ruled that the plaintiffs' contracts did not support a breach of contract claim against the defendants.

The appellate court then dealt with the plaintiffs' claim that, because the payor agreements only required the defendants to steer to the extent allowed under applicable law, the agreements were contrary to how a PPO was meant to be operated and what is required of PPO arrangements under Illinois administrative regulations. The plaintiffs directed the court's attention to 50 Ill. Adm. Code §2051.55(c)(1)(A) which states that payor agreements "shall contain terms requiring that incentives be provided to the insured or beneficiary to utilize the services of a provider that has entered into an agreement with the administrator." New requirements, effective December 16, 2009, in 50 Ill. Adm. Code §2051.280(a), state that the agreements must contain the, "terms requiring and specifying all incentives that are to be given to the beneficiary to utilize services of a provider that has entered into an agreement with the administrator." The plaintiffs argued that these regulatory requirements should be read into the payor agreements as implied terms.

The court disagreed. First, the court stated that the plaintiffs had provided no authority that would permit the rewriting of the contract so that the provision regarding steerage only being required as "permitted by applicable law" would be changed to conform with the regulations. Secondly, the court stated that if the limiting language within the agreements somehow caused the agreements to violate these regulations, the remedy would not be a cause of action for breach of contract, but rather for the Illinois Department of Insurance to determine that the agreements were unlawful.

The court then dealt with the plaintiffs' claim that the defendants violated the Illinois Consumer Fraud Act. Under the Consumer Fraud Act, which prohibits unfair and deceptive business practices, the elements for an actionable claim are: (1) a deceptive act or practice by the defendant; (2) that the defendant intend for the plaintiff to rely upon this deception; (3) that the deception occur in the course of conduct involving trade or commerce; (4) that actual damage occurred to the plaintiff, and (5) that the damage was proximately cause by the deception. As to the plaintiffs' initial claim that the defendants misrepresented that they were entitled to the

PPO discount when they failed to abide by the contract and provide financial incentives to patients, the court found this was merely a reallegation of their breach of contract claim and not actionable under the Consumer Fraud Act. As to the plaintiffs next complaint, namely that the defendants misrepresented the fact that they belonged to the workers' compensation network, it was clear from the record the court said that the defendants did in fact belong to the network. Therefore, the court ruled that the plaintiffs had no actionable misrepresentation claim under the Consumer Fraud Act.

Finally, the court held that because the defendants had a clear, legal basis for obtaining the PPO discounts at issue, the plaintiffs' unjust enrichment claim was not a credible one. Based on this analysis, the court ruled that the circuit court abused its discretion in certifying the class and the case was remanded. *Coy Chiropractic Health Center Inc.. v. Travelers Casualty and Surety Co.*, No. 5-08-0578 (Ill. App. 5th Dist., May 9, 2011).

To *ex parte* or not *ex parte*-- that is the question

A recent medical malpractice case revolves around the issue of whether a physician-defendant's employer, a medical clinic, which was joined as a defendant, could communicate ex parte with other of its employees who had contact with the plaintiff, and whose actions could be the basis for liability against the clinic, but who were not joined as defendants. The appellate court ruled against the defendant-clinic.

The plaintiff claimed that the physician-defendant was negligent in diagnosing his lung cancer in February 2007 that initially developed in September 2005. The plaintiff, a 20 year cigarette smoker, argued that after many complaints of chest pain, congestion, and wheezing, the physician-defendant failed to send him to a specialist, order a chest x-ray, or schedule any additional visits in regard to these complaints. Although the physician was the plaintiff's primary care physician, other individuals employed by the clinic who were not joined as defendants also treated the plaintiff on several occasions.

The original complaint by the plaintiff alleged that the medical care in question was provided by the clinic "through its agents, servants and/or employees." In October 2009, defense counsel wrote counsel for the plaintiff, requesting permission to contact the other employees and physicians who had contact with the plaintiff. Plaintiff's counsel objected to this request, stating the other physicians and employees were not parties to the case. In November 2009, defendants filed a motion for leave to have ex parte communications with the other employees who provided care to the plaintiff. Prior to the court ruling on this motion, plaintiff amended the complaint, changing the language of "through its agents and/or employees" to "through the conduct of defendant." The trial court initially granted the defendant's motion, but later reversed this decision on plaintiff's motion to reconsider. The defendants then requested a certified question to allow them to appeal the trial court's rejection, pursuant to Supreme Court Rule 308. This request was granted.

The defendants contended before the First District Appellate Court that they would be prejudiced if they were unable to communicate ex parte with the employees in question. The defendants argued that, according to *Porter v. Decatur Memorial Hospital*, 227 Ill. 2d 343, 882 N.E.2d 583 (2008), a plaintiff may add a new claim after the statute of limitations has run if there is a "sufficiently close relationship" to the original claim. Under this rationale, according to the defendants, although the other employees who had treated the plaintiff were not currently joined as defendants, there still remained a possibility that they could be joined as defendants in the future. The defendants therefore argued that they should be allowed to communicate ex parte with these employees.

The court disagreed with the defendants' reasoning, citing several cases in support of this decision. The earliest Illinois case governing a defendant's ex parte communications with a plaintiff's physician is within *Pertillo v. Syntex Laboratories, Inc.,* 148 Ill. App. 3d 581, 499 N.E.2d 952 (1st Dist. 1986). In that case, the treating physician's conduct was not a basis for the defendant's liability. The trial court refused to allow defense counsel to communicate ex parte with this physician, and this decision was supported in the appellate court. That appellate court reasoned that, based upon certain obligations created by confidential and fiduciary relationships, ex parte communications between defense counsel and a plaintiff's physician are barred. Similarly, in *Ritter v. Rush-Presbyterian St. Luke's Medical Center*, 177 Ill. App. 3d 313, 532 N.E.2d 337 (1st Dist. 1988), the appellate court held that, although barring a hospital from communicating with an employee-physician for whose conduct the hospital was allegedly liable would prevent it from effectively defending itself, this rationale did not extend to communications with employees whose conduct was not the basis for the hospital's liability. In those situations, the court stated, the hospital's right to defend itself did not trump the physician-patient privilege.

In another decision discussed by the appellate court, *Testin v. Dreyer Medical Clinic*, 238 Ill. App. 3d 883, 605 N.E.2d 1070 (2d Dist. 1992), the *Ritter* holding was upheld where the defendant-clinic sought to communicate ex parte with its employees, some of whom were named as defendants and some who were not. The court held that, while the physician-patient privilege did not disallow the medical facility from communicating with the accused physicians through whom the facility might be vicariously liable, the privilege did protect the plaintiffs from disclosures by the other physician-employees of the facility whose conduct was not a basis of the plaintiff's claim.

The court in the instant case also discussed *Morgan v. County of Cook,* 252 Ill. App. 3d 947, 625 N.E.2d 136 (1st Dist. 1993). In *Morgan* , the appellate court held that when a plaintiff brings suit against a hospital due to the conduct of its physician-employees, the hospital is included within the physician-patient privilege and thus, the plaintiff-patient has impliedly consented to releasing their medical information to the counsel of the hospital. The court went on to hold that ex parte communications between defense counsel and plaintiff's physician are forbidden when that physician-employee's conduct was not the basis for the hospital's liability.

In the case at bar, the appellate court acknowledged that, according to *Porter*, it was conceivable that the plaintiff could add additional claims against the defendant-clinic based on the actions of other employees. However, while this remained a possibility, it had yet to occur and remained totally hypothetical. The plaintiff had shown a contrary intention by amending his complaint and removing all other individuals except the defendant-physician and defendant-clinic. The amended complaint went so far as removing the language from the initial complaint that left open the possibility that any other physician-employee of the defendant-clinic would be held liable. The court firmly stated that until any other employees of the defendant-clinic were added to the plaintiff's complaint, the defendant-clinic could not engage in ex parte communications with any of its employees whose actions were not the basis for its liability. *Aylward, Jr., v. Settecase.,* ___ Ill. App. ___, 948 N.E.2d 769 (1st Dist. 2011). ■

How does a violation of the Nursing Home Care Act affect a facility's right to recover unpaid amounts?

Continued from page 1

unsigned documents.[3] This article will first explore the legal and statutory arguments at issue on appeal in *Carlton*, and the contours of the decision itself. Next, it will explain how, in spite of the *Carlton* decision, there is still hope for nursing homes to maintain breach of contract claims without the signed contract mandated by the Act, in light of a recent Illinois Supreme Court decision addressing the appropriate penalty for the violation of a comprehensive consumer protection statute that, within its own provisions, sets forth sanctions.

Background of the *Carlton* case

The facts of *Carlton* are simple. A man named Robert became a resident of Carlton at the Lake's nursing home facility.[4] Carlton tendered a contract to Robert's daughter and attorney-in-fact.[5] The contract set forth the terms and conditions of Robert's care. Robert's daughter physically accepted the contract, and although she did not affix her signature to that document, she signed a host of ancillary admission documents, fourteen in total,[6] which unequivocally indicated acceptance of the terms of the contract on Robert's behalf. Robert became and remained a resident of Carlton's facility for approximately two years. He received all services and benefits outlined in the contract.[7] Robert was eventually involuntarily discharged from the facility, leaving behind a hefty unpaid bill.[8]

Carlton filed suit to recover the amount owed, naming Robert and his wife, Jean[9] as defendants, alleging breach of contract and quantum meruit in the alternative. Defendants moved to dismiss all counts, arguing that because Carlton failed to "execute" a "written contract" under the Act, it could not state a claim for breach of contract or quantum meruit. Their arguments were straightforward. The contract was unenforceable because Carlton did not obtain signatures and since Carlton was at fault in committing an act in violation of the public policy expressed by the Act (admitting Robert to its facility without first obtaining a signature on the contract), Carlton could not circumvent the Act and receive safe haven in equity. The trial court agreed,[10] sending a dramatic message to nursing homes: no signed contract, no possibility of recovery. Carlton appealed.

Breach of Contract and Quantum Meruit—The Arguments on Appeal

Carlton took one overarching position on appeal, namely that the appropriate sanctions for failing to "execute" a "written contract" under the Act were found in the "Violations and Penalties" section of the Act,[11] and that the judicial imposition of dismissal of the breach of contract cause of action was not mandated by the statutory scheme. Since the Illinois legislature did not contemplate stripping a non-compliant nursing home of the ability to sue to recover amounts owed to it, dismissal solely on the basis of the statutory violation was unwarranted.

As to the breach of contract claim specifically, Carlton urged that because the Act does not provide that unsigned contracts are unenforceable, Carlton should be permitted to state a claim for breach of contract, and be given the opportunity to demonstrate the traditional elements of a valid and binding contract (offer, acceptance, consideration), performance by Carlton, breach by Robert, and resulting injury. Carlton argued that "a party named in a contract may, by his acts and conduct, indicate his assent to its terms and become bound by its provisions even though he has not signed it."[12] This is especially true, Carlton argued, when the conduct relates specifically to the written terms of the contract. So, while Carlton's failure to obtain Robert's signature prior to admitting him to its facility was a violation of the Act, such a violation did not preclude Carlton from having the opportunity to present the existence of a valid, enforceable contract.

Carlton's quantum meruit appeal was somewhat more nuanced. The trial court had ruled that Carlton could not "allege a claim in quantum meruit when the contract has been determined to be unenforceable as a violation of public policy…[w]here enforcement of an illegal contract is sought, the courts will aid neither party but will leave them where they have placed themselves since the parties are *pari delicto* and can recover nothing under the contract."[13]

On appeal, Carlton challenged this reasoning by explaining that, while it is true that parties to an illegal contract should not be aided in equity, there is a key distinction between contracts that violate public policy due to the illegality of their subject matter (e.g. fee splitting arrangements), and contracts whose subject matter is perfectly legal, but some "public policy" (such as formation or execution requirements) renders the contract unenforceable. When individuals enter a contract to perform an illegal act, it is intuitive that equity will give refuge to no one. But when a contract is unenforceable on technical grounds alone, that logic dissolves. Indeed, it is precisely when a contract is unenforceable due to deficiencies in formation or execution, that a party looks to quantum meruit to be made whole.

After arguing that the doctrine of *pari delicto* did not apply to its situation, Carlton stressed that the legislature did not "clearly and plainly express" an intent to abrogate the common law doctrine of quantum meruit, and pointed out that "such an intent will not be presumed from ambiguous or doubtful language."[14] In other words, if the legislature sought to preclude a non-compliant nursing home's ability to seek equitable relief, it would have done so with clarity.

The *Carlton* Appellate Decision

The appellate court agreed that Carlton's quantum meruit claim was wrongfully dismissed. It first noted that "it does not appear that any Illinois appellate court has addressed what impact, if any, a violation of the provisions of the Act has on the rights of a nursing home to recover in equity…."[15] It also recognized the "distinction between the availability of quantum meruit where the *subject matter* of an underlying contract makes it unenforceable, and a situation where only some issue with *formation* or *execution* makes the underlying contract unenforceable."[16]

The court then expressly adopted the reasoning contained in *K. Miller Construction Co., Inc. v. McGinnis,*[17] which was then in its appellate stage, but ultimately went to the Illinois Supreme Court some months after the *Carlton* decision. As more fully discussed below, the appellate court in *McGinnis* allowed quantum meruit to remain an available remedy to violators of the Home Repair and Remodeling Act, because the legislature did not clearly and plainly state otherwise.[18] The *Carlton* court extended this reasoning to the Nursing Home Care Act concluding that a nursing home that fails to comply with

the Nursing Home Care Act's contract provisions may still maintain an action in quantum meruit to recover the reasonable value of its services.[19] Currently, that remains good law, and nursing homes are free to pursue this equitable avenue for recovery.

The breach of contract dismissal, however, was upheld by the *Carlton* court. It echoed the trial court's reasoning, essentially reiterating that courts will not "enforce a private agreement which is contrary to public policy" and agreeing " with the circuit court that the unsigned contract was unenforceable under the Act."[20] Carlton walked away with only a partial victory, and, under this decision, Illinois nursing homes that violate the contract provisions of the Nursing Home Care Act may not recover on the contract, but may only prove at trial the reasonable value of services pursuant to a theory of quantum meruit.

The Impact of the Illinois Supreme Court's Decision In *McGinnis*

Shortly after the *Carlton* decision, the Illinois Supreme Court reviewed the *McGinnis* case. In doing so, it possibly breathed vitality into the breach of contract claims that appeared dead in the wake of *Carlton*. The *McGinnis* case involved interpretation of the Home Repair and Remodeling Act, which states that "[p]rior to initiating home repair or remodeling work for over $1,000, a person engaged in the business of home repair or remodeling shall furnish to the customer for signature a written contract or work order."[21] The issue before the Illinois Supreme Court was whether a home remodeling contractor who entered into an oral contract for work over $1,000, rather than furnishing the customer for signature a written contract, could enforce the oral contract or seek recovery in quantum meruit against a homeowner who had refused to pay for the completed project. Like the appellate court in *Carlton*, the appellate court in *McGinnis* concluded that statutory violators could recover under quantum meruit, but that the non-complying contract was unenforceable.[22] The Illinois Supreme Court reversed that part of the appellate decision striking down the breach of contract remedy, holding that "recovery is available under *both theories*."[23]

Without belaboring the details of the *McGinnis* court's analysis, a few points are worth noting. First, the court identified an important analytical distinction. On the one hand, "if a statute explicitly provides that a contractual term which violates the statute is unenforceable…the term is unenforceable… Conversely, if it is clear that the legislature did not intend for a violation of the statute to render the contractual term unenforceable, and that the penalty for a violation of the statute lies elsewhere, then the contract may be enforced."[24] But, when the statute is silent, the court endorsed a balancing between the public policy of the statute and the countervailing policy in enforcing agreements.[25]

The court then classified the Act as falling within the last category, requiring a balancing test.[26] Typically, the case would have been remanded in order to allow the lower court to apply the standards set out on appeal. However, after the *McGinnis* appellate decision, the Illinois General Assembly had amended the Home Repair Act by removing all references to the word "unlawful" in an apparent attempt to make clear that it did not intend for the Act to render contracts *ipso facto* unenforceable.[27] The Illinois Supreme Court thus reached its decision based, in large part, on this amendment and clarification of legislative intent. It is unclear how the court would have ruled if the statute remained unchanged throughout, but the decision contains some clues. "[A]ccording to the appellate court, because there was a statutory violation…the contract was, *ipso facto*, unenforceable. This was error. The General Assembly is capable of stating when a contractual term that violates a statute is unenforceable."[28] The court observed that "it was not the legislature that said any violation of the Home Repair Act*, ipso facto*, renders the contract unenforceable; it was some judges."[29]

The Home Repair Act at issue in *McGinnis*, and the Nursing Home Care Act, are similar. Both Acts require that the provider of a particular service, prior to providing services, execute (or, "provide for signature") a written contract to the recipient of that service. Also, penalty provisions are provided for in both Acts, which comprehensively address what consequences flow from violations of the Act. Neither Act provides for the elimination of a contract-based remedy just because there was a statutory violation in the execution of the contract between the parties. Although the clarifying amendment to the Home Repair Act gave guidance to the Illinois Supreme Court in *McGinnis* in addressing the penalty scheme within the Home Repair Act, there is strong language in the *McGinnis* opinion that suggests that the *Carlton* decision should not have excluded a breach of contract remedy, because the Act did not provide for that sanction.

What remains unclear is what effect, if any, the *McGinnis* decision will have on future litigation involving facts similar to those in *Carlton*. The Illinois Supreme Court's reasoning in *McGinnis* is inherently at odds with the *Carlton* decision. Logically, the reasoning in *McGinnis* should apply to the Nursing Home Care Act because that Act is analogous to the Home Remodeling Act. Perhaps the scope of *McGinnis* is narrow, given the legislative amendment which clarified the enforceability of contracts in violation of the statute. However, the arguments in favor of extending the *McGinnis* reasoning to the Nursing Home Care Act are compelling ones.

It is clear today that a nursing home that violates the contract signature provisions of the Nursing Home Care Act may still pursue recovery of unpaid amounts under a theory of quantum meruit. These nursing homes will have to prove the reasonable value of their services, rather than pursue contract damages. And, while *Carlton* remains the only appellate decision directly addressing the enforceability of unsigned contracts under the Act, it is fair to suggest that this opinion is inconsistent with the *McGinnis* decision that followed. Nursing homes that seek to recover amounts owed on unsigned contracts should consider raising *McGinnis* as they may discover that the arguments favoring the enforceability of contracts that violate the Home Repair Act likewise support the enforcement of unsigned contracts under the Nursing Home Care Act. Moving forward, nursing homes may also consider avoiding the entire headache by implementing more rigorous procedures for obtaining signatures prior to admittance. ■

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1. 220 ILCS 45/2-202(a).

2. See "Violations and Penalties" of the Act, 210 ILCS 45/3-301. Some penalties include a facility being subject to a plan of correction, issuing of a conditional license, assessment of penalties, or license suspension or revocation. The "Duties" section of the Act states that a resident "may maintain an action under this Act for any other type of relief… permitted by law." 210 ILCS 45/3-603.

3. *Carlton at the Lake, Inc. v. Barber*, 401 Ill.. App. 3d 528, 928 N.E.2d 1266 (1st Dist. 2010).

4. Id. at 529, 928 N.E.2d at 1268.

5. Id. at 530, 928 N.E.2d at 1269.

6. Robert's daughter and attorney-in-fact signed the following admission documents, to

name just a few: Residents Rights and Facility Responsibilities; Assignment of Insurance Benefits and Release of Medical Records Information; Eyecare Authorization; Physical Restraint Informed Consent; Nursing Facility-Resident Rights.

7. 401 Ill. App. 3d at 530, 928 N.E.2d at 1269.

8. Id.

9. Count II of Carlton's Complaint sought recovery from Jean Barber pursuant to the Illinois Rights of Married Persons Act.

10. *Carlton at the Lake v. Barber*, 2008 WL 8029298, Ill. Cir., Dec. 18, 2009.

11. See 210 ILCS 45/3-301

12. 401 Ill. App. 3d at 531, 928 N.E.2d at 1270 (quoting *Landmark Properties, Inc. v. Architects International-Chicago*, 172 Ill. App.3d 379, 383, 526 N.E.2d 603, 606 (1st Dist. 1988)).

13. 2008 WL 8029298 (citing to *Leoris v. Dicks*, 150 Ill.App.3d 350, 354 (1st Dist. 1986) (internal quotation marks omitted).

14. 401 Ill. App. 3d at 535, 928 N.E.2d at 1273 (quoting *Maksimovic v. Tsogalis*, 177 Ill.2d 511, 518, 687 N.E.2d 21, 24 (1997).

15. 401 Ill. App. 3d at 534, 938 N.E.2d at 1272.

16. Id.

17. 394 Ill. App. 3d 248, 913 N.E.2d 1147 (1st Dist. 2009).

18. Id. at 259, 913 N.E.2d at 1156.

19. 401 Ill.App.3d at 534-536, 928 N.E.2d at 1272-1274 .

20. Id. at 533, 928 N.E.2d at 1271.

21. 815 ILCS 513/515

22. 394 Ill. App.3d at 264, 913 N.E.2d at 1161.

23. *K. Miller Construction Company, Inc. v. McGinnis*, 238 Ill.2d 284, 287, 938 N.E.2d 471, 474 (2010) (emphasis added).

24. Id. at 293-294, 938 N.E.2d at 478.

25. Id. at 297, 938 N.E.2d at 480 ("The General Assembly is capable of stating when a contractual term that violates a statute is unenforceable.") This sentiment is somewhat at odds with the balancing test the court endorsed for times when the legislature is "silent" as to enforceability. If the legislature is capable of indicating when a contract is unenforceable, isn't the silence then meaningful? If so, there is no use for a balancing test, because the legislature has spoken in its silence.

26. Id. at 298, 938 N.E.2d at 480 ("Accordingly, the appellate court should have conducted a balancing analysis and considered the relevant facts and public policies before concluding that plaintiff could not pursue other relief for breach of contract.")

27. Id. at 298-301, 938 N.E.2d at 481-82.

28. Id. at 297, 938 N.E.2d at 480.

29. Id. (quoting *Fandel v. Allen*, 398 Ill. App. 3d 177, 192, 937 N.E.2d 1124, 1135 (3rd Dist. 2010) (Schmidt, J., specially concurring) (internal quotation marks omitted).

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