Medical Studies Act: Challenging Unjustified Claims of Privilege

by Lee Gunter

The purpose of the Medical Studies Act is to improve the quality of health care by protecting medical professionals who engage in peer review,1 and “to encourage candid and voluntary studies and programs used to improve hospital conditions and patient care or to reduce the rates of death and disease.”2

But in many cases hospitals are aggressive in claiming that documents, conversations, even the identity of meeting participants, are privileged from disclosure under the Medical Studies Act (“MSA”). These claims of privilege are not always justified, and may be nothing more than an attempt to avoid responding to proper discovery requests.

Hospitals have set up schemes to block discovery of relevant information relating to an occurrence in potential medical malpractice cases. Using a resolution of the board, or hospital bylaws or policies, the hospital declares that to effectuate the goal of the Medical Studies Act, the board names this or that person or group to investigate an occurrence on behalf of a committee and to make decisions for the committee without having timely involved a committee.

Of course, hospitals don’t really consider every complaint or adverse outcome to be an event worthy of committee involvement. Complaints are routinely investigated by the hospital’s risk management, claims management, or administrative, medical or nursing staff. As a practical matter, the staff member checks into the occurrence without necessarily even considering whether this is an event worthy of committee involvement. Upon discovery that the event could impose liability on the hospital, the hospital simply claims all of the information of the investigator is privileged. (The author was told in one instance that all Risk Management records were privileged under the MSA including the plaintiff’s own statements.)

This article gives an overview of the MSA and will attempt to address specific defense claims of privilege purportedly made pursuant to the MSA, in hopes of helping plaintiff attorneys to obtain full disclosure of discoverable information.

The Medical Studies Act - 735 ILCS 5/8-201

“Sec. 8-2101. Information obtained. All information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner’s professional competence, or other data of . . . committees of licensed or accredited hospitals or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees and Executive Committees, or their designees (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 or increasing organ and tissue donation, shall be privileged, strictly confidential and shall be used only for medical research, increasing organ and tissue donation, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges.

Sec. 8-2102. Admissibility as evidence. Such information . . . shall not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person. The disclosure of any such information or data, whether proper, or improper, shall not waive or have any effect upon its confidentiality, nondiscourability, or nonadmissibility.

Sec. 8-2105. Improper disclosure. The disclosure of any information, records, reports, statements, notes, memoranda or other data obtained
in any such medical study except that necessary for the purpose of the specific study is unlawful, and any person convicted of violating any of the provisions of Part 21 of Article VIII of this Act is guilty of a Class A misdemeanor. (Emphasis added.)”

Entities Covered by the Act

The Medical Studies Act covers far more than hospitals. The list includes health departments, Illinois State Medical Society (and other medical societies), HMOs, surgicenters, tissue and organ banks, and physician owned health insurance companies. In this article, “hospital” is intended to encompass all entities listed in the MSA.

What is covered?

“Peer review,” as the MSA states, includes “third party confidential assessments of a health care practitioner’s professional competence.” In addition to “peer review,” the MSA is also intended to protect medical studies. A “medical study,” in this context, is generally an investigation of any adverse medical occurrence with the idea that such a review will assist the hospital to improve patient care and quality of care. This allows the medical staff, through a committee, to inquire freely into and investigate any occurrence at the hospital. Anything the committee does in this process is privileged against disclosure and is inadmissible.

In medical malpractice, the MSA can protect from disclosure the investigation by a committee of any occurrence. Hospitals often use the language of the Joint Commission in determining what the occurrence is called, and that is: a “sentinel event.”

The Joint Commission defines a “sentinel event:” “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of a limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Such events are called ‘sentinel’ because they signal the need for immediate investigation and response.”

Sentinel event will be used hereafter.

The idea seems somewhat analogous to courts not allowing evidence of a “subsequent remedial measure.” Without the shield of inadmissibility, there is a disincentive to undertake remediation of dangerous conditions - or dangerous medical practices. But the privilege against disclosure under the Medical Studies Act is far more amorphous/ill-defined than merely being a subsequent remedial measure.

What is protected/privileged

“[I]nformation . . . of . . . committees. . . .”

“Information” is fairly broad and can encompass everything from statements, reports, committee minutes, medical studies act continued on page 20
and even articles from medical journals. Research done for a committee shows the thought processes of the committee and is therefore subject to the MSA privilege.4

To be privileged under the MSA, a document must be “generated specifically for the use of a peer-review committee.”5 “Committee” is also fairly broad. The MSA names several specific committees as examples, but there is no specific committee that must be constituted to act. Decisions don’t address whether this or that committee was appropriate. It seems that virtually any “committee,” which is tasked with the function of investigating sentinel events, will do. But to be privileged, the information gathered must be “information of [the] committee.” (When the legislature amended the MSA in 2003, the aforementioned list of “committees” was expanded to include “or their designees.”) To date, there is no decision interpreting “or their designees”.

The seminal case in Illinois interpreting the Medical Studies Act is Roach v. Springfield Clinic.6 Roach was a medical malpractice case alleging a delay in timely administering anesthesia to the mother resulting in a delay in delivering her newborn who developed cerebral palsy. Subsequently the Chief of the anesthesiology department at Memorial Hospital, Dr. Draper, had a conversation with a nurse anesthetist who had been on duty at the time of the delivery. Dr. Draper also had conversations with Nursing Supervisor Dentinger. The hospital claimed that the conversations were privileged under the MSA and the trial court excluded the conversations. Judgment was entered on the verdict in favor of all defendants and affirmed by the appellate court. The Illinois Supreme Court reversed in part granting a new trial against Memorial Hospital finding that the conversations were not privileged under the Medical Studies Act.

Initially, the court noted that it was the hospital’s burden of establishing that the information sought was privileged.

“...[W]e observe that Memorial made no showing that what Draper learned from Dentinger was, in fact, ever conveyed to the department. All Draper was allowed to say at his deposition was that his report to the department followed his conversations with Dentinger and his review of reports from (anesthetist and anesthesiologist). He testified that he summarized (anesthetist’s and anesthesiologist’s) reports in his presentation to that body, but he said nothing about the information he acquired from Dentinger. The responsibility for not making a more complete record on this point must be placed squarely on Memorial, not plaintiffs, for the burden of establishing the applicability of an evidentiary privilege rests with the party who seeks to invoke it. (Citation omitted.)”7

The hospital claimed that the

---

**ATG LegalServe**

To learn more contact us:  
312.752.1992  
info@atglegalserve.com

One South Wacker Dr., 24th Floor  
Chicago, Illinois 60606-4654  
www.atglegalserve.com  
License: IL #117-001494

---

Flexible, Fast, Responsive

- Service of Process
- Court Filing
- Document Retrieval
- Skip Tracing
- Background Checks

ATG LegalServe, Inc.® is a process serving and full-service litigation support provider. We are fully licensed, insured, and serving papers daily from our Chicago location. Our staff is experienced and our prices are competitive. We deliver the finest process serving available to lawyers today. We serve all 102 counties in Illinois and offer nationwide reach through our extensive network.

ATG LegalServe combines modern techniques with old-fashioned hard work to get the job done on time, every time.
statements were nevertheless privileged because they were later given to a committee. The court disagreed:

“If the simple act of furnishing a committee with earlier-acquired information were sufficient to cloak that information with the statutory privilege, a hospital could effectively insulate from disclosure virtually all adverse facts known to its medical staff, with the exception of those matters actually contained in a patient’s records. As a result, it would be substantially more difficult for patients to hold hospitals responsible for their wrongdoing through medical malpractice litigation. So protected, those institutions would have scant incentive for advancing the goal of improved patient care. The purpose of the act would be completely subverted.”

“Where the statements were not initiated, created or generated by the quality assurance committee, defendants have failed to establish that the privilege is applicable . . . .”

Information generated prior to or after the peer review process is generally discoverable and, even when statements are made in anticipation of peer review, the confidentiality provisions of the MSA are not invoked until there is a committee meeting on that incident.

Many times information is acquired and documents are generated for “routine” occurrences. “[A] document . . . created in the ordinary course of the hospital’s medical business, or for the purpose of rendering legal opinions, or to weigh potential liability risk, or for later corrective action by the hospital staff, . . . should not be privileged, even though it later was used by a committee in the peer-review process.”

Routine investigation feeds improvements in loss control. (Reports prepared shortly after incident and used by oversight committee to review incident were not privileged where reports were not requested by, and therefore did not belong to, a committee engaged in the peer-review process.)

A hospital administrator’s investigation does not yield information privileged under the MSA “where the administrator is not conducting the investigation as part of the peer review process, even if the investigation results are shared with the peer review committee.”

A letter from doctor which was written at the request of a hospital’s credentialing committee, could be privileged since granting staff privileges could constitute internal quality control.

“Or Their Designees”

It appears after the amendment which added the “or their designee” language to the Medical Studies Act, hospitals began introducing schemes in their bylaws, policies, and board resolutions which purportedly identified designees to act on behalf of an appropriate committee - without a committee ever having to meet. “[O]r their designees” is likely to be a fertile area for hospitals to cultivate while...
making ever expanding privilege claims.

These designations seek to completely undermine the intent of the Medical Studies Act protecting a collaborative review process by authorizing various individuals or groups to act on behalf of a committee.

Then the Second District Appellate Court decided *Kopolovic v. Shah* in 2012, perhaps the most important recent decision regarding the Medical Studies Act. The plaintiff brought suit against a surgical center and another doctor, Shah, for defamation. Dr. Shah had authored a memorandum critical of Dr. Kopolovic’s treatment of a patient. Dr. Shah had voiced his concern to various other physicians including the president of the surgical center’s board. Dr. Shah was not a member of any peer-review or quality-control committee, and he wrote the memorandum prior to any committee involvement.

The court in *Kopolovic* stated:

“‘Information of’ has a specific meaning here: it encompasses only information ‘initiated, created, prepared or generated by’ a peer-review or quality-control committee. (Citation omitted) Information generated or created before the time that the relevant committee became aware of the incident that the information relates to, or before the committee met to address the incident, is not ‘information of’ the committee and cannot be made privileged by its later submission to the committee. (Citation omitted.)”

The *Kopolovic* court went on to note:

“[T]he actions of individual members of a committee are not the same as the actions of that committee itself. In *Roach*, the supreme court explicitly rejected the hospital’s argument that the investigation undertaken by the chair of the anesthesiology department was tantamount to an investigation by the department itself. *Roach*, . . . . Similarly, in *Pietro*, . . . , an administrator, who was a member of the facility’s quality-assurance committee and was ultimately responsible for investigating all institutions to pursue the goal of improved patient care, thereby subverting the purpose of the Act. *Id.* (Citation omitted.) Accordingly, Illinois courts have long held that information regarding an incident that is generated prior to the relevant committee’s decision to review the incident is not protected by the Act. (Citation omitted.)”
the incidents that occurred at the facility, asked three employees to prepare statements regarding the incident at issue in the lawsuit. The court found that the quality-assurance committee had not met regarding the incident before the statements were created, and “there was no evidence of a request by the committee for the information.” *Id.* . . . . Thus, the statements could not be considered information generated by the committee, despite the fact that they were created at the request of a member of the committee. *Id.* . . . . Noting that “[o]ur courts have repeatedly distinguished between nonprivileged information reported to a committee and privileged information generated by * * * a committee,” the court held that the statements were not protected under the Act. *Id.*. Here, the defendants have not submitted evidence that either Dr. Martucci or Dr. Wander was authorized by the MCDS board to investigate Dr. Shah’s concerns before Dr. Shah wrote his memorandum. Accordingly, we must hold that the suggestion (or direction) by members of the MCDS board that Dr. Shah put his concerns in writing did not render the resulting memorandum privileged under the Act as a document generated by the board.”16

“As there was no evidence that any hospital committee had specifically asked the administrator to investigate the incident at the time of the conversations at issue, those conversations were not privileged. *Id.* “[A]n investigation generally undertaken by hospital administration is not protected by the Act.” *Id.* (Citation omitted.) This is so despite the fact that the goal of the administration’s investigation might be consistent with the goal of improving patient care. *Id.* (“The Act does not protect all information used for internal quality control [citation] * * *.”)”17

It certainly appears that a hospital’s scheme to bypass committee involvement until after its investigation is completed or at least well underway places the scheme squarely within the court’s analysis in *Kopolovic.* Neither the MSA nor its jurisprudence allows a defendant to use its policy, board resolutions or regulations to make an advance declaration that cloaks all incident documents within the Act’s privilege:

“The Hospital seems to be saying its H(ospital) O(versight) C(ommittee) can invoke the Act’s protection by declaring in advance that all incident documents prepared by the Hospital staff are part of the peer-review process. The Hospital’s position goes too far. Such a policy, if effective, would swallow the rule. The Act would not create exceptions to disclosure. It would make everything confidential, except for the patient’s own medical records.”18

*Medical Studies Act* continued on page 24

---

**When you or someone you care about needs early access to a Structured Settlement, Annuity, Fee, or other Future-Dated Asset, call us.**

*We are the Experts.*

**ASFMoney.com**

*Aftercare for Structured Settlements*

**1.866.601.7700**
A doctor’s application for hospital privileges is not subject to the MSA privilege since the application necessarily predates peer review committee involvement. 19

The necessity of committee involvement works as a safeguard against the hospital’s discovery abuse and using the privilege under the Act as a complete bar to discovery. Committee members would be in constant session if they had to meet to make sure every routine occurrence could be a protected-from-discovery “sentinel event.” As a practical matter, only after the hospital considers an event important enough for committee involvement is the occurrence presented to a committee to investigate.

“Designees” can act for a committee but are not a committee. Trying to claim committee involvement without the necessity of committee involvement would thwart discovery.

Can the Privilege Be Waived?

“The privilege set forth in the Act cannot be waived.”20

But note that if the hospital also claims the disputed information is subject to the attorney-client privilege, the Medical Studies Act privilege will not apply. Claiming the attorney-client privilege requires the hospital to assert that the information represents a communication between a defendant or potential defendant and its attorney for the purpose of defending a future lawsuit, not for peer review or medical study.

Hospital Discovery

Discovery requests should, of course, be as broad as possible in seeking information. This should include any and all documents relating to the plaintiff from the hospital’s risk management department, or the person or department functioning in that capacity, and any documents relating to the plaintiff maintained by the hospital administration (such as claims reports or incident reports). Electronic Health Records are not maintained by risk management or administration. The risk manager may have prepared a “Root Cause Analysis” of the injury and an “Action Plan” for corrective action.

Asking for risk management and claims records should result in a privilege log pursuant to Illinois Supreme Court Rule 201(n), and the plaintiff’s attorney will then have a better idea of what to look for.

To establish that either risk management or claims records are privileged, the privilege log should identify the committee that requested the information, the date the information was requested, who collected the information, when it was collected, to whom the information was transmitted, and when it was transmitted. Failure to include that information will make it difficult to establish a privilege under the MSA.

Sequence of Discovery

After receiving the privilege log, a plaintiff’s attorney may want to go forward with discovery before engaging in motion practice. Why before motion practice? The author of any document can be deposed and questioned about routine hospital practices before getting into sentinel events and, in particular, the sentinel event giving rise to the lawsuit. Consider this: It may turn out that the risk manager was engaged in a routine risk management investigation as is their usual practice. The investigation may have come to the attention of the hospital administration who then determined that this was a potentially significant event; the hospital then retroactively declared the occurrence to be a sentinel event and the investigation to be that of a committee or a previously identified designee. This entire sequence occurs without actual committee involvement. The hospital claims this was all information of a committee, but the risk manager has already given sworn testimony that the investigation was only a routine risk management function.

A physician, even one on the committee conducting a peer review, may have acquired knowledge outside medical studies act continued on page 26
the peer review process. Did someone speak to him and tell him what happened before the peer review process had started? Did someone speak to him and confirm the information after the peer review process was complete? Or did someone speak to him outside of the peer review process while it was still ongoing? If he had the information confirmed outside the peer review process, then no privilege would apply to the information so obtained. The physician should disclose who gave him information outside the peer review process.

**Focus During Discovery**

The claim of privilege is inviolable if the hospital complies with the MSA in conducting its medical study/peer review and in generating any documents related thereto.

To support the claim of privilege a hospital must show proof of committee involvement. The hospital must show that the committee knew of the sentinel event before the committee investigation begins. The committee (or perhaps its designee) must have met to determine a course of action. The committee must request the review.

The hospital may claim a committee’s designee determined to undertake an investigation. Does the designee, such as a “Event Triage Team” really exist? Or is it just on paper?

Was the information created at the request of any committee? Was the information transmitted to the committee? It will be hard for the hospital to establish that the information was a committee’s if it was not created at the request of the particular committee; likewise, if it is never received by the committee.

It is entirely possible that there will be no evidence that a duly constituted committee ever met, ever asked for action, received a document, or ever heard about the plaintiff’s sentinel event until weeks or months after the information has been generated.

There may have been someone other than a committee or even a staff member who asked for an investigation. It may have been the plaintiff or a relative or friend, or a staff member from janitor to nurse. For example, establishing that the plaintiff’s spouse requested the investigation would rule out initial committee involvement. Patient complaints are not generated at the request of a medical staff committee, nor are complaints by staff part of a medical study. Furnishing the information gained to a committee would not make it privileged under the MSA.

When was the process initiated? Dates are extremely important. A committee must direct the action and must have met before the information can be considered privileged. The privilege log should state when the meeting occurred. Did a committee meet before the information was acquired? Even then, the committee must have specifically acted on the plaintiff’s sentinel event by requesting information.

While the statutory use of the term “committee” is broad, it still must be an
appropriate committee. With mergers and cooperative agreements between institutions, joint committees may not be covered under the MSA. A hospital and, say, a medical center are separately licensed and required by applicable regulations to maintain separate committees, any claimed privilege by a hospital’s committee is lost because of third-party involvement with the committee. Licensing requirements and regulations may mandate separate review committees regardless of whether the entities share a common corporate owner. Thus when a representative of one attends a meeting of the other, the privilege is lost.

Who was present for meetings can determine the purpose of the meeting and whether privilege applies.

Discovery of the incident reports created in a case does not threaten open communication in the peer review setting. The incident report may simply be required following any complaint as a matter of hospital policy, or incident reports may be required by the hospital’s insurance policy. Such incident reports are not information of a committee and are therefore discoverable.

While information of the committee is privileged, it may be possible to gather the same non-privileged information from the original source. The privilege does not cover documents or information that exists separately from the credentialing process.\textsuperscript{21}

Further, “conclusions or final recommendations” of the committee are not privileged.\textsuperscript{22}

**Discovery Strategy**

In addition to whatever standard requests are made under Supreme Court Rules, the plaintiff attorney may also specifically request all records of risk management and claims that relate in any way to the plaintiff. This should lead to a privilege log naming (at least some of) the documents you will want to pursue.

If there are risk management records (or even if the hospital says there are none) the plaintiff’s attorney may want to depose the risk manager to inquire about their procedures and your client’s sentinel event. If the depositions of everyone in the risk management department are sought, the hospital could object to some of the depositions. By objecting, the hospital is limiting the witnesses it can name later. The plaintiff’s attorney may want to consider whether to move to compel the depositions, or simply allow the hospital to reduce the pool of potential witnesses on its behalf.

If the plaintiff’s attorney is going to move to compel documents or depositions, a strategy may be needed to determine what will benefit the plaintiff the most: should the motion be brought early, or after some discovery. The hospital will likely respond to any motion to compel by citing bylaws, resolutions of the board, and/or policies and procedures relating to “sentinel events.” If the plaintiff’s motion to compel is a little later in discovery, the plaintiff’s attorney will have already determined how the hospital acted in your specific case medical studies act continued on page 28
through the deposition of the risk manager, and the hospital may have limited their potential witnesses who could otherwise dispute or “explain” the risk manager’s testimony.

If the risk manager has given testimony that is consistent with a routine investigation, and there has been no involvement of a committee, the court will likely order the hospital to produce all information acquired prior to the first committee meeting.

Once that information is produced, it should be examined to determine what other information has been generated that the hospital inadvertently failed to identify.

Conclusion

While the legislature has expanded the Medical Studies Act over the years, the courts have narrowly construed “committee involvement” as still being tested.

If there is an occurrence, and in investigating the hospital strictly follows the procedures set forth in the decisions interpreting the Medical Studies Act, any information generated during the investigation can’t be used, nor even if it is inadvertently or even intentionally disclosed to the plaintiff. There are significant penalties for improper disclosure.

On the other hand, the Medical Studies Act is intended to allow confidentiality for the processes of peer review of physicians and medical studies to improve patient care. But hospitals and other healthcare entities defined by the MSA may have a tendency to claim a much broader privilege than allowed under the decisions interpreting the MSA and, in that way, withhold information that should be disclosed to plaintiffs in the discovery process. Developing a discovery strategy, vigorously pursuing it, and motion practice may yield information that the hospital would prefer not to disclose – to the benefit of the plaintiff.

Endnotes


Lee Gunter is a solo practitioner in Joliet. He started in general practice then moved to insurance defense. He made partner before starting his plaintiff’s personal injury practice over a decade ago. Lee has tried nearly 100 jury cases to verdict. A substantial portion of his practice focuses on medical negligence.