No. 126748

IN THE

SUPREME COURT OF ILLINOIS

JILL M. BAILEY, as Independent Representative of the Estate of Jill M. Milton-Hampton, Deceased, and JILL M. BAILEY, Individually, Plaintiff-Appellee, v. MERCY HOSPITAL AND MEDICAL CENTER, Defendant, SCOTT A. HEINRICH, M.D., BRETT M. JONES, M.D., AMIT ARWINDEKAR, M.D., HELENE CONNOLLY, M.D. Defendants-Appellants, TARA ANDERSON, R.N., Defendant, And EMERGENCY MEDICINE PHYSICIANS OF CHICAGO, LLC. Defendant-Appellant.	On Appeal From The Illinois Appellate Court, First Judicial District, Case No. 1-18-2702 On Appeal to that Court from the Circuit Court of Cook County, County Department, Law Division, Case No. 2013-L-8501 Honorable Thomas V. Lyons II, Trial Judge Presiding

BRIEF FOR DEFENDANTS-APPELLANTS SCOTT A. HEINRICH, M.D., BRETT M. JONES, M.D., AMIT ARWINDEKAR, M.D., HELENE CONNOLLY, M.D., AND EMERGENCY MEDICINE PHYSICIANS OF CHICAGO, LLC

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POINTS AND AUTHORITIES

NATURE OF THE ACTION

This is a medical malpractice action in which plaintiff alleges that defendants failed to timely diagnose and treat a bacterial infection, allegedly causing decedent's death. The jury rendered a general verdict in favor of all defendants, resulting in entry of a judgment for all defendants. The Appellate Court reversed the judgment as to these defendants (the four ER physicians and their professional corporation) on grounds of instructional error, and this appeal is taken from that decision. No questions are raised on the pleadings.

ISSUES PRESENTED FOR REVIEW

I Whether the Appellate Court erred in holding that a new trial is required for the failure to give a non-pattern jury instruction on "lost chance."

II Whether the Appellate Court erred in holding that a new trial also is required for the failure to give a modified jury instruction on an "informed consent" theory.

JURISDICTION

Following a jury trial and a verdict for all defendants, the circuit court entered judgment in favor of all defendants on May 3, 2018. (C.4435 V3). Following denial of post-trial motions, plaintiff filed a notice of appeal. (C. 8450-51 V5). The Appellate Court exercised jurisdiction pursuant to Illinois Supreme Court Rules 301 and 303.

The Appellate Court issued an opinion on September 30, 2020, partially reversing the judgment and remanding for a new trial. See *Bailey v. Mercy Hosp and Med Center*, 2020 IL App (1st) 182702. These defendants, the ER physicians and EMP, timely filed a petition for rehearing, submitting that there was no instructional error, that any error was harmless, and that in any event a new trial should be limited to only the "informed consent" theory involving claims against one physician, or, if tried on all theories, should

include the ER physicians, EMP, and the hospital. The petition was denied on November 9, 2020. Defendants timely filed a petition for leave to appeal to this Court. The petition was allowed on March 24, 2021. This Court has jurisdiction over this appeal pursuant to Supreme Court Rule 315.

STATEMENT OF FACTS

This is a medical malpractice action involving allegations of failure to timely diagnose and treat infection. Plaintiff Jill Bailey, personal representative of the estate of Jill Hampton-Milton, seeks damages for the decedent's death. Plaintiff's claims against the defendants, including these defendants (four individual ER physicians and their professional corporation), were tried to a jury in the May 2018. The jury returned a general verdict in favor of all defendants, and a judgment was entered in favor of defendants by the circuit court. On appeal by plaintiff, the Appellate Court partially reversed the judgment and ordered a remand for a new trial only as to the emergency physicians and their professional corporation, holding that error occurred when the trial court did not give the jury a non-pattern instruction on "lost chance," and when the trial court did not give a separate, modified jury instruction on an "informed consent" theory. This Court allowed defendants' petition for leave to appeal.

A. Underlying Facts.

This action involves medical care provided to plaintiff's decedent Jill Milton-Hampton during two visits to the emergency department at Mercy Hospital and Medical Center in March 2012. Ms. Milton-Hampton first came to the ER at approximately 6:45 p.m. on March 16, 2012, complaining of abdominal pain, nausea, vomiting, and diarrhea. She was assessed by ER physician Dr. Scott Heinrich, who believed that she had gastroenteritis, and ordered tests and IV fluids (C. 7579 V5, C. 7584-7585 V5).

Sometime after 3:00 a.m. on March 17, while the patient was still receiving IV fluids, the patient's care was transferred to ER physician Dr. Brett Jones, who also believed that the patient probably had gastroenteritis, and planned to continue monitoring and giving fluids (C. 7587 V5, C. 7602 V5, C. 7603 V5, C. 7622 V5, C. 7689-7691 V5).

At approximately 6 a.m. on March 17, Dr. Jones evaluated the patient and had a discussion with her, recommending that she be admitted to the hospital for further observation (C. 7606 V 5). He explained that, based on her lab values and response to fluids, he believed that she had a viral gastroenteritis, but "was concerned that there could be something else" (C. 7608 V 5). Dr. Jones explained that the patient continued to be nauseated and he was concerned that, if she went home, she would get worse (C. 7606 V 5). He also was concerned about the patient's low hemoglobin, the fact that she was still dehydrated after receiving fluids, and her continued elevated heart rate (C. 7606 V 5). Dr. Jones stated that there are a "number" of "serious causes" that "can account for that," including a blood clot in the lungs (pulmonary embolism), elevated thyroid levels, gastrointestinal bleeding, infection, or sepsis (C. 7606 V 5). Dr. Jones testified that he explained to Ms. Milton-Hampton that her heart rate was elevated, that he would have expected it to normalize after fluids, that there is "something else going on," and there are "multiple possibilities," many of which could be "very, very serious" (C. 7606 V 5). Dr. Jones did not tell the patient specifically that she might have a pulmonary embolism, gastrointestinal bleeding, or sepsis, but told her that she might have a "very serious condition" (C. 7611-12 V 5).

Dr. Jones testified, however, that the patient was "adamant" about going home and she declined admission (C. 7607 V 5). Dr. Jones asked the patient if there was "any

way I could get you to stay," but she stated that she felt better (C. 7608 V 5). Thus, after almost twelve hours in the hospital, the patient declined to be admitted and observed as recommended by Dr. Jones, and instead decided to leave the hospital, with an instruction to return if she changed her mind about admission or if her condition worsened (C. 7608 V5, Sec. C 1450). Dr. Jones's discharge note states as follows:

> I did see and evaluate the patient. She continues to be nauseated. I recommended further observation and admission Especially given her persistent nausea, persistent tachycardia, and abnormal laboratory studies However, the patient declines this and really would like to go home. He does demonstrate decisional capacity. She received her prescriptions as above. She agrees to return to the ER for worsening symptoms, severe pain, or for any other concerns. Her partner is with her and appears to be reliable and will bring her back for worsening pain. [Sec. C. 1467.]

Ms. Milton-Hampton returned to the ER at around 5:45 p.m. on March 17 (Sec. C. 1231). Defendant ER physician Dr. Helene Connolly ordered testing, including a CT scan (C. 7777-7779 V5). The patient was transferred from triage to the "main" emergency department at around 9:50 p.m. (Sec. C 1247). Ms. Milton-Hampton was cared for in the "main" emergency department by resident Dr. Rodriguez and defendant ER physician Dr. Amit Arwindekar, whose plan was to rehydrate the patient, control pain and nausea, wait for results of a CT scan and chest x-ray, and later to admit the patient to the hospital due to intractable vomiting and some abnormalities on chest x-ray and CT scan (C. 7844 V5, 7848-7849 V5, C. 7582 V 5, C. 7854 V5, C. 7859 V 5, C. 7861 V5). Approximately eleven hours after her second arrival at the ER, at approximately 4:30 a.m. on March 18, the patient was transferred to an observation unit near the ICU (C. 7861 V5, C. 7855 V5). At approximately 5:50 a.m., the patient went into cardiopulmonary arrest and was intubated and resuscitated (C. 6911 V5; Sec. C 1307).

The patient later died in the ICU after multiple codes, with the last at 11:30 a.m. (C. 6911 V5).

B. Trial Proceedings: Expert Testimony On Breach Of The Standard Of Practice And Causation.

Personal representative Jill M. Bailey brought suit alleging medical malpractice against ER physicians Dr. Heinrich, Dr. Jones, Dr. Connolly, and Dr. Arwindekar, as well as the physicians' professional corporation (EMP), an ER nurse, Tara Anderson, and Mercy Hospital and Medical Center (C. 1296-1460). As to the hospital, plaintiff alleged vicarious liability for the four ER physicians and hospital nurses (C. 1298-1299).

During the nearly four-week jury trial, plaintiff's experts contended that Ms. Milton-Hampton died of sepsis (overwhelming response to infection) resulting from a bacterial infection that the experts claimed had resulted from toxic shock syndrome caused by a retained tampon (Sec. C. 487, 497, 506, 521, 524-525, 768, 775, 779, 876, 906-908, 920, 962, 975, 986, 994, 1055, 1082, 1084, 1200). Plaintiff's expert Dr. D'Ambrosio, an ER physician, contended that the first ER physician, Dr. Heinrich, appropriately considered viral gastroenteritis initially and appropriately gave fluids, but was negligent, after two liters of fluid were given, in failing to "consider" or "suspect" sepsis, and either should have ordered a "sepsis workup" or told Dr. Jones, the physician to whom he transferring care, that Dr. Jones should order a "sepsis workup" if a third liter of fluid did not resolve the patient's symptoms (Sec. C. 1074; C. 6589 V 4). Dr. D'Ambrosio contended that, after the third liter of fluid was given (while Dr. Jones was caring for the patient), the ER physician was required to start a "sepsis workup," including a lactic acid test, blood cultures, urine cultures, an EKG, a chest xray, and a CT scan of the abdomen, and also should have ordered antibiotics, and that he breached the

standard of care by not doing so (Sec. C. 1074-1076, C. 6590 V 4). As to Dr. Jones's discussion with the patient at the end of the first ER visit, Dr. D'Ambrosio contended that, if Dr. Jones had been "armed with" the results of tests he did not order, such as a chest xray, lactic acid, and CT scan, then a "discussion about the possibility of sepsis and her dying from going home would have been appropriate" (Sec. C. 1077, C. 6591 V 4).

Dr. D'Ambrosio also contended that Dr. Connolly, the physician assigned to triage during the second ER visit, should have sent the patient back to the main emergency department and ordered a CT scan, chest xray and EKG (Sec. C. 1079). Finally, as to hospital resident Dr. Rodriguez and attending ER physician Dr. Arwindekar, Dr. D'Ambrosio contended that they needed to perform a "sepsis workup," order antibiotics, and obtain an EKG and chest xray, and that Dr. Arwindekar should not have transferred the patient from the ER to an observation unit, but to an "intermediate care unit" or the ICU with a "higher level of care" (Sec. C. 1079, 1081, 1086).

As to causation, plaintiff's infectious disease expert Dr. Noto testified that antibiotic treatment should be given, "the earlier, the better"; that delay in giving antibiotics increases the risk of harm or death from sepsis and septic shock (and each hour of delay increases the risk of death by 7 percent); and that he could not say when the "point of no return" occurred such that this patient would not have survived, even with treatment (Sec. C. 927-28, 971, 973, 1215-1216).

In contrast, plaintiff's expert Dr. Jacob, a hematologist, testified that the "death rate" of toxic shock syndrome is "low," only 1 to 3 percent, and that if the patient had received appropriate therapy, the therapy "more likely than not" would have saved her life (Sec. C. 519-520, 522). He testified that, more likely than not, the decedent lost the

ability to survive sometime during the day of the 18th (the day of her death), but it is more likely than not that she would have survived if given antibiotics on the 17th (Sec. C. 526). He later clarified that the "cut off" time for when more likely than not survival became more likely than not death would have been at the time of the first code on the 18th (which occurred at 5:50 a.m.) (Sec. C. 537).

Plaintiff's other expert, Dr. Hudson, a cardiothoracic surgeon who testified that he "co-manages" septic patients with infectious disease specialists, also stated that, had decedent received "appropriate" treatment, more probably than not she would have survived (Sec. C. 1052, 1054, 1056, 1065).

The ER physicians, EMP, and Mercy submitted expert testimony from ER physicians to establish that all four ER physicians complied with the standard of practice in caring for Ms. Hampton-Milton, and specifically that it was appropriate to consider and treat for viral gastroenteritis, and that it was not a breach not to order a "sepsis workup" or antibiotics or suspect a bacterial infection (C. 6993-98 V 5, C. 7002-7005 V 5, C. 7017 V 5, C. 7926-27 V 5, C. 7957-71 V 5, C. 7986-7990 V 5, C. 8004 V 5, C. 8008 V 5, C. 8024-8025 V 5, C. 8027-8028 V 5, C. 8089-8090 V 5). As to the communication between Dr. Jones and the patient at the conclusion of the first ER visit, defense experts Dr. Courtney and Dr. Ward testified that Dr. Jones complied with the standard of care (C. 7002-7705 V 5, C. 7972-74, 7977 V 5).

Defendants also submitted expert testimony to establish all of the following: (1) that Ms. Milton-Hampton did not have a bacterial infection or toxic shock syndrome at all, but instead a viral infection, fulminant myocarditis (sudden, severe cardiac inflammation); (2) that the decedent did not have a retained tampon, and that plaintiff's

radiologist expert actually was pointing out the patient's urethra; (3) that the ER physicians never could have diagnosed a bacterial infection that the patient did not have; (4) because the infection was viral and not bacterial, antibiotic treatment--which is effective only against bacterial infections--would not have had any effect; and (5) there was no treatment for the fulminant myocarditis, and no way to avoid the decedent's death. (C. 6661-6663 V 5, C. 6677-78 V5, C. 6684-6689 V 5, C. 6717-6738 V 5, C. 6805 V 5, C. 6809-6814 V 5, C. 6821-6831 V 5, C. 6968-73 V 5, C. 7004 V 5, C. 7927-28 V 5, C. 7087-7145 V5, C. 8029-8030 V 5, C. 9927-28 V 5, Sec. C 672-64).

C. Proceedings And Ruling On Proposed Non-Pattern "Informed Consent" Instruction.

Plaintiff submitted to the jury the following claims of breach by the ER physicians: (1) that three of the ER physicians—Dr. Heinrich, Dr. Jones, and Dr. Arwindekar—were negligent in "failing to order a sepsis workup"; (2) that the fourth ER physician, Dr. Connolly, was negligent in failing to "take Jill Milton-Hampton to the main emergency department in 15-30 minutes"; and (3) that ER physician Dr. Jones also was negligent because he "failed to inform Jill Milton-Hampton of the risks associated with leaving the hospital" (C. 4374 V3).

The claim of professional negligence by Dr. Jones in failing to "inform" the decedent of the "risks associated with leaving the hospital" was based on the discussion between Dr. Jones and the decedent at the conclusion of the first ER visit. As set forth above, plaintiff's expert Dr. D'Ambrosio asserted that, if Dr. Jones had been "armed with" the results of tests he did not order, such as a chest xray, lactic acid, and CT scan, and those tests suggested sepsis, then a "discussion about the possibility of sepsis and her dying from going home would have been appropriate" (Sec. C. 1077, C. 6591 V 4).

Defense expert Dr. Courtney testified that Dr. Jones complied with the standard of care (C. 7002-7705 V 5). Dr. Courtney further testified that, if Dr. Jones had a "diagnosis" or a "high probability" that a patient had a pulmonary embolism, or if that was Dr. Jones's "number one diagnosis" and the "most probable diagnosis," then the doctor would be obligated to have "some conversation" about that (C. 7009 V 5). If Dr. Jones was "seeing, diagnosing" a GI bleed, he should discuss it as "one of the diagnoses that he's made" (C. 7010 V 5).

Defense expert Dr. Ward also testified that Dr. Jones complied with the standard of care in talking to the decedent and asking her to stay in the hospital (C. 7972-74, 7977 V 5). Dr. Ward testified that Dr. Jones was not required to tell the patient that she had a life-threatening condition or that she would die if she left the hospital (C. 7974 V 5). Dr. Ward also testified that if Dr. Jones was "concerned" that the patient might have a life-threatening condition, he should explain his concerns and offer further treatment, but that he is not required to "go through each and every individual thing that may or may not be present" (C. 8049-8053 V 5).

It was plaintiff's theory that, if Dr. Jones had informed decedent, decedent would have stayed in the hospital instead of leaving (after approximately 12 hours in the ER) at approximately 6:00 a.m. and returning at 5:45 p.m. (to spend approximately another 11 hours in the hospital until her death the next morning).

Plaintiff requested a modified version of one of the "informed consent" instructions, IPI Civil (2011) No. 105.07.02[1]. The standard "informed consent"

[1] The Appellate Court discussed IPI Civil (2011) 105.07.01, but a review of the proposed instruction reflects that it is a modified version of a different instruction, IPI Civil (2011) 105.07.02.

instruction in 105.07.02 states as follows:

> The plaintiff claims that the defendant failed to inform the plaintiff of those [risks of] [and] [or] [alternatives to] the [describe the procedure performed] which a reasonably well qualified [insert appropriate medical professional] would have disclosed under the same or similar circumstances;
>
> The plaintiff further claims that if the defendant had disclosed those [risks] [and] [or] [alternatives], a reasonable person in the plaintiff's position would not have submitted to the [describe the procedure performed]; and
>
> The plaintiff further claims that he was injured, and that the defendant's failure to disclose those [risks] [and] [or] [alternatives] was a proximate cause of that injury.
>
> The defendant [denies that he failed to inform the plaintiff of those (risks of) (and) (or) (alternatives to) the [describe the procedure performed] which a reasonably well-qualified [insert appropriate medical professional] would have disclosed under the same or similar circumstances;] [denies that a reasonable person in the plaintiff's position would not have submitted to the [describe the procedure performed] after being told of those (risks) (and) (or) (alternatives)]; [denies that the plaintiff was injured or sustained damages (to the extent claimed);] [and] [denies that any failure to disclose those (risks) (and) (or) (alternatives) was a proximate cause of any injury].

Plaintiff's proposed instruction was modified to state that it was plaintiff's claim that Dr. Jones failed to inform the patient of the "risks of" the patient's potential, undiagnosed, medical conditions, and that, if fully informed, the patient would not have "left the hospital" without obtaining any treatment:

> The plaintiff claims that the defendant, Brett Jones, M.D. failed to inform Jill Milton-Hampton of the risks associated with pulmonary embolism, gastrointestinal bleed, infection and sepsis prior to being discharged the morning of March 17, 2012, which a reasonably careful emergency medicine physician would have disclosed under the same or similar circumstances;
>
> The plaintiff further claims that if the defendant had disclosed those risks, a reasonable person in Jill Milton-Hampton's position would not have left the hospital the morning of March 17, 2012; and

> The plaintiff further claims that Jill Milton-Hampton was injured, and that the defendant's failure to disclose the aforementioned risks was a proximate cause of her injury.
>
> The defendant denies that he failed to inform the plaintiff of those risks which a reasonably careful emergency medicine physician would have disclosed under the same or similar circumstances; denies that Jill Milton-Hampton was injured and denies any failure to disclose risks was a proximate cause of any harm or injury. [C. 4426 V3.]

The trial court declined to give this modified instruction, stating that it agreed with the defense that no separate instruction on this theory was appropriate (C. 8307 V 5). The court, however, acknowledged that "there was testimony that the standard of care would have required the doctor to say certain things," and stated that "I'll certainly permit you – you can do it while we're arguing – to step out with one of the attorneys and add in your issues instruction a line about a mark – you know, in other words, defendants were negligent in certain respects. I'll permit you to add 'failed to adequately inform her' – you work on the language" (C. 8307-8309 V 5).

The parties then submitted the agreed-upon language as to this claim based on the discussion with Dr. Jones, and the jury was instructed as follows:

> The plaintiff claims that Jill Milton-Hampton was injured and sustained damage, and that the defendants were negligent in one or more of the following ways:
>
> * * *
>
> Dr. Brett Jones failed to inform Jill Milton-Hampton of the risks associated with leaving the hospital. (C. 4374 V3).

In separate instructions, the jury also was instructed that plaintiff has the burden of proving that the defendant "acted or failed to act in one of the ways claimed by the plaintiff as stated to you in these instructions and that in so acting, or failing to act, the defendant was negligent"; that the plaintiff was injured; and that defendant's negligence was a proximate cause of the injury (C. 4373 V3). The jury also was instructed that an

emergency medicine physician's "failure to do something that a reasonably careful emergency medicine physician would do, or the doing of something that a reasonably careful emergency medicine physician would not do" under similar circumstances, is "professional negligence" and a "deviation from the standard of care" (C. 4385 V3).

D. Proceedings And Trial Court Ruling On Proposed Non-Pattern "Lost Chance" Instruction.

As set forth above, while plaintiff's expert Dr. Noto could only say that delay in giving antibiotics increased the risk of death from sepsis, two of plaintiff's experts (Dr. Jacob and Dr. Hudson) asserted that, if a bacterial infection had been diagnosed and antibiotics given on March 17 or before the code on March 18 (according to Dr. Jacob), or if "appropriate" treatment had been given (Dr. Hudson), the decedent more probably than not would have survived (Sec. C. 519-520, 522, 526, 537, 1052, 1054, 1056, 1065).

Plaintiff requested a non-pattern jury instruction on the "lost chance" doctrine, which would have stated as follows:

> If you decide or if you find that plaintiff has proven that a negligent delay in the diagnosis and treatment of sepsis in Jill Milton-Hampton lessened the effectiveness of the medical services which she received, you may consider such delay one of the proximate causes of her claimed injuries or death. [C. 4424 V3.]

The trial court declined to give the instruction (No. 8) on the ground that it is a non-IPI instruction (C. 8305-8306 V5). Instead, the trial court gave the "long form" instruction on proximate cause, IPI Civil No. 15.01, as follows:

> When I use the expression "proximate cause," I mean a cause that, in the natural or ordinary course of events, produced the plaintiff's injury. It need not be the only cause, nor the last or nearest cause. It is sufficient if it combines with another cause resulting in the injury. [C. 4372 V3.]

E. Other Jury Instructions And Jury Verdict.

As to Mercy, the jury was instructed on an "apparent agency" claim of vicarious

liability for the four ER physicians (C. 4386 V3), and a separate claim of vicarious liability for hospital nurses, including Nurse Tara Anderson (C. 4383 V3). The jury was instructed to use a general verdict form, and it found for defendants Mercy Hospital and Medical Center, Dr. Heinrich, Dr. Jones, Dr. Arwindekar, Dr. Connolly, and EMP, and against the plaintiff (C. 4436 V3). No one requested special interrogatories. After entry of judgment on May 3, 2018 (C. 4435 V3), plaintiff filed a post-trial motion for new trial, which was denied (C. 8432 V5).

F. Appellate Court Proceedings.

Plaintiff appealed to the Appellate Court, First District, seeking a new trial on several grounds. In a published opinion, the Appellate Court held that a new trial is required (but only as to the ER physicians and EMP) because the trial court did not give (1) the proposed non-pattern instruction on "lost chance"; and (2) the proposed modified jury instruction on "informed consent." See *Bailey v Mercy Hosp and Med Center,* 2020 Il App (1st) 182702, ¶¶ 95-98, 112.

As to the "lost chance" instruction, the First District recognized that the Appellate Court has "consistently affirmed" the refusal to give a nonpattern "lost chance" instruction and has held that the proximate cause instruction in IPI Civil (2011) No. 15.01 "properly states the law in lost chance medical malpractice cases." *Id.* at ¶ 113. The Court, however, suddenly departed from all of these prior cases, citing this Court's decision in *Holton v. Memorial Hospital,* 176 Ill. 2d 95 (1997) as support for the proposition that "loss of chance" is a distinct "theory," and concluding that if no "lost chance" instruction is given, a jury will be "forced to understand a plaintiff's loss of chance theory argued at trial without an instruction to guide them on the law and how it

should be applied to the general proximate causation concept" in IPI Civil (2011) No. 15.01. *Id.* at ¶ 114. The Court therefore held that the nonpattern "lost chance" instruction should have been given, and that a new trial was required here (but only as to the four ER physicians and EMP only).[2] *Id.* at ¶¶ 115-116.

The Court also held that the failure to give plaintiff's proposed modified instruction on "informed consent" also required a new trial, stating that the instruction actually given (which the Court characterized as a "one-line instruction on informed consent") did not "explain the elements of informed consent, including Dr. Jones's duty to disclose material risks" (*Id.*, ¶ 97). The Court held that the modified instruction should have been given because plaintiff alleges that Dr. Jones "did not disclose that leaving the hospital could result in grave injury or death" and that plaintiff therefore "could not give informed consent to being discharged" (*id.*, ¶ 98).

The Court therefore remanded the case for a new trial, apparently as to all theories of breach except those based on the conduct of Nurse Anderson, but against only the ER physicians and EMP (*Id.*, ¶ 137). These defendants, the ER physicians and EMP, filed a petition for rehearing, submitting that there was no instructional error, that any error was harmless, and that in any event trial should be limited to only the "informed consent" theory involving claims against one physician, or, if tried on all theories, should include the ER physicians, EMP, and the hospital. The petition was denied on November 9,

[2] The Court held that no new trial is required as to claims against Mercy based on conduct of Nurse Anderson because the plaintiff "did not argue" and the "record does not support" sufficient evidence of a "lost chance" theory as to Nurse Anderson (¶ 111). The Court, however, failed to recognize or address the need for a new trial as to the claims against Mercy based on the claim of Mercy's vicarious liability for the four ER physicians.

2020. Defendants then filed a petition for leave to appeal to this Court. The petition was allowed on March 24, 2021.

STANDARD OF REVIEW

Generally, a trial court's decision to grant or deny a jury instruction is reviewed for an abuse of discretion. *Dillon v. Evanston Hospital,* 199 Ill. 2d 483, 505, 771 N.E.2d 357, 264 Ill. Dec. 653 (2002). "The standard for determining an abuse of discretion is whether, taken as a whole, the instructions are sufficiently clear so as not to mislead and whether they fairly and correctly state the law." *Dillon,* 199 Ill. 2d at 505. When the question is whether the applicable law was conveyed accurately, however, the issue is a question of law, and the standard of review is *de novo*. *Studt v. Sherman Health Sys.,* 2011 IL 108182, P 13, 951 N.E.2d 1131 351 Ill. Dec. 467 (2011).

ARGUMENT

I THE APPELLATE COURT ERRED IN HOLDING THAT A NEW TRIAL IS REQUIRED DUE TO FAILURE TO GIVE A NON-PATTERN "LOST CHANCE" INSTRUCTION.

The Appellate Court erred in reversing the judgment in favor of these defendants and holding that a new trial is required in part because the trial court declined to give a non-pattern "loss of chance" instruction. The Court's conclusion that a non-pattern "loss of chance" instruction was not only appropriate, but necessary, represents a sudden departure from precedent and is based on an erroneous characterization of "loss of chance" as a unique "theory" of causation. Rather than a unique causation "theory," "loss of chance" properly is understood as a "concept" that already is encompassed within "traditional" proximate cause and the pattern jury instruction on tort causation, IPI (Civil) No. 15.01.

Alternatively, if this Court concludes that a "lost chance" instruction should be

given in "lost chance" cases, this Court should recommend instructions based on a "proportional" theory of recovery, similar to those adopted for "increased risk of future harm" as a result of *Dillon v. Evanston Hosp.,* 199 Il. 2d 483 (2002). Regardless of whether this Court concludes that a "lost chance" instruction is appropriate in some cases, the Court's conclusion that a "loss of chance" instruction was required in this case also represents an improper expansion of "loss of chance" doctrine well beyond its limited bounds, to a case like this one that does not involve a disputed issue on "loss of chance." Finally, even if this Court concludes that some "lost chance" instruction should have been given in this case, failure to give the instruction was harmless error and does not warrant a new trial.

A. The Appellate Court Erred In Concluding That A Non-Pattern "Lost Chance" Instruction Must Be Given In Cases In Which The Plaintiff Presents Evidence Of "Lost Chance," Where Its Conclusion That Such An Instruction Is Required Is Based On An Incorrect Understanding And Characterization Of The Lost Chance "Concept."

The Appellate Court's holding below that a non-pattern "lost chance" instruction not only is appropriate, but necessary, in a case in which the plaintiff presents evidence of "lost chance," rests on its view of "lost chance" as a distinct "theory" of causation outside the scope of "traditional" proximate cause principles addressed in the pattern instruction, IPI (Civil) No. 15.01. This view, however, is inconsistent with this Court's explanation of the "loss of chance" "concept" in *Holton v. Mem'l Hosp.,* 176 Ill. 2d 95 (1997) and *Holton's* harmonization of the "lost chance" concept with "traditional" proximate cause described in *Borowski v. Von Solbrig,* 60 Ill. 2d 418 (1975). It also is inconsistent with all prior and subsequent Appellate Court decisions, all of which reject the claimed need for a non-pattern "lost chance" instruction.

1. Cases regarding the relationship between "traditional" proximate

cause and the "lost chance" causation "concept."

a. "Traditional" proximate cause analysis.

The "traditional" burden of proof of causation in medical malpractice actions was set forth in *Borowski v. Von Solbrig,* 60 Ill. 2d 418 (1975). In *Borowski,* the plaintiff's leg was injured in an automobile accident. The plaintiff claimed that the defendant physician failed to timely and/or properly perform surgery, resulting in the need for an above-the knee amputation. Following a jury verdict for the plaintiff, the defendants sought a judgment n.o.v., submitting that the plaintiff failed to establish a genuine issue of material fact as to causation because the plaintiff could not establish that he would have achieved a better result (avoiding amputation) with proper treatment.

This Court held that a j.n.o.v. was not warranted and that the plaintiff's claim properly was submitted to the jury. The Court rejected the "better result" requirement, stating that this would "extend the burden-of-proof requirements of a medical malpractice case beyond those of an ordinary negligence case…" and would "inject" "collateral ramifications." *Id.* at 424. The *Borowski* Court held that the plaintiff simply must prove that, more probably than not, the negligence was the proximate cause of his injury. *Id.* at 424. In response to concerns that the jury would be permitted to speculate about the relative amount of injury due to the original fracture and the subsequent malpractice, the Court stated this could be addressed by "appropriate instructions." *Id.* at 424.

b. Post-*Borowski* Appellate Court cases rejecting recovery based on "increased risk of harm" or "lost chance" as inconsistent with *Borowski's* statement of "traditional" proximate cause.

After *Borowski,* the Appellate Courts grappled with the issue of causation in cases involving claims that the defendants' conduct caused an increased risk of harm, or

decreased the chance of recovery or survival. In several cases, the courts either affirmed a jury verdict for the defendant, holding that the plaintiff was not entitled to a non-pattern jury instruction on liability for increased risk of harm, or held that judgment as a matter of law for the defendant was proper where the plaintiff's proofs did not establish "traditional" proximate cause.

For example, in *Curry v. Summer,* 136 Ill. App. 3d 468 (4th Dist. 1985), the plaintiff claimed that the defendants were negligent in failing to order an EKG to diagnose heart failure, resulting in the decedent's death. The plaintiff's expert declined to say whether it was "probable or reasonably likely" that the patient would have survived, even with diagnosis and treatment. *Id.* at 473. The trial court instructed the jury with the "short form" of IPI Civil No. 15.01 (2d ed. 1971), and declined to give the plaintiff's proposed non-pattern instruction based upon section 323(a) of the Restatement of Torts, which would have stated that "[o]ne who undertakes…to render services to another…is subject to liability for physical harm" if failure to exercise "reasonable care" "increases the risk of such harm." *Id.* at 474, 477.

Following a jury verdict for the defendant, the plaintiff sought a new trial for failure to give the proposed instruction, contending that the jury might have concluded that the plaintiff's chance of survival was less than 50% even absent negligence, and that the jury should have been instructed that it could allow the plaintiff to recover under those circumstances. *Id.* at 477. The *Curry* Court noted that courts have "struggled" with "lost chance" cases, but concluded that the proposed instruction properly was rejected. In so holding, the Court noted that section 323(a) of the Restatement is not specifically addressed to causation, but instead deals with the creation of a duty through the

defendant's voluntary assumption of duty, an issue not present in *Curry*. *Id.* at 477. The *Curry* Court also held that the proposed instruction misstates the law by suggesting that the plaintiff can recover for "any increase in the risk of harm, no matter how slight," a rule that the Court concluded would "completely eliminate the element of proximate cause." *Id.* at 477-78. The Court therefore affirmed the defense verdict. *Id.* at 482.

In *Russell v. Subbiah*, 149 Ill. App. 3d 268 (3rd Dist. 1986), the plaintiff claimed that the defendant physician failed to timely diagnose a spinal cord tumor, resulting in a delay in treatment, causing injury to the plaintiff's leg and a longer recovery period. Summary judgment was granted for the defendant after the plaintiff's expert testified at deposition that he could not say with a reasonable degree of medical certainty that delay in diagnosis caused a longer recovery or whether anything the defendant failed to do "directly" caused the problems, and where the plaintiff's expert later attested that the plaintiff would have had only a "50/50" chance of a briefer recovery with earlier diagnosis. *Id.* at 269-71. The Appellate Court affirmed summary judgment and held that the plaintiff failed to meet the *Borowski* standard, because "the probabilities are equal" that the defendant's conduct either had no effect, or proximately caused the injury. *Id.* at 272.

In *Hare v. Foster G. McGaw Hosp.*, 192 Ill. App. 3d 1031 (1st Dist. 1989), the decedent died from hepatic encephalopathy, a condition that the plaintiff's expert acknowledged cannot be prevented or treated, and that has only a 20% survival rate. *Id.* at 1033. The plaintiff's expert asserted that the defendant improperly failed to admit the decedent to the hospital for "general supportive care" such as rest and diet, to keep him in the best condition to fight the disease. *Id.* at 1035. The Appellate Court affirmed a

directed verdict for the defendant, holding that this testimony did not establish "more probable than not" causation as to the failure to hospitalize the decedent, under *Borowski*. *Id.* at 1035. While acknowledging the "loss of chance" cases, the Court concluded that permitting the plaintiff to recover on these proofs for only an increased risk of harm was inconsistent with *Borowski*. *Id.* at 1038.

In *Netto v. Goldenberg*, 266 Ill. App. 3d 174 (2nd Dist. 1994), the plaintiff claimed that the defendant failed to timely respond and treat a hemorrhage, resulting in the decedent's death. The plaintiff sought a new trial in part for the refusal to give a proposed non-standard instruction that, like the instruction in *Curry*, was based on Restatement of Torts section 323(a) and would have stated that a physician is liable for harm "resulting from" the failure to exercise reasonable care, if the failure was a "substantial factor in bringing about the resultant harm." *Id.* at 180. The *Netto* Court affirmed the refusal to give the instruction, concluding that the plaintiff was required to prove that physician negligence proximately caused injuries, not merely that physician negligence was a "substantial factor" in causing the injuries (although the Court granted a new trial on other grounds). *Id.* at 180-181.

c. Post-*Borowski* cases that would permit recovery based on proof of increased risk of harm or lessened effectiveness of treatment.

In other cases, however, the Appellate Court held that claims that a negligent delay in diagnosis or treatment increased the risk of harm or lessened the effectiveness of treatment could be permitted to go a jury. For example, in *Northern Trust Co v. Louis A. Weiss Mem'l Hosp.*, 143 Ill. App. 3d 479 (1st Dist. 1986), the Court affirmed a jury verdict for the plaintiff where the plaintiff's expert testified at trial that the hospital's negligent failure to provide a specially trained nurse resulted in delay in calling a

physician; that there was a "reasonable probability" that the delay was associated with an increase in the patient's morbidity; and that, had a physician been called, oxygen could have been given earlier. *Id.* at 488. The Court also held that there was "evidence in the record" that failure to give sufficient oxygen was a "substantial factor" in contributing to brain damage. *Id.* at 489. The Court concluded that the expert's testimony that delay "increased the likelihood of permanent damage" was sufficient to present the case to a jury. *Id.* at 487. Relying on section 323(a) of the Restatement of Torts, the *Northern Trust* Court adopted the rule that "[e]vidence which shows to a reasonable certainty that negligent delay in diagnosis or treatment * * * lessened the effectiveness of treatment is sufficient to establish proximate cause." *Id.* at 487-88.

In *Chambers v. Rush-Presbyterian-St. Luke's Medical Ctr.*, 155 Ill. App. 3d 458 (1st Dist. 1987), the defendant sought a j.n.o.v. on the ground that the plaintiff had failed to prove causation. The plaintiff claimed that the defendants failed to monitor and treat the decedent's high blood sugar, causing the decedent to incur brain injury and go into a coma from which the decedent recovered, but that delayed the diagnosis and treatment of an underlying cancer. The plaintiff's expert testified that the decedent's death four months later was partly due to the untreated cancer and partly due to brain injury from the coma, acknowledging that the overall survival rate for that type of cancer was 33%. *Id.* at 462. The defendant submitted that, because the plaintiff could not establish a greater than 50% chance of surviving the cancer, the plaintiff's theory was a "lost chance of survival" claim that was inconsistent with "traditional" proximate cause. *Id.* at 463. The Court concluded that, in contrast to cases such as *Curry* and *Russell*, the plaintiff here "never presented" a "lost chance of survival argument." *Id.* at 463. The Court purported

to apply the *Northern Trust* rule, holding that the plaintiff had offered sufficient proof of causation to go to a jury by demonstrating that the defendants' negligence caused the decedent to become comatose, which increased the risk of harm by causing his underlying cancer to go undiagnosed and untreated, such that the "negligently induced coma was a substantial factor in causing decedent's death." *Id.* at 465. The Court also held that the "long form" instruction, IPI No. 15.01, was appropriate, and affirmed the jury verdict for the plaintiff. *Id.* at 467.

In *Pumala v. Sipos,* 163 Ill. App. 3d 1093 (2nd Dist. 1987), the plaintiff alleged that the defendant's delay in referring her to orthopedic specialist resulted in delay in diagnosis of a tumor and partial amputation of her leg. The plaintiff's expert testified that it was "almost impossible" to say when amputation could have been avoided, but if an earlier diagnosis had been made, the tumor "might well have" been able to be removed without amputation. *Id.* at 1097. The plaintiff appealed the grant of a directed verdict for the defendant. Citing *Borowski* and *Northern Trust,* the *Pumala* Court held that a plaintiff can present evidence to show "with a reasonable degree of medical certainty that a negligent delay in diagnosis or treatment lessened the effectiveness of treatment in order to establish proximate cause in this case." *Id.* at 1098. The Court, however, affirmed the directed verdict for the defendant, concluding that neither the plaintiff's treating physician nor the plaintiff's expert had offered testimony to establish to a "reasonable degree of medical certainty" that amputation would not have occurred. *Id.* at 1099.

In *Galvin v. Olysav,* 212 Ill. App. 3d 399 (5th Dist. 1991), the plaintiff alleged that the defendant failed to timely diagnose and surgically repair a wrist injury, with the delay

resulting in the need to later surgically fuse the wrist. The plaintiff's expert testified that, to a "reasonable degree of medical certainty," earlier x-rays would have shown abnormalities that could have led to ligament reconstruction surgery, and there is an overall 40% chance of successful surgery to avoid the need for a fusion. *Id.* at 403-405. The trial court granted summary judgment in favor of defendant. The Appellate Court reversed, adopting the *Northern Trust* rule that "[e]vidence which shows to a reasonable certainty that negligent delay in diagnosis or treatment * * * lessened the effectiveness of treatment is sufficient to establish proximate cause," and holding that the expert's testimony here was sufficient to meet this standard. *Id.* at 403-406.

In *Hajian v. Holy Family Hosp.,* 273 Ill. App. 3d 932 (1st Dist. 1995), the plaintiff sought, in part, a new trial for failure to instruct the jury consistent with *Northern Trust*. The plaintiff alleged that defendants negligently failed to recognize and treat signs of an impending stroke. The trial court gave the pattern proximate cause instruction, IPI (Civil) No. 15.01, rather than the plaintiff's proposed non-IPI instruction, which would have modified the "long form" proximate cause instruction to state that (1) a cause is a "proximate cause" if it is a "substantial factor" in producing the injury; and (2) the negligence in that case was a "proximate cause" of the stroke if it "increased the risk of a completed stroke." *Id.* at 940-941.

Hajian sought to harmonize *Northern Trust* and *Borowski,* stating that the plaintiff must show a "reasonable degree of medical certainty that the negligent delay in diagnosis or treatment increased the risk of harm to the plaintiff and that the harm was actually sustained…" *Id.* at 939-940. The Court concluded that the "short form" proximate cause instruction, IPI Civil No. 15.01, was appropriately given, and that the

plaintiff's "lost chance" instruction properly was rejected for several reasons, including that it presented the defendant's claimed negligence as fact, and that it was based on the "long form" proximate cause instruction, which was itself inappropriate. *Id.* at 941. The *Hajian* Court stated that an instruction that "properly" sets forth the *Northern Trust* rule "might be appropriate," but no such instruction was offered here. *Id.* at 941.

d. This Court's clarification of the proximate cause standard in *Holton v. Mem'l Hosp.*, 176 Ill. 2d 95 (1997).

Thus, at the time this Court decided *Holton v. Mem'l Hosp.*, 176 Ill. 2d 95 (1997), some panels of the Appellate Court had held that a plaintiff in a medical malpractice action could be permitted to present to a jury evidence to establish that, to a "reasonable degree of medical certainty," a "negligent delay in diagnosis or treatment" "lessened the effectiveness of treatment" or "increased the risk of harm" that was actually sustained, and that such recovery is consistent with *Borowski*, *supra.* See *Northern Trust*, *supra; Hajian, supra.* Other panels, however, had concluded that permitting recovery for <u>any</u> "increased of risk of harm," no matter how slight, or permitting recovery in a case in which the plaintiff cannot establish a greater than 50% chance of a better result even without malpractice, is legally inconsistent with *Borowski* (either with or without ruling on the sufficiency of causation proofs in that particular case). See *Curry, supra* (rejecting an instruction permitting the plaintiff to recover for an "increased risk of harm" as inconsistent with *Borowski*); *Hare*, *supra* (affirmed directed verdict on ground that the plaintiff cannot recover merely by showing an increased risk of harm); *Netto*, *supra* (rejecting a proposed instruction permitting recovery for increased risk of harm).

This Court in *Holton* sought to clarify these divergent views of recovery for "increased risk of harm" or "lost chance." In *Holton*, the plaintiff claimed that the

defendants' delay in diagnosing and treating an infection resulted in the plaintiff's paraplegia. The plaintiff presented evidence that hospital nurses failed to timely and/or accurately report to physicians the plaintiff's gradual decline into paresis (muscular weakness or paralysis). *Id.* at 107-108. The plaintiff's treating physicians testified that their diagnosis was based on an inaccurate belief that the onset of paresis was sudden rather than gradual, and that there is a "good probability" of avoiding or minimizing paralysis if paresis is detected and treated "early enough" with decompression or drainage. *Id.* at 108. The trial court instructed the jury with the "long form" IPI (Civil) No. 15.01 (the same instruction given in the instant case), and the jury found in favor of the plaintiff. *Id.* at 110-111. The defendant sought a judgment n.o.v. on the basis that the plaintiff's proofs did not meet the "traditional" standard of proof of causation, but only could survive under a "relaxed" standard of proof. The Appellate Court affirmed the judgment.

This Court first reaffirmed that, under *Borowski*, the "traditional" statement of proximate cause requires only that the plaintiff prove that negligence "more probably than not" caused the injury, not that a "better result" could have been achieved. *Id.* at 106-107. The Court held that the plaintiff's proofs satisfied the "traditional" standard, because the plaintiff need not prove that an earlier call by a nurse to report gradual onset of paresis to physicians would have resulted in a better outcome (avoiding paralysis). Proof of delay in, or inaccurate reporting of, symptoms coupled with the physicians' testimony that different treatment would have been offered with a "good probability" of a different outcome, was held to be sufficient. *Id.* at 107-108. The *Holton* Court noted that the "traditional" proximate cause formulation applied in that medical malpractice case is

the "same standard" used in other negligence actions, and is stated accurately in IPI (Civil) 3d No. 15.01. The Court stated that, while it "may appear" more difficult for a jury to assess exactly what harm negligent treatment caused in the context of a preexisting illness or injury, juries "routinely" are asked to decide whether, and to what extent, negligent treatment proximately caused injury. *Id.* at 110.

Although the *Holton* Court concluded that the plaintiff's proofs satisfied the "traditional" *Borowski* causation standard and further discussion was unnecessary to the outcome, the Court went on to address the "ongoing dispute" over application of the "loss of chance doctrine" in medical malpractice actions. *Id.* at 111. The *Holton* Court held that "lost chance" or "loss of chance" "refers to the injury sustained by a plaintiff whose medical providers are alleged to have negligently deprived the plaintiff of a chance to survive or recover from a health problem, or where the malpractice has lessened the effectiveness of treatment or increased the risk of an unfavorable outcome to the plaintiff." *Id.* at 111. The Court explained that, in an attempt to apply the traditional *Borowski* "more probable than not" standard, some courts, such as in *Curry* and *Russell*, had held that a plaintiff cannot recover in a medical malpractice action where the plaintiff is unable to prove that the chance of survival or recovery from preexisting illness or injury, absent malpractice, is greater than 50%, while other courts, such as in *Chambers*, would permit the plaintiff to recover damages for medical malpractice even where the chance of recovery or survival absent malpractice is less than 50%. *Id.* at 112.

The *Holton* Court also identified two "opposing views" of the "loss of chance" doctrine in literature and case law: (1) the "relaxed causation" approach, which would "relax" the burden of causation but hold the defendant liable if there was a "substantial

possibility" of survival that the defendant "destroyed" a chance of survival or if the defendant's acts increased the risk of harm and the increased risk of harm was a "substantial factor" in producing the harm; or (2) the "separate injury" or "pure chance" approach, a separate cause of action that permits the plaintiff to recover damages proportionate to the "lost chance" of avoiding harm. *Id.* at 112 fn. 1. The Court noted that the Illinois cases had not analyzed "lost chance" under a "separate injury" analysis, and that the Court had not been asked to do so in the *Holton* case. *Id.* The *Holton* Court noted, instead, that most of the "controversy" in Illinois arose from differing views about whether loss of chance "doctrine" or "concept" "relaxes" traditional proximate cause, or instead can be harmonized with "traditional" proximate cause under *Borowski*. *Id.* at 112-114.

After examining several of the "lost chance" decisions discussed above, the *Holton* Court resolved the disagreement in favor of the analysis in *Northern Trust, Chambers, Pumala,* and *Hajian*. Quoting *Northern Trust*'s formulation--requiring evidence showing a "reasonable certainty that negligent delay in diagnosis or treatment * * * lessened the effectiveness of treatment," the *Holton* Court stated that the "reasonable certainty" language "conforms to traditional principles of proximate cause." *Id.* at 115. The Court further stated that *Northern Trust* and *Chambers* "reflect the correct application of traditional proximate cause principles when a defendant's negligent medical care is alleged to have denied the patient a chance of survival or recovery." *Id.* at 116.

The Court then examined the Appellate Court decisions in *Hare* and *Netto,* which the Court characterized as rejecting the *Northern Trust* analysis and holding that rejection

of a "loss of chance" concept impermissibly undermines or lessens the *Borowski* proximate cause standard. The *Holton* Court acknowledged that the "specific dispositions" in *Hare* and *Netto* "may have been justified," but overruled the "loss of chance" analysis in those cases, specifically rejecting the suggestion that "loss of chance" necessarily results in an impermissible, "relaxed" causation standard. *Id.* at 118-119. The *Holton* Court also explicitly rejected any rule that would disallow a plaintiff, as a matter of law, from recovering damages in a medical malpractice action where the plaintiff is unable to prove a greater than 50% chance of survival or recovery absent malpractice. *Id.* at 119.

The Court also examined *Pumala* and *Hajian,* noting that *Pumala* required a plaintiff to show "with a reasonable degree of medical certainty that the negligent delay in diagnosis or treatment lessened the effectiveness of the medical services rendered to the plaintiff," and that *Hajian* sought to harmonize *Northern Trust* and *Borowski* "as was attempted in *Pumala…*" *Id.* at 118. The *Holton* Court concluded the reasoning of *Pumala* and *Hajian* "reflects the correct understand of the loss of chance concept." *Id.* at 118. Finally, the Court held that "the loss of chance concept, when properly analyzed, does not relax or lower plaintiffs' burden of proving causation. Rather, the concept comports with the *Borowski* standard." *Id.* at 120.

Thus, *Holton* can be understood as setting forth several principles. First, *Holton* reaffirms *Borowski* and holds that the plaintiff must prove that the defendant's negligence more probably than not caused the injury, but need not prove that a "better result" would have been obtained. Second, *Holton* defines "loss of chance" cases as cases in which injury is "sustained by a plaintiff whose medical providers are alleged to have negligently

deprived the plaintiff of a chance to survive or recover from a health problem, or where the malpractice has lessened the effectiveness of treatment or increased the risk of an unfavorable outcome to the plaintiff." Third, *Holton* explicitly rejects any rule that would disallow recovery, as a matter of law, where the plaintiff is unable to establish a greater than 50% chance of survival or better result, absent malpractice. Fourth, in a "lost chance" case where the plaintiff's "chance of survival or recovery is lessened by the malpractice," *Holton* requires the plaintiff to prove that "the defendant's malpractice, to a reasonable degree of medical certainty, proximately caused the increased risk of harm or lost chance of recovery." *Id.* at 119. Fifth, this view of the "loss of chance concept" comports with *Borowski* and does not relax or lessen the burden of proof under *Borowski*.

Thus, *Holton* did not hold that "lost chance" is a distinct theory of causation, or that a "lost chance" instruction is appropriate or necessary. Instead, *Holton* holds, or suggests, just the opposite: that "lost chance" is not a distinct causation "theory" but a "concept" applied to rebut or remove a supposed legal bar to recovery where the plaintiff cannot prove, absent malpractice, a greater than 50% chance of survival or recovery; that "traditional" proximate cause does not require the plaintiff in a medical malpractice action to prove a greater than 50% chance of survival or recovery, absent malpractice; that "lost chance" is not distinct from "traditional" proximate cause; and that the pattern "proximate cause" instruction given in *Holton* accurately states the law in all medical malpractice actions.

2. Post-*Holton* Appellate Court decisions confirming that "lost chance" is not a separate theory of recovery, and rejecting requests for a "lost chance" jury instruction.

(a) Post-Holton decisions applying *Holton* analysis.

Following *Holton*, the Appellate Court applied *Holton* in examining the

sufficiency of proofs of proximate cause in medical malpractice cases. In some cases, the Court held that judgment as a matter of law for the defendant was proper where the plaintiff was unable to present evidence to establish, to a reasonable degree of medical certainty, that a negligent delay in diagnosis or treatment "lessened the effectiveness" of treatment or deprived the patient of a chance of recovery. See *Aguilera v. Mount Sinai Hosp. Med. Ctr. (On Remand),* 293 Ill. App. 3d 967 (1st Dist. 1997) (affirming j.n.o.v. for defendant, where the plaintiff could not establish that an earlier CT scan would have resulted in surgery, where the only surgeons who testified stated that surgery would not have been appropriate); *Townsend v. University of Chi. Hosps.*, 318 Ill. App. 3d 406 (1st Dist. 2000) (j.n.o.v. should have been granted in favor of defendant where the plaintiff could not establish that negligent delay in diagnosing a kidney stone or transferring the decedent to the intensive care unit "lessened the effectiveness" of treatment, where the plaintiff did not present any qualified expert to testify that the only possible treatment, surgery, actually would have been performed); *Reed v. Jackson Park Hosp. Found.*, 325 Ill. App. 3d 835 (1st Dist. 2001) (affirming summary judgment for the defendant where the plaintiff could not show that delay in treating the plaintiff's eye injury "lessened the effectiveness" of treatment, where the plaintiff's expert only could say that the plaintiff may have had a 20% chance of saving the eye); *Scardina v. Nam,* 333 Ill. App. 3d 260 (1st Dist. 2002) (affirming directed verdict for the defendant where the plaintiff failed to demonstrate with reasonable certainty that timely diagnosis of diverticulitis would have resulted in surgery being performed differently); *Krivanec v. Abramowitz,* 366 Ill. App. 3d 350 (1st Dist. 2006) (defendant was entitled to a directed verdict where the plaintiff failed to establish that defendant's negligence in failing to inform of the decedent of a test

result deprived the decedent of the chance for a better result, where the decedent was later treated by his own physician who had an opportunity to perform the necessary treatment, but did not do so).

In other cases, however, the Court held that the defendant was not entitled to judgment as a matter of law where the plaintiff's proofs sufficiently established proximate cause. See *Meck v. Paramedic Servs.*, 296 Ill. App. 3d 720 (1st Dist. 1998) (reversing summary judgment for the defendant; rejecting the defendant's sole argument that judgment was proper because the plaintiff could not establish a greater than 50% chance of survival absent malpractice); *Suttle v. Lake Forest Hosp.*, 315 Ill. App. 3d 96 (1st Dist. 2000) (reversing j.n.o.v. for the defendant where the plaintiff presented evidence that delay in diagnosis lessened the effectiveness of treatment); *Perkey v. Portes-Jarol,* 2013 Il App (2d) 120470 (affirming in part judgment for plaintiff and denial of directed verdict, where the plaintiff's expert testified that the plaintiff would have had a 12% or 36% chance of recovery with earlier diagnosis of cancer, instead of a 6% chance of recovery); *Hemminger v. LeMay,* 2014 Il App (3d) 120392 (reversing directed verdict for defendant where the plaintiff presented expert testimony that delay in cancer diagnosis caused chance of survival to be reduced by 26% to 58%); *Vanderhoof v. Berk,* 2015 Il App (1st) 132927 (affirming denial of judgment n.o.v. for the defendant where the plaintiff presented expert testimony that the failure to use proper surgical technique resulted in an increased risk of cutting the common bile duct).

The Appellate Court also restated the *Holton* holding that "lost chance" is not a separate theory of recovery, but rather a "concept that enters into the proximate cause analysis in medical malpractice cases where a plaintiff alleges a defendant's 'negligent

delay in diagnosis or treatment * * * lessened the effectiveness of treatment." *Aguilera,* 293 Ill. App. 3d at 973; *Townsend,* 318 Ill. App. 3d at 410.

(b) Cases rejecting proposed non-pattern "lost chance" jury instruction.

Consistent with the holding in *Holton* that "lost chance" is not a separate theory of recovery, the IPI committee never has adopted a pattern "lost chance" jury instruction. The Appellate Court also repeatedly has rejected arguments for a separate, non-pattern "lost chance" jury instruction.

None of the "lost chance" cases prior to *Holton* supported the use of a non-pattern "lost chance" instruction. The Appellate Court rejected proposed non-pattern "lost chance" jury instructions, regardless of whether a particular panel would or would not have permitted recovery for "lost chance," and found that IPI Civil (2011) No. 15.01 was appropriate. The Court in *Curry v. Summer,* 136 Ill. App. 3d 468 (4th Dist. 1985), rejected a proposed "lost chance" instruction based on Restatement section 323, noting that section 323 of the Restatement primarily is addressed to the creation of a duty through voluntary undertaking, not proximate cause, and stating that the Restatement language stating that a defendant may be liable for physical harm "resulting from" negligence if negligence "increases the risk of harm" would permit "a full recovery for the decedent's death by a showing any increase in harm, no matter how slight." *Id.* at 477-78. The Court in *Netto v. Goldenberg,* 266 Ill. App. 3d 174 (2nd Dist. 1994), rejected a different proposed instruction that stated that a defendant could be liable for harm "resulting from" negligence if the negligence was a "substantial actor in bringing about the resultant harm." *Id.* at 180. The *Netto* Court concluded that the "substantial factor" language was inconsistent with the *Borowski* standard of proximate cause.

Even in *Hajian v. Holy Family Hosp.*, 273 Ill. App. 3d 932 (1st Dist. 1995), where the Court recognized a "lost chance" theory, the Court rejected a proposed non-pattern "lost chance" instruction that would have supplemented the "long form" proximate cause instruction to state that proximate cause could be found if "[t]he defendant's negligence increased the risk of a completed stroke to a person in the plaintiff's position." *Id.* at 940-41. The Court concluded that, while some instruction that properly sets out the *Northern Trust* rule might be appropriate, the proposed instruction properly was rejected because it assumed the defendant's negligence and was based on the "long form" instruction No. 15.01, while the "short form" should have been given. *Id.* at 941.

In *Holton,* the trial court gave the "long form" of IPI Civil No. 15.01. *Holton* did not address whether a non-pattern instruction should have been given instead of, or in addition to, No 15.01, but only whether judgment as a matter of law should have been granted. In addressing that issue, the Court confirmed that the *Borowski* standard continues to apply; that the "lost chance concept" is consistent with *Borowski*; and that the "long form" instruction No. 15.01 correctly describes application of *Borowski* in cases like that one, involving negligent medical treatment for a preexisting illness or injury. *Id.* at 110-111. The *Holton* Court also discussed IPI Civil (2011) No. 15.01 in the context of the defendant's challenge to omission of another causation instruction, and affirmed its use and the omission of the other instruction on those facts. *Id.* at 132-34

After *Holton,* the first Appellate Court decision to address, and reject, a proposed non-pattern "lost chance" instruction was *Henry v. McKechnie,* 298 Ill. App. 3d 268 (4th Dist. 1998). The plaintiff alleged failure to timely diagnose and treat infection, resulting in partial amputation of his leg, and proposed a non-pattern instruction based on

Restatement of Torts section 323 which would have stated that a person who undertakes to render services is liable for harm resulting from failure to exercise reasonable care if that failure increased the risk of harm, as well as other modified instructions referring to "any increased risk of harm or lost chance of recovery." The plaintiff sought a new trial for the refusal to give the instructions, arguing that a specific "lost chance" jury instruction is necessary under *Holton,* and that *Holton*'s rejection of the Appellate Court decision in *Curry* meant that *Holton* approved an instruction like that rejected in *Curry.*

The *Henry* Court noted that *Holton* discussed objections to instructions "without discussing any modifications to IPI instructions to refer to the lost chance doctrine." *Id.* at 274. The *Henry* Court also concluded that, while *Holton* explicitly rejected the *Curry* approach to cases involving less than a 50% chance of survival or recovery, *Holton* "did not express disapproval of that portion of the *Curry* analysis that rejected the instruction tendered in that case…" *Id.* at 275. The *Henry* Court also noted that the out-of-state cases relied upon by the plaintiff did not support the proposed instruction because they either did not offer specific language, or involved an instruction that would limit a defendant's liability to the value of the "lost chance," which the plaintiff's proposed instruction here did not do. *Id.* at 276. The *Henry* Court therefore affirmed the use of the "long form" causation instruction given in that case, IPI Civil 3d No. 15.01.

In *Lambie v. Schneider,* 305 Ill. App. 3d 421 (4th Dist. 1999), the plaintiff alleged that the defendant's improper performance of a surgery lessened the plaintiff's chance for a better result. The plaintiff sought a new trial for refusal to give a non-pattern "lost chance" instruction similar to that proposed in *Henry,* based on section 323 of the Restatement, which would have stated that a physician is subject to liability for harm

"resulting from" failure to exercise reasonable care, if failure to exercise such care "increases the risk of harm to the patient." *Id.* at 427. Like *Henry,* the *Lambie* Court examined *Curry,* noting that *Curry* had rejected a similar instruction in part because the Court concluded that the "resulting from" language could mislead the jury into concluding that the defendant is liable whenever he increases the risk of harm to a patient. *Id.* at 428. The *Lambie* Court noted that "lost chance," as explained by *Holton*, does not relax or lower the burden of proving causation. *Id.* at 428. The Court stated that, even if "lost chance" doctrine is accepted, the Restatement language is "still misleading" because the "resulting from" language suggests that the defendant may be liable for any increased risk, even if not foreseeable, and because the language "subject to liability" is not defined and suggests a jury could find the defendant liable without finding that the defendant's conduct was the legal cause of the injury. *Id.* at 429. The *Lambie* Court, relying on both *Hajian* and *Curry,* also concluded that the "long form" of IPI No. 15.01 given in *Lambie* was an appropriate causation instruction. *Id.* at 429. The Court therefore affirmed the verdict in favor of the defendants.

Prior to the decision in this case, the First District also repeatedly rejected the claimed need for a "lost chance" instruction, beginning with *Sinclair v. Berlin*, 325 Ill. App. 3d 458 (1st Dist. 2001). In *Sinclair,* the plaintiff sought a non-pattern jury instruction that would have stated that "[p]roximate causation may be established by proving or showing that Defendant's conduct increased the risk of harm to the Plaintiff, or lessened the effectiveness of the Plaintiff's treatment." *Id.* at 466. The trial court refused the instruction, and instead gave the "long form" of IPI Civil 3d No. 15.01. *Id.*

The *Sinclair* Court concluded that the non-pattern instruction was unnecessary.

Relying on *Lambie,* the Court concluded that the long-form proximate cause instruction "accurately states the law in lost chance medical malpractice cases." *Id.* at 466. The Court held that, although the proposed "lost chance" instruction was an accurate statement of the law, the trial court was required to give an IPI instruction where applicable and where it adequately informs the jury of the law. *Id.* at 466-67. The Court noted that, under *Holton,* "lost chance is not a separate theory of recovery but rather is a concept that enters into proximate cause analysis…" *Id.* at 466, that the long-form IPI instruction adequately informed the jury, and that the "lost chance doctrine, as a form of proximate cause, was encompassed within the instruction given to the jury." *Id.* at 467.

In *Cetera v. DiFilippo,* 404 Ill. App. 3d 20 (1st Dist. 2010), the First District followed *Sinclair, Lambie,* and *Henry,* affirming the refusal to give a proposed non-pattern instruction that was described as "similar" to those in the prior cases, stating that it saw "no reason to depart from our previous determinations" that IPI Civil 3d No. 15.01 properly states the law in lost chance medical malpractice cases. *Id.* at 45. See also *Vanderhoof v. Berk,* 2015 IL App (1st) 132927, ¶ 97 (in denying a new trial to defendants, reaffirming that lost chance doctrine "is not a separate theory of recovery" but "is encompassed by a standard proximate cause analysis," such that IPI Civil 3d. No. 15.01 "accurately states the law in lost chance medical malpractice cases").

Thus, the decision below was the only Appellate Court decision to hold that a non-pattern "lost chance" instruction was appropriate or required, and is a sudden and sharp departure from this line of precedent. Even after the decision in this case was issued, the Appellate Court in *Gretencord-Szobar v. Kokoszka,* 2021 Il App (3d) 200015 returned to the prior line of cases. The trial court in that case gave the "long form" IPI

Civil 3d No. 15.01, and refused a proposed non-pattern "lost chance" instruction that would have stated that a jury could find delay in treatment to be a proximate cause if it "deprived [plaintiff] of a chance at better recovery or deprived him of a chance of a better outcome…" ¶ 46-47. Citing the line of cases above, the Court held that "[w]e see no reason to deviate from these holdings." ¶ 47. The Court also addressed the decision in this case, declining to say whether it was wrongly decided, but distinguishing it on the basis that the instant case supposedly involves a claim that delay lessened the effectiveness of antibiotic treatment, while *Gretencord* involved a claim of negligent failure to perform surgery. ¶ 49.

3. The characterization of the "lost chance" concept in the decision below as a separate "theory" requiring a separate "lost chance" instruction is incorrect and inconsistent with *Holton*.

In suddenly departing from the line of cases above, the Appellate Court in this case held for the first time that a non-pattern "lost chance" instruction is required, and that IPI (Civil) 3d. No. 15.01 does not adequately instruct the jury in a "lost chance medical malpractice case." This was based on the Court's view that "lost chance" is a distinct causation "theory" that requires a separate instruction so the jury can understand the "theory." This view, however, is contrary to the explanation of the "lost chance" "concept" in *Holton*, which states that "lost chance" is encompassed in "traditional" proximate cause, as reflected in IPI (Civil) No. 15.01.

The Appellate Court in this case held that the plaintiff was denied a fair trial when the court gave only IPI Civil (2011) No. 15.01 and declined to give plaintiff's proposed non-pattern instruction regarding whether a "negligent delay in the diagnosis and treatment of sepsis in Jill Milton-Hampton lessened the effectiveness of the medical services which she received." The Appellate Court concluded that the instruction was

appropriate and should have been given because the plaintiff submitted "sufficient evidence" to support the loss of chance theory. ¶ 11. In holding that the "long form" IPI Civil (2011) No. 15.01 was insufficient and a non-pattern "lost chance" instruction was required, the Court explicitly disagreed with prior decisions, *Cetera, Sinclair, Lambie,* and *Henry*. ¶ 113. The Court concluded that following *Cetera* and the other cases would mean that "a plaintiff may never be able to submit an instruction explaining a loss of chance theory to the jury," and jury would be "forced to understand a plaintiff's loss of chance theory argued at trial without an instruction to guide them on the law and how it should be applied to the general proximate causation concept described in IPI Civil (2011) No. 15.01." ¶ 114. The Court stated that, although the other courts held that "the loss of chance theory is encompassed in" the long form of IPI Civil (2011) No. 15.01, that instruction does not "distinctly" inform the jury of loss of chance. ¶ 115. Thus, the Court's conclusion that a non-pattern instruction is necessary is based on its view of "lost chance" as a separate "theory" not encompassed within "traditional" proximate cause.

This conclusion, however, is inconsistent with the explanation of "lost chance" in *Holton* and the understanding of *Holton* set forth by the Appellate Court in all other decisions. The Court in *Holton* concluded that "lost chance" is not a separate theory of recovery and does not "relax" or alter the "traditional" standard of proximate cause, which is appropriately stated in IPI (Civil) No. 15.01. Instead, the Court held that, under "traditional" proximate cause, the plaintiff is not required to show that he or she had a greater than 50% chance of survival or recovery without malpractice, or that the plaintiff probably would have achieved a "better result." The plaintiff is required to show, to a reasonable degree of medical certainty (the same standard applicable to all medical

malpractice actions), that the negligence lessened the effectiveness of treatment, or deprived the plaintiff of a chance of survival or recovery.

The *Holton* Court's focus was on rejecting any understanding of *Borowski* that would preclude a plaintiff from satisfying *Borowski* where the plaintiff cannot establish that he or she had a greater than 50% chance of survival or a better outcome, absent malpractice. The focus was on whether the plaintiff's proofs failed such that the defendant was entitled to judgment as a matter of law, and on clarifying that traditional proximate cause does not require a greater than 50% chance of survival or recovery absent malpractice, or proof of a "better result." As the Appellate Court repeatedly recognized in all other decisions, *Holton* Court did not view this clarification as adoption of a new or separate theory of recovery. In fact, *Holton* declined to adopt either of the alternative views of a separate "lost chance" theory in other jurisdictions (the "relaxed causation" view, or the "proportional"/ "pure chance" approach).

The *Holton* also did not suggest any new instruction would be needed on "lost chance." In fact, it affirmed use of IPI (Civil) No. 15.01 in that case without any discussion of any need for modification or additional causation instructions, and confirmed that that instruction appropriately describes the proximate cause principles.

Thus, under *Holton*, "lost chance" is not a separate theory of recovery at all, but is consistent with the traditional proximate cause instruction. As held by the Appellate Court in all other cases, under *Holton*--which simply removes any claimed legal bar to recovery for less than a 50% chance of survival or a better result--there is no need to instruct the jury on a separate theory that does not exist. In holding that "lost chance" is a separate theory requiring its own instruction, the Appellate Court erred.

B. Alternatively, If This Court Concludes That "Lost Chance" Is A Separate Theory Of Recovery Requiring Its Own Jury Instruction, This Court Should Recommend Instructions Similar To Those Adopted For "Increased Risk Of Future Injury," As Discussed In *Dillon v. Evanston Hosp.*, 199 Il. 2d 483 (2002).

Alternatively, if this Court disagrees with the view of "lost chance" in *Hilton* and concludes that it is a distinct causation "theory" that requires a separate jury instruction, this Court should recommend instructions similar to IPI (Civil) Nos. 30.04.03 and 30.04.04, adopted as a result of the decision in *Dillon v. Evanston Hosp.*, 199 Il. 2d 483 (2002), and reflecting a "proportional" or "pure chance" theory of recovery.

In *Dillon*, the plaintiff claimed that the defendant negligently left behind a fragment of a chest catheter, which migrated to her heart. Several physicians recommended against removing the catheter, and the plaintiff chose not to do so. Leaving the catheter in the heart presented risks of future infection and other risks, none of which had occurred by the time of trial. The experts testified that most of these risks were less than 5%, with the risk of infection possibly up to 20%.

The trial court instructed the jury that it could award damages for the "increased risk of future injuries." The *Dillon* Court noted a "trend" in other jurisdictions toward "allowing compensation for increased risk of future injury" so long as it can be shown "to a reasonable degree of certainty" that the defendant's wrongdoing increased the risk. *Id.* at 500. In recognizing damages for the increased risk of future injury, the *Dillon* Court quoted from *Hilton, supra* and its discussion permitting recovery for increased risk of harm even where the chance of survival or a better outcome is less than 50%. The *Dillon* Court noted that "[t]he theories of lost chance of recovery and increased risk of future injury have similar theoretical underpinnings." *Id.* at 503.

The *Dillon* Court, however, limited recovery of damages to the amount of the

increased risk. The Court concluded that it is the plaintiff's burden to prove that the defendant's negligence increased the plaintiff's risk of future injuries, and that the plaintiff "can obtain compensation for a future injury that is not reasonably certain to occur, but the compensation would reflect the low probability of occurrence." *Id.* at 504. While holding that the jury should be permitted to award damages for increased risk of future injuries even for a low probability of occurrence, the *Dillon* Court concluded that the non-pattern jury instruction in that case failed to inform the jury that the evidence of increased risk must be based on evidence and not speculation, and that "the size of the award must reflect the probability of occurrence." *Id.* at 506. The Court quoted with approval a Connecticut jury instruction that states, in relevant part, that the plaintiff is entitled to compensation "to the extent that future harm is likely to occur as measured by multiplying the total compensation to which the plaintiff would be entitled if the harm in question were certain to occur by the proven probability that the harm in question will in fact occur." *Id.* at 506.

Following *Dillon*, the IPI committee adopted two new pattern jury instructions. IPI (Civil) No. 30.04.03, when inserted into IPI (Civil) No. 30.01, states that the jury should reasonably and fairly compensate the plaintiff for any damages resulting from the negligence, including "[t]he increased risk of future [specific condition] [harm] resulting from the [injury] [injuries] [condition] [conditions]." IPI (Civil) No. 30.04.04 must be given with IPI (Civil) No. 30.04.03, and states that "[t]o compute damages for increased risk of future [specific condition] [harm] only, you must multiply the total compensation to which the plaintiff would be entitled if [specific condition] were certain to occur by the proven probability that [specific condition] will in fact occur." The Note on Use states

that the instructions must be given together, but that neither instruction should be used unless the plaintiff is claiming damages that are less than 50% certain to occur. The instructions, as sanctioned by *Dillon,* adopt a partial "proportional" theory of recovery for the increased risk of future injury where the risk is less than 50%, while permitting full recovery where the increased risk is greater than 50%.

If this Court disagrees with *Holton's* view and concludes that "lost chance" is a separate theory of recovery warranting a separate jury instruction, a similar, partial "proportional recovery" should be adopted here. *Holton* did not adopt a "proportional" theory, but noted this was because it was not asked to do so. *Id.* at 112 fn. 1. *Dillon,* which adopted the proportional theory for the analogous "increased risk of future injury," recognized that "[t]he theories of lost chance of recovery and increased risk of future injury have similar theoretical underpinnings." *Id.* at 503. Both concepts are based on the idea that a plaintiff should not be barred from recovering damages for increased risk of harm, either past harm that actually occurred or future harm yet to occur, even where the plaintiff cannot establish that the risk of harm occurring is greater than 50%. To maintain consistency with *Dillon,* if recovery for a less-than-probable risk of increased future harm warrants a "proportional recovery" instruction only where the risk is less than 50%, then similar instructions should be adopted for "lost chance."

A "proportional" theory of recovery for "lost chance," not only is consistent with *Dillon,* but also is consistent with the view of many jurisdictions that have permitted "lost chance" recovery. *Roberts v. Ohio Permanente Med. Grp.,* 668 N.E.2d 480 (Oh. 1996); *Delaney v. Cade,* 255 Kan. 199 (Kan. 1994); *Dickhoff v. Green,* 836 N.W.2d 321 (Minn. 2013); *Scafidi v. Seiler,* 574 A.2d 398 (N.J. 1990). In the event that the Court concludes

that a "lost chance" instruction is necessary, a proportional instruction would be appropriate and consistent with *Dillon* and with the view in other jurisdictions.

C. Even If "Lost Chance" Is A Distinct Causation Theory That Could Support A "Lost Chance" Instruction, The Appellate Court Erred In Holding That The Instruction Was Proper In A Case Like This One.

Even if "lost chance" is a distinct causation theory that could support or require a non-pattern "lost chance" causation instruction, no "lost chance" instruction is appropriate in this case. *Holton*'s focus was on removing a legal bar to recovery in cases where the plaintiff cannot prove that, absent malpractice, there was a greater than 50% chance of survival or recovery. *Holton, supra* at 111-112. Typically, a plaintiff asserts that negligence lessened the effectiveness of treatment or decreased the chance of survival or a better result where the experts are unable to state that, absent a delay in diagnosis or treatment, the plaintiff probably would have survived or achieved a better outcome. See *Aguilera, supra.*

That is not the case here. While plaintiff's expert Dr. Noto was only able to say that delay in antibiotics increased the risk of death, two of plaintiff's experts, Dr. Jacob and Dr. Hudson, explicitly testified that if plaintiff had been diagnosed with a bacterial infection and given antibiotics earlier, she more probably than not would have survived. The Appellate Court recognized this. *Bailey, supra,* ¶¶ 43, 45, 111. Plaintiff did not argue that delay "lessened the effectiveness" of antibiotics during closing argument, but instead focused on the dispute over viral versus bacterial infection. Defendants likewise did not present testimony that it was "too late" for antibiotics to be effective, but submitted expert testimony that plaintiff had a viral, not bacterial, infection that could not be treated by antibiotics, and for which there was no treatment at all.

Thus, the jury was not presented with a disputed issue of whether delay "lessened

the effectiveness" of antibiotic treatment. Two of plaintiff's experts testified that if antibiotics had been given, decedent probably would have survived. Defendants' experts testified that antibiotics would not have worked at all because the decedent had a viral infection for which there no treatment. Therefore, the causation issue was controlled entirely by the jury's conclusion of the disputed issue of viral versus bacterial infection.

D. Alternatively, Even If A "Lost Chance" Instruction Could Have Been Appropriate Or Necessary, Failure To Give Such An Instruction Is Harmless Error And Does Not Warrant A New Trial In This Case.

Even where there is instructional error, a new trial is not required if there was no reasonable basis for a conclusion that the error might have resulted in a different verdict. *National Enameling & Stamping Co. v. McCorkle,* 219 Ill. 557 (1906). A "lost chance" only could have affected the finding on proximate cause. The jury here returned a general verdict for the defendants. Breach of the standard of practice was disputed. Defendants presented expert testimony to establish that the ER physicians were not required to perform a "sepsis workup" or diagnose and treat a bacterial infection. Given the general verdict, there is no way to establish that the jury found breach and proceeded to decide causation. See *Goldschmidt v. Chicago Transit Auth.,* 335 Ill. App. 461 (1st Dist. 1948) (no new trial where plaintiff cannot establish that error relating to only one claim affected the general defense verdict). Even assuming the jury decided causation, there is no reasonable basis to conclude that an instruction on "lessened effectiveness of treatment" affected the verdict, where the only disputed issue was whether the decedent had a viral infection (no treatment) or a bacterial infection (antibiotics "probably" would have resulted in survival).

II THE APPELLATE COURT ALSO ERRED IN HOLDING THAT A NEW TRIAL WAS REQUIRED DUE TO FAILURE TO GIVE A SEPARATE, MODIFIED "INFORMED CONSENT" INSTRUCTION.

The Appellate Court's holding that a new trial is warranted because a separate, modified "informed consent" instruction, based on IPI Civil No. 105.07.02, should have been given, also was error.

A. The "Informed Consent" Theory And Accompanying Jury Instruction Is Limited To Cases In Which A Patient Gives Consent To A Treatment Or Procedure Without Being Appropriately Informed Of Relevant Risks Or Alternatives, And Where The Patient Would Not Have Undergone That Procedure If Fully Informed.

"Informed consent" is a unique theory recognized in this limited scenario: (1) a patient gives consent to a procedure or treatment; (2) the patient claims the consent was not "informed" because the physician failed to appropriately advise the patient of the risks of, or alternatives to, the treatment or procedure; (3) the patient claims that, if fully informed, he or she would not have given consent to, and undergone, the treatment or procedure; and (4) the patient was injured by the consented-to treatment or procedure. See *Coryell v. Smith,* 274 Ill. App. 3d 543 (1st Dist. 1995) (the plaintiff must prove, in part, that as a direct and proximate result of failure to disclose risks, that the patient "consented to treatment she otherwise would not have consented to" and "plaintiff was injured by the proposed treatment"); *Welton v. Ambrose,* 351 Ill. App. 3d 627, 636 (4th Dist. 2004) (same). The "essential elements" typically are framed as follows: (1) the physician had a duty to disclose material risks; (2) the physician failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and (4) plaintiff was injured by the proposed treatment. *Davis v. Kraff,* 405 Ill. App. 3d 20 (1st Dist. 2010). The theory often arises in the context of consent to an "unnecessary" or "contraindicated" surgery. *Coryell, supra* (stomach surgery resulting in scarring); *Davis, supra* (LASIK surgery resulting in nighttime vision problems).

These "essential elements" also are reflected in IPI (Civil) No. 105.07.02, which informs the jury that (1) the plaintiff claims that the defendant failed to inform the plaintiff of the "risks of" and/or "alternatives to" "[the procedure performed]"; (2) that, if the defendant had disclosed those risks, a reasonable person "would not have submitted to" "[the procedure performed]"; and (3) that failure to disclose those risks or alternatives was a proximate cause of the injury. Plaintiff did not present evidence of these elements and the proofs did not support an "informed consent" instruction.

B. The Appellate Court Erred In Holding That A Modified "Informed Consent" Instruction Should Have Been Given Here, Where Plaintiff Did Not Present A True "Informed Consent" Claim.

The Appellate Court erred in holding that the trial court was required to give a modified, non-pattern "informed consent" instruction based on IPI Civil (2011) No. 105.07.02, where plaintiff never presented evidence of a true "informed consent" theory to the jury. There is no claim that the patient was asked to, or did, consent to a treatment or procedure; or that risks of or alternatives to that treatment or procedure were not disclosed; or that the patient was injured by treatment to which she consented without being fully informed. Instead, plaintiff's theory is that the defendants improperly failed to diagnose decedent's condition and failed to offer her any treatment. Plaintiff contended that, if Dr. Jones had informed decedent that she might have one of several possible medical conditions that he did not diagnose (some of which admittedly never would have been diagnosed), the decedent would not have left the hospital without treatment, and might have had her condition diagnosed and treated earlier.

Neither plaintiff nor the Appellate Court cited authority for expanding the "informed consent" theory to apply on such facts, where there was no "consent" given to treatment or a procedure. Instead of a claim that a physician improperly obtained consent

to treatment without fully disclosing risks and alternatives, plaintiff's claim here is that no treatment was actually offered. Plaintiff's claim that tests were not done is a "garden variety" medical malpractice claim of delay in diagnosing her condition and failing to offer timely treatment, not a true "informed consent" claim where the patient's consent to a treatment is claimed to be "defective," such that the patient would not consented to treatment, or would have chosen a different treatment, if fully informed.

The fact that this is not a true "informed consent" claim also is evident in the substantial modification to state that patient should have been informed of "risks" presented by potential underlying medical conditions (instead of the risks of or alternatives to a proposed treatment or procedure); and that, if the risks had been disclosed, decedent "would not have left the hospital" (instead of that she would not have "submitted to" the proposed treatment). The Court's mandate of this instruction represents a fundamental misunderstanding of the "informed consent" theory and confusion with a "garden variety" claim of simple failure to diagnose and treat.

C. Even If Plaintiff Had Alleged And Presented A True "Informed Consent" Theory That Could Support An "Informed Consent" Instruction, No New Trial Was Required Because The Error Was Harmless.

Even if plaintiff had presented at trial an "informed consent" theory that could support a modified "informed consent" instruction, a new trial was not required here. Instructional error warrants a new trial only if the erroneous instruction clearly misled the jury and resulted in prejudice to the appellant. *Sinclair*, 325 Ill. App. 3d at 464. The grant of a new trial requires a reasonable basis for a conclusion that, absent the error, the verdict might have been different. *Lambie,* 305 Ill. App. 3d at 429-430. The test in determining the propriety of instructions is whether the jury was fully, fairly, and

comprehensively informed as to relevant principles, considering the instructions in their entirety. *Leonardi v. Loyola Univ.,* 168 Ill. 2d. 83 (1995).

Here, the instructions as a whole adequately informed the jury on this theory. The proposed modified instruction stated that "[t]he plaintiff claims that the defendant, Brett Jones, M.D., failed to inform Jill Milton-Hampton of the risks associated with pulmonary embolism, gastrointestinal bleed, infection and sepsis prior to being discharged the morning of March 17, 2012, which a reasonably careful emergency medicine physician would have disclosed under the same or similar circumstances." Though the court declined this instruction, the jury was instructed that the standard of care is what a "reasonably careful emergency medicine would or would not do" and that plaintiff claimed that Dr. Jones was negligent because he "failed to inform Jill Milton-Hampton of the risks of leaving the hospital" (the latter language having been agreed to by plaintiff's counsel after the parties were instructed to "work out" the language).

Plaintiff's proposed modified instruction further stated that "[the plaintiff further claims that if the defendant had disclosed those risks, a reasonable person in Jill Milton-Hampton's position would not have left the hospital the morning of March 17, 2012." The jury was given an instruction that the claimed negligence, including failure to disclose risks, was claimed to be a proximate cause of the injury. Thus, while the instructions did not single out the supposed "informed consent" theory, the instructions as a whole adequately informed the jury of all aspects of plaintiff's theory.

Second, even if the instructions as a whole did not adequately inform on the "informed consent" theory, any error was harmless because, even if the instruction had been given, the jury could not have found in favor of plaintiff as to this theory, where

plaintiff could not establish proximate cause. Plaintiff's "informed consent" theory was that, if the decedent had been fully informed, she would not have left the hospital before returning later for a second ER visit; and, if she had stayed, the ER physicians would have performed a "sepsis workup" and diagnosed and treated a bacterial infection. Thus, this was a claim that Dr. Jones caused a delay in performing a "sepsis workup."

The jury, however, also rejected a separate claim that both Dr. Jones and Dr. Arwindekar, who treated decedent during the subsequent ER visit, were negligent in failing to perform a "sepsis workup," and therefore necessarily accepted the defendants' experts' testimony as to one or both: (1) that no "sepsis workup" ever was required, or (2) that failure to perform a "sepsis workup" did not proximately cause the death because the infection was viral, not bacterial, and could not have been treated with antibiotics.

Because the "informed consent" theory was that Dr. Jones delayed a "sepsis workup" by not convincing the decedent to stay in the hospital, it was dependent on findings that a "sepsis workup" was required and would have resulted in a diagnosis of bacterial infection and treatment with antibiotics that could have increased the chance of survival. By rejecting the separate "sepsis workup" theory, the jury necessarily rejected either one or both of these necessary findings. Therefore, the jury never could have found that Dr. Jones's failure to convince decedent to stay in the hospital proximately caused the decedent's death, and any failure to instruct on this theory was harmless error.

III ALTERNATIVELY, EVEN IF FAILURE TO GIVE EITHER OR BOTH OF THE INSTUCTIONS WAS ERROR WARRANTING A NEW TRIAL, A NEW TRIAL SHOULD BE LIMITED TO THE "INFORMED CONSENT" THEORY ONLY AND/OR SHOULD INCLUDE ALL OF THE APPROPRIATE DEFENDANTS.

Alternatively, even if one or both instructions should have been given and a new trial is warranted, the remand order should be clarified. First, a new trial should be

limited only to the "informed consent" theory, the only theory as to which the Court found instructional error as to both breach and causation. No other theory can be shown to have been affected by instructional error. Second, regardless of whether trial is limited to an "informed consent" theory, the Court incorrectly identified the parties subject to a new trial. If the trial is limited to an "informed consent" theory, that theory applied to three defendants: Dr. Jones, EMP, and Mercy. The other three ER physicians were not involved in the "informed consent" claim. As to Mercy, there was a disputed claim over whether Mercy was vicariously liable for the conduct of all ER physicians, including Dr. Jones. Therefore, the "informed consent" theory would be tried against Dr. Jones, EMP, and Mercy (claimed to be vicariously liable for Dr. Jones). If the trial involves all theories of breach, the defendants in a new trial should be all four ER physicians, EMP, and Mercy (Mercy was claimed to be vicariously liable for all ER physicians).

CONCLUSION

WHEREFORE, Defendants-Appellants respectfully request that this Court reverse the September 30, 2020 Appellate Court judgment and reinstate the judgment entered in favor of all defendants. Alternatively, if this Court concludes that a new trial is warranted, defendants-appellants request that this Court clarify the theories, instructions, and parties to be included in a new trial as set forth in this brief.

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CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rules 341(a) and (b). The length of this merit brief, excluding the pages or words contained in the Rule 341(d) cover, the Rule 341(h)(1) table of contents and statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is 50 pages.

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NOTICE OF FILING AND PROOF OF SERVICE

You are hereby notified that on April 29, 2021, I submitted for filing a copy of the Supreme Court Merit Brief by Defendants-Appellants pursuant to Supreme Court Rule 315 to the Office of the Clerk of the Supreme Court of Illinois, 200 East Capitol Avenue, Springfield, IL 62701 via E-File electronically on the Clerk's office via Odyssey and (upon approval of the court, file-stamped copies mailed to the office of the Clerk of the Supreme Court via U.S. mail) and a copy to each of the opposing counsel named in the service list below by e-mail as well as depositing the same in the U.S. mail, proper postage pre-paid at 5:00 p.m. on April 29, 2021.

[X] Under penalties as provided by law pursuant To 735 ILCS 5/1-109 the undersigned Certifies that the statements set forth Herein are true and correct.

/s/Chad Wilkinson
Chad Wilkinson

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APPENDIX

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Carolyn Taft Grosboll
SUPREME COURT CLERK

Appendix Table of Contents

Order (Rev. 02/24/05) CCG N002

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

Jill M. Bailey, as Independent Representative of the Estate of Jill M. Milton Hampton

v.

Mercy Hospital, Dr. Scott Heinrich, Dr. Brett Jones, Dr. Amit Arwindekar, Dr. Helene Connolly, Emergency Medicine Physicians of Chicago

No. 13 L 008501

ORDER

This cause coming to be heard for trial, all parties present,

IT IS HEREBY ORDERED:

Judgment is hereby entered on the jury's verdict in favor of all defendants and against the plaintiff. 9102

Judge Thomas V. Lyons, II

MAY 03 2018

ENTERED: Circuit Court-1986

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Judge Judge's No. 1280

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DOROTHY BROWN, CLERK OF THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

2020 IL App (1st) 182702

SIXTH DIVISION
September 30, 2020

No. 1-18-2702

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

JILL M. BAILEY, Individually and as Independent Representative of the Estate of Jill J. Milton-Hampton, Deceased Plaintiff-Appellant, v. MERCY HOSPITAL AND MEDICAL CENTER, an Illinois Corporation; SCOTT A. HEINRICH, M.D.; BRETT M. JONES, M.D.; AMIT ARWINDEKAR, M.D.; HELENE CONNOLLY, M.D.; TARA ANDERSON; and EMERGENCY MEDICINE PHYSICIANS OF CHICAGO, LLC, Defendants-Appellees.	)	Appeal from the Circuit Court of Cook County. No. 2013 L 8501 Honorable Thomas V. Lyons, II Judge, Presiding.

JUSTICE CONNORS delivered the judgment of the court, with opinion.
Justices Cunningham and Harris concurred in the judgment and opinion.

OPINION

¶ 1 Plaintiff, Jill M. Bailey, independent administrator of the estate of Jill M. Milton-Hampton, deceased, appeals the jury's verdict that found against plaintiff and for defendants Mercy Hospital and Medical Center (Mercy); Scott A. Heinrich, M.D.; Brett M. Jones, M.D.; Amit Arwindekar, M.D.; Helene Connolly, M.D.; Tara Anderson, RN ; and Emergency Medicine Physicians of Chicago, LLC (EMP).

¶ 2 On appeal, plaintiff contends the trial court deprived her of a right to a fair trial when it denied her requests to give Illinois Pattern Jury Instructions, Civil, No. 105.07.01 (2011) (hereinafter IPI Civil (2011)), which is the instruction on informed consent, and IPI Civil (2011) No. 5.01, which is the instruction on missing evidence. She argues the trial court abused its discretion and denied her a fair trial when it denied her request to give a nonpattern jury instruction on the loss of chance doctrine. She claims she was denied a fair trial when the court permitted Dr. Arthur Reingold, who was unqualified, to testify and allowed defendant Mercy's expert, Dr. Gary Schaer, to testify about a demonstrative exhibit that was unsupported and misleading. Plaintiff lastly asserts that the jury's verdict was against the manifest weight of the evidence.

¶ 3 The trial court erred when it refused to give IPI Civil (2011) No. 105.07.01 and a nonpattern jury instruction on the loss of chance doctrine. The trial court did not err when it refused to give IPI Civil (2011) No. 5.01, permitted defendants' expert, Dr. Arthur Reingold, to testify, and allowed defendants' expert to testify about a demonstrative exhibit.

¶ 4 I. BACKGROUND

¶ 5 This is a medical malpractice case involving Jill M. Milton-Hampton (Jill) who died on March 18, 2012, after she sought treatment in the emergency department at Mercy during the evenings of March 16, 2012, and March 17, 2012. Plaintiff filed a civil complaint against certain physicians and nurses who cared for Jill when she was in the emergency department at Mercy. Plaintiff asserted claims for medical negligence and wrongful death, alleging that defendants failed to timely diagnose and treat her for sepsis or toxic shock syndrome. Some physicians and nurses who were originally involved in the litigation were voluntarily dismissed before trial. Plaintiff proceeded at trial against Heinrich, Jones, Arwindekar, Connolly, Anderson, Mercy, and

EMP. Plaintiff's theory against Mercy was that the physicians—Heinrich, Jones, Arwindekar, and Connolly—were apparent agents of Mercy and that one of the nurses involved in her care—Anderson—was an agent of Mercy. Plaintiff's theory against EMP was that the physicians were agents of EMP. The jury returned a verdict in favor of all defendants and against plaintiff.

¶ 6 A. Defendants and Litigation

¶ 7 Defendants Heinrich, Jones, Connolly, and Arwindekar were the physicians who cared for Jill in the emergency room. They were employees of EMP, which had a contract with Mercy to provide emergency medicine services. Anderson was an employee of Mercy and was Jill's nurse during Jill's second visit to the emergency room.

¶ 8 At trial, the parties disputed Jill's cause of death. Plaintiff's theory was that Jill died of toxic shock syndrome and sepsis caused by a retained tampon, which could have been treated with antibiotics. Defendants' theory was that Jill died of acute viral myocarditis, which could not be treated with antibiotics. Each party presented experts supporting its respective theory.

¶ 9 Heinrich, Jones, Connolly, and Arwindekar testified about their roles in the case. Each physician testified that he or she complied with the standard of care. Each physician also testified that Jill did not have sepsis or toxic shock syndrome. The facts below about Jill's visits at Mercy are taken from the testimonies of the treaters who cared for Jill at Mercy.

¶ 10 B. Mercy's Emergency Room

¶ 11 In March 2012, when a patient arrived at the emergency department at Mercy, the patient would first inform the person at the registration desk of her chief complaint. If the complaint was anything other than chest pain, a triage nurse would evaluate the patient, which would include taking vitals and determining the patient's acuity level, or "ESI classification." The ESI classification system used a scale from one to five, with a level one being used for

patients with the most urgent needs. The triage area was staffed by nurses. During certain times of the day, a "physician in triage" would work with the triage nurses to expedite the process. The physician in triage initiated certain tests and took care of the patients who had minor complaints. The physician in triage did not see every patient and did not diagnose patients. The physician in the main emergency department performed the comprehensive physical examination on the patient.

¶ 12 C. First Visit to the Emergency Room

¶ 13 Jill, who was a 42-year old woman, first arrived in the emergency department at Mercy at about 6:45 p.m. on March 16, 2012. She was evaluated by a triage nurse and complained of abdominal pain, nausea, vomiting, and diarrhea. She had experienced the abdominal pain for the last four days, and she had recently recovered from experiencing flu-like symptoms, including sore throat, chills, and fevers. The triage nurse noted that Jill had tachycardia, or an elevated heart rate, but did not have a fever and her respiratory rate was normal. The physician in triage ordered a comprehensive metabolic panel (CMP), a pregnancy test, and a urinalysis. After the initial assessment by the triage nurse, Jill waited in the waiting room. Around 11 p.m., Jill was sent back to the main emergency department, where she was seen by Heinrich.

¶ 14 Heinrich performed a physical evaluation on Jill, who complained of nausea, vomiting, diarrhea, and abdominal pain. Jill did not have a fever, chest pain, or shortness of breath. Her heart rate was elevated at 124. The normal resting heart rate for a woman Jill's age was between 60 and 100. Her systolic blood pressure was 96. The normal range was 90 to 140. Her skin was warm and dry, which meant she was not perfusing. Jill had no neurological deficits, and there was nothing unusual with her face, scalp, neck, eyes, ear, nose, or throat.

¶ 15 The CMP results showed that Jill's glucose and liver function were normal. Her blood urea nitrogen, glomerular filtration rate, and creatine, which assess kidney function, were also normal. Jill's sodium and chloride levels were a little low but were consistent with a patient who was dehydrated. Heinrich ordered a hemoglobin and hematocrit test to evaluate Jill's blood count and determine if she was anemic. The results showed that Jill's hemoglobin was low at 7.5L, which could be a result of chronic anemia, as she was currently menstruating and had a history of heavy periods. According to Mercy's parameters, a normal hemoglobin level for Jill would have been 12 to 15 mg/dl.

¶ 16 Heinrich ordered three bags of intravenous fluids to help with Jill's dehydration. He also ordered medicine for her nausea, epigastric discomfort, and pain. At about 3:40 a.m., Heinrich evaluated Jill and prepared a note to transfer her care to Jones. He indicated in his note that Jill still complained of nausea but was starting to feel better. He also noted that Jill's blood count was low, which was likely due to menstruation. At that time, Heinrich did not have a definitive diagnosis but believed Jill had gastroenteritis, or a stomach flu most commonly caused by a virus. He saw a patient with gastroenteritis during every shift. His conclusion that Jill had gastroenteritis was based on his physical examination, the results of the CMP, Jill's symptoms, and the fact that she had started to feel better after receiving the fluids. Jill did not have a fever or rash, which, according to Heinrich, were cardinal signs of toxic shock syndrome. Heinrich did not think Jill had toxic shock syndrome that led to bacterial sepsis or shock.

¶ 17 At about 3:30 a.m. on March 17, 2012, Heinrich transferred Jill's care to Jones. During the transfer of care process, Heinrich and Jones discussed Jill's history, the tests that had been ordered, and the "running diagnosis" of gastroenteritis. Jones reviewed Heinrich's notes, which indicated that Jill had responded to the fluids and medicine. When Jones took over Jill's

care, she was receiving her third bag of fluids. Jones's plan was to continue the treatment to see how Jill responded. The urinalysis results, which returned when Jones was caring for Jill, were negative for a urinary tract infection and showed no signs of dehydration. Her respiratory rate was high at times, and her hemoglobin was low, which was consistent with chronic anemia. Her chloride was a little bit low, which was consistent with having symptoms of diarrhea and vomiting. After Jill received the fluids, her elevated heart rate improved, and she told Jones she felt better. Based on Jill's lab results and response to fluids, Jones believed that Jill had viral gastroenteritis.

¶ 18 Jones evaluated Jill around 6 a.m. He recommended that Jill be admitted to the hospital for observation and further testing because he needed more information and was concerned Jill could have something else. Jill declined admission. Jones's discharge note stated:

> "I did see and evaluate the patient. She continues to be nauseated. I recommended further observation and admission, especially given her persistent nausea, persistent tachycardia, abnormal laboratory studies, however, the patient declines this and would really like to go home. [S]he, does demonstrate decisional capacity. *** She agrees to return to the ER for worsening symptoms, severe pain, or for any other concerns. Her partner is with her, appears to be reliable and will bring her back for worsening pain."

¶ 19 Jones testified about the conversation he had with Jill before she left the hospital. Jill's ex-husband and Jill's nurse, Mary Kotan, were present for the conversation. Jones testified that he outlined the risks of Jill leaving, including that he was concerned she had gastroenteritis and an elevated heart rate. He explained that there was something else going on that they needed to figure out and there were "multiple possibilities that this could be[,] many of which are very,

very serious." Jones told Jill that he wanted her to return to the hospital if she experienced worsening symptoms.

¶ 20 Jones also testified about his concerns about Jill's condition when she left the hospital. Jones was concerned that Jill's hemoglobin level was 7.5 mg/dl, but he believed it was a result of chronic anemia. He testified that "I think that's what it was, but with one value and no prior values, I don't know what to make out of that. Could she have heavy bleeding, internal bleeding, [gastrointestinal (GI)] bleeding? It is possible. So that was concerning to me." Jones did not take any steps to determine why Jill's hemoglobin was low.

¶ 21 Jones was also concerned that Jill had persistent tachycardia, or an elevated heart rate, when she left. He would have expected her heart rate to return to normal after she received three liters of fluid. He testified that persistent tachycardia "throws up red flags for any emergency physician," such as pulmonary embolism, a blood clot in the lungs, gastrointestinal bleeding, or an infection. Jones also testified that sepsis was one of the "main possibilities" he was concerned about with Jill. He did not order tests with respect to determining whether she had a pulmonary embolism or sepsis. He never told Jill that he was concerned about a blood clot in her lungs, gastrointestinal bleeding, or sepsis, and he did not document these concerns in the record. He testified that these conditions could be life-threatening and could not recall whether he told Jill that she had a life-threatening condition. During the time Jones cared for Jill, he did not order any tests.

¶ 22 D. Second Visit to the Emergency Room

¶ 23 When Heinrich returned to Mercy on March 17, 2012, he reviewed Jill's chart and learned that she had refused admission. Heinrich called Jill and spoke with her ex-husband, who told Heinrich that Jill was not doing better and was returning to the emergency room. Heinrich

called Connolly, who was the triage physician in the emergency department, and informed her that Jill had previously been in the emergency department with abdominal pain and was returning with symptoms of nausea, vomiting, and diarrhea. He advised Connolly that she should order a computed tomography (CT) scan of the abdomen.

¶ 24 Jill arrived at the emergency department at 5:49 p.m. on March 17, 2012. When Connolly saw Jill's name appear in the system, she ordered a CT of the abdomen, a complete blood count (CBC), and a CMP. She did not order a chest X-ray or electrocardiogram (EKG). Connolly did not evaluate Jill, participate in her triage, or review her records. Jill complained to the triage nurse that she had a cough, vomiting, diarrhea, shortness of breath, and chest pain. The record regarding Jill's complaint in triage stated: "Seen in Mercy ER. Released at 6:00 a.m. Cough, vomiting, diarrhea, shortness of breath, chest pain." Jill rated her abdominal pain a 10 out of 10, which was the worst possible pain, and her chest pain an 8 out of 10. Jill's heart rate was 116. Her blood pressure was 90 over 53, which was low for diastolic blood pressure. Her respiratory rate was 20, and her skin was warm and dry. The triage nurse testified that Jill did not have an imminent cardiac need and that she rated Jill's ESI classification, or acuity level, a three out of five, which meant she believed Jill could wait in the waiting room for an open bed and Jill's condition was not likely to deteriorate. Connolly, as the physician in triage, never received a call about any concerns with Jill and did not request that Jill be sent back to the main room. Jill did not go back to the main emergency department until about four hours later. Connolly agreed that, if Jones suspected Jill had sepsis or a gastrointestinal bleed, it would have been inappropriate for her to wait in the waiting room for four hours.

¶ 25 At about 9:43 p.m. on March 17, 2012, Tara Anderson, who was Jill's primary emergency room nurse, took an initial assessment on Jill in the main emergency department.

Anderson indicated in her initial assessment note that Jill was alert and oriented and had symptoms of vomiting and cramping. Her skin, which was warm and dry, and respiratory patten were normal. Jill did not complain of chest pain or shortness of breath. Anderson testified that she had no reason to believe that she did not do her job and act as a nurse and advocate for Jill. Anderson's role as a nurse was to carry out a physician's orders.

¶ 26 Marco Rodriguez, an emergency medicine resident, and Arwindekar, an attending physician, cared for Jill when she was in the main emergency room. A few minutes after Anderson's evaluation, Rodriguez performed a history and physical evaluation on Jill, who complained of nausea, vomiting, and diarrhea. She did not have a fever, chest pain, or shortness of breath. According to Rodriguez, pain with urination and blood in the urine could be signs of an infection, and Jill did not have these symptoms. Jill did not have a rash, and her skin was warm and dry. She was tachycardic but did not have any other abnormalities with respect to her heart. Her respiratory rate was normal, and she was alert and oriented. Jill's white blood cell count was 12.2, which, according to Arwindekar, was very minimally elevated and could be caused by stress, including traumatic injury, infection, or dehydration. The neutrophils in Jill's white blood count were not elevated, suggesting that she did not have an acute infection. Jill's hemoglobin level was 7.2, which had dropped a small amount from the first visit and was consistent with chronic anemia.

¶ 27 At 10:03 p.m., Rodriguez ordered intravenous fluids and medicine for nausea and for pain. He ordered a chest X-ray for her cough. At 12:07 a.m. on March 18, 2012, Rodriguez re-examined Jill, stating in his note that her pain and nausea improved and her condition was stable. Based on Rodriguez's physical examination and Jill's history, Rodriquez suspected Jill had a virus and did not suspect that she had sepsis. Rodriguez was unaware that Jones had been

concerned that Jill could have had sepsis or a pulmonary embolism. If he had been aware, his care and treatment for Jill would not have changed. Rodriguez left his shift around midnight and transferred Jill's care to his attending physician, Arwindekar.

¶ 28 At about 12:54 a.m. on March 18, 2012, Jill had a CT scan for "abdominal pain," and the report indicated that her clinical indication for the test was "persistent abdominal pain, shortness of breath and vomiting." The results of the CT scan showed no signs of abdominal bleeding but indicated there was a "heterogenous density" in the vagina area, "which should be correlated clinically." According to Arwindekar, the "heterogenous density" noted in the CT report indicated Jill had blood clots, not a tampon, as blood clots would be consistent with a woman who is menstruating. He did not take any measures to determine whether there was a tampon present in Jill.

¶ 29 At 1:59 a.m., Anderson documented that Jill's pulse, blood pressure, temperature, and respiratory rate were normal. Around 2:37 a.m., Arwindekar placed an order to transfer Jill to the observation unit, a floor outside of the intensive care unit for patients expected to be discharged within 24 to 48 hours. At this time, Jill's tachycardia, or elevated heart rate, had improved, her vital signs were normal, her condition was stable, and she did not have a fever. She was still nauseous and continued to have diarrhea. Based on Jill's response to fluids and vital signs, Arwindekar believed Jill's condition was consistent with viral gastroenteritis. During the time Arwindekar cared for Jill, she was never pain-free.

¶ 30 At 4:30 a.m., Jill was transferred to the observation unit in stable condition with normal vital signs. Dr. Shanu Gupta, the hospitalist who cared for Jill in the observation unit, concluded that Jill had gastroenteritis. At about 5:50 a.m., Jill went into cardiopulmonary arrest and received antibiotics. Jill was intubated, and the health care providers engaged in "aggressive

efforts" to resuscitate her. Jill was resuscitated, after which she was transferred to the intensive care unit where she continued to suffer cardiopulmonary arrest and "coded" eight times. Jill died at 11:30 a.m.

¶ 31 At some point when Jill was in the intensive care unit, a hematologist, Dr. Subramanian, was called to consult with the physicians caring for Jill. Subramanian noted in the record that Jill's code was due to "peripheral smear most compatible with DIC [disseminated intravascular coagulation] due to sepsis and shock." Subramanian did not testify at trial. During the same time when Jill was coding, Dr. Deepa Dharanipragada ordered blood cultures to be drawn. Dharanipragada did not testify at trial. The record does not contain any report on the blood cultures, and as explained below, according to one of defendants' experts, the medical records showed the order was "discontinued," meaning it was not completed.

¶ 32 Cook County medical examiner Lauren M. Woertz prepared a report of postmortem examination. Woertz's report indicated that Jill had intravascular access catheters in the left side of her neck and anterior aspect of her right wrist, drainage tubes from the right and left sides of her chest, a central line in the left groin, and orogastric and endotracheal tubes from the oral cavity. Woertz's report listed 11 different conditions under the category "diagnoses," including myocarditis and methicillin-resistant staphylococcus aureus (MRSA) sepsis. Woertz's report indicated that the blood samples were submitted for analysis, and the toxicology blood cultures showed that MRSA was present in Jill's blood. According to Woertz's report, Jill's cause of death was due to myocarditis resulting from sepsis. James Bryant performed a second autopsy at the request of Jill's family. He concluded that Jill's cause of death was acute and chronic congestive heart failure due to dilated cardiomyopathy. Bryant's report did not indicate that Jill had myocarditis or sepsis. Woertz and Bryant did not testify at trial.

¶ 33 Plaintiff's counsel asked Heinrich whether he knew why the billing records showed that Mercy billed Jill's health insurance, Aetna Insurance, for "septicemia, shock, and sepsis"; Heinrich responded that he did not know, as he did not do billing. The record contained Mercy's claim to Aetna Health Inc., which listed numerous "diagnose codes," including "septicemia NOS," "shock NOS," and "sepsis NOS."

¶ 34 E. Plaintiff's Case

¶ 35 As previously discussed, plaintiff's theory was that Jill died of bacterial sepsis caused by toxic shock syndrome due to a retained tampon. The experts testified about sepsis and toxic shock syndrome. Sepsis is a body's response to an untreated infection and causes systemic inflammation, an elevated heart rate, damage to organs, and pain. MRSA is a common pathogen that can cause toxic shock syndrome. MRSA can be caused from tampon use.

¶ 36 Plaintiff argued that the "heterogenous density" in the CT report was a tampon, which was the source of Jill's infection, and that Woertz's report indicating that MSRA grew from the postmortem toxicology blood sample supported her theory that Jill had a bacterial infection leading to sepsis. Plaintiff argued Jill would have survived had the physicians timely administered antibiotics.

¶ 37 F. Plaintiff's Experts

¶ 38 Dr. Michael D'Ambrosio, an emergency medicine physician, testified that Jill's cause of death was untreated sepsis. When Jill initially presented to the emergency department, her symptoms were consistent with viral gastroenteritis. However, after she received the first or second liter of fluids, her symptoms should have improved. Because her symptoms did not improve, Heinrich and Jones should have suspected that she had an infection and should have ordered additional testing and done a "sepsis workup" to look for sepsis, which would include a

lactic acid test, blood and urine cultures, a CT scan, an EKG, and chest X-ray. They violated the standard of care when they did not do so.

¶ 39 D'Ambrosio testified that, with respect to Arwindekar, he should have taken note that the CT results showed fluid in her lungs, as that could indicate an infection. He testified that the standard of care required admitting Jill to a higher level of intensive care unit rather than the observation unit. He deviated from the standard of care when he did not order a sepsis workup. With respect to Connolly, when Jill returned to the emergency room with the same symptoms from her first visit as well as with chest pain and shortness of breath, Connolly should have brought Jill back to the main emergency room and ordered additional testing, including tests to look for sepsis. She should have ordered a chest X-ray and EKG, if the triage nurse had not already done so. Connolly deviated from the standard of care when she did not do so.

¶ 40 Ambrosio testified about the standard of care required for Jones with respect to his conversation with Jill before she left the hospital. When a patient wants to leave the hospital, the physician must inform the patient of his concerns about the patient leaving the hospital. The physician must do the necessary tests so that the patient has complete information about her decision to leave the hospital. He testified that, "[t]o have informed consent, you have to have done the necessary tests, if the patient gave you sufficient time to do them, to give them a good decision to make." Jones did not complete the necessary tests to give Jill adequate information. Had Jones completed the necessary testing, he could have informed Jill of his concerns. Jones should have told Jill that she had a blood infection and required antibiotics and that she could die if she left the hospital before she received treatment. He testified that sepsis "kills people" and the antibiotics treatment is "very time sensitive."

¶ 41 Dr. Michael Noto, a specialist in pulmonary critical care and infectious disease medicine, testified that Jill had toxic shock syndrome that led to bacterial sepsis. Sepsis can present with a history of fever, sore throat, congestion, nausea, abdominal pain, vomiting, and diarrhea. The patient has a better outcome if sepsis is treated early with antibiotics. Because the physicians did not diagnose her with sepsis or administer early treatment of antibiotics, Jill's risk of dying increased.

¶ 42 Noto further testified that, when Jill presented to the emergency room on March 16, 2012, she met the criteria for sepsis. Her history of symptoms that had resolved before she presented to the emergency room, including fevers, sore throat, abdominal pain, and vomiting, supported Noto's opinion that she had an infection. He testified that a fever is "very common" with toxic shock syndrome and that the presence of a rash can be helpful in the diagnosis. The fact that Jill did not have a documented fever or rash did not exclude a diagnosis of toxic shock syndrome, as a fever and rash could have been present at the onset of the illness before she came to the hospital. The results of Jill's chest X-ray, which were available at 1 a.m. on March 18, 2012, were consistent with Jill having sepsis. During Jill's second visit, her white blood cell count was "abnormally high" and increased during the course of her condition, suggesting her body was responding to an infection. Noto testified that a tampon caused Jill's infection, which was identified as the "heterogeneous density" in the CT report. Noto testified that the MRSA finding from the postmortem blood sample in Woertz's report was unlikely a contaminant. He acknowledged that there was no specific source of a bacterial infection other than the MRSA finding from Woertz's blood sample.

¶ 43 Dr. Harry Jacob, an internal medicine physician specializing in hematology and oncology, testified that Jill died from sepsis and toxic shock syndrome. He testified that her

history of symptoms several days before she came into the hospital, including vomiting, chills, fever, and abdominal pain, were consistent with a patient who had ongoing worsening sepsis. When Jill presented to the emergency room, she had an elevated heart rate, which was one of the major signs of a patient who had shock due to sepsis. She also had low blood pressure, nausea, vomiting, and abdominal pain, which were also symptoms consistent with toxic shock syndrome. Jill's elevated white blood count, fluid identified in the CT report, and heterogenous density finding in the CT report, which he identified as a tampon and the site of infection, supported his opinion that she had toxic shock and sepsis. The physicians should have considered toxic shock syndrome because Jill was menstruating and toxic shock can be caused by bacteria from a tampon. Jill would have survived if she received the proper course of treatment for sepsis.

¶ 44 Dr. Michael C. Fishbein, a pathologist, testified that Jill died of multiorgan failure due to shock from sepsis, which was caused by bacterial MRSA. He concluded that Jill's clinical course of her condition was consistent with bacterial sepsis. His opinion was based on the presence of a tampon identified as the heterogenous density in the CT report, which was the source of the infection, and the MRSA finding from Woertz's autopsy report. He testified MRSA is not a common postmortem contaminant and the MRSA finding from Woertz's postmortem toxicology blood sample was a true, positive culture. He agreed that the autopsies did not show there was any bacteria in Jill's body other than the MRSA blood culture. He acknowledged that, if there was no positive MRSA blood culture and the heterogenous density was not a tampon, he did not know the source of infection and would not be able to conclude that Jill had bacterial sepsis.

¶ 45 Dr. Hilton Hudson, a cardiothoracic surgeon, testified that Jill died of sepsis. Jill's history of fever before she presented to the hospital and her symptoms in the hospital of chest

pain, abdominal pain, nausea, and an elevated heart rate were consistent with sepsis. If Jill had been treated with antibiotics and been taken to the intensive care unit earlier, she would have survived. He testified that hospital-acquired MRSA was a common problem, as MRSA can enter the body when tubes and catheters are inserted. Woertz's autopsy report concluded that Jill died of myocarditis secondary to sepsis. Her conclusion was based on the MRSA culture performed after she died. Hudson acknowledged that the second autopsy performed by Bryant concluded that Jill died of cardiomyopathy, which can be a form of myocarditis, and that there was no reference in his report to sepsis.

¶ 46 Dr. Rolf Gobien, a diagnostic radiologist, testified that the CT images showed Jill had a tampon in her vagina. He acknowledged that autopsies did not mention the presence of a tampon.

¶ 47 With respect to Anderson and the nurses involved in Jill's care, Gerald Craig Felty, a registered nurse for 24 years, testified for plaintiff. He testified that Anderson should have performed an EKG, placed her on a cardiac monitor, and recorded certain vital sign readings during her care of Jill. From 2 a.m. to 4:31 a.m., on March 18, 2012, Anderson did not record certain measurements in Jill's record, including pulse, respiratory rate, and lung status, and she deviated from the standard of care when she did not do so. He opined that Anderson did not take measures to advocate on behalf of Jill.

¶ 48 G. Defendants' Case

¶ 49 As previously discussed, defendants' theory was that Jill died of acute myocarditis. Defendants argued that there was no evidence of bacterial infection found on the autopsy reports and there was no identified infection site. Defendants contended that Woertz's MRSA finding from the postmortem blood sample was a contaminant that was introduced in Jill when she was

coding and various lines were inserted. They argued that the "heterogenous density" indicated on the CT report was not a tampon. Defendants' experts testified that each health care provider met the standard of care and that Jill did not have sepsis or toxic shock syndrome.

¶ 50 H. Defendants' Experts

¶ 51 Dr. Edward Ward, an emergency room physician, testified that it was his opinion that all the emergency medicine physicians complied with the standard of care. Jill died of myocarditis and she did not have sepsis or toxic shock syndrome. Jones complied with the standard of care with respect to his discussion with Jill before she left the hospital against his recommendation.

¶ 52 Ward testified that Heinrich's history and physical on Jill was complete and thorough and that he ordered all necessary tests and provided appropriate care. Heinrich's conclusion that Jill had viral gastroenteritis was "completely within the standard of care." Viral gastroenteritis was an "extraordinarily common" chief complaint, and the treatment includes evaluation, hydration, and following the patient over time.

¶ 53 Ward testified that the record did not show that Jones informed Jill that she had a life-threatening condition. He also testified that, based on the medical record, it did not appear that Jill had a life-threatening condition when she left the hospital. If Jones had suspected Jill had a pulmonary embolus, GI bleeding, sepsis, or any life-threatening condition, he should have explained his concerns and offered further testing. If Jones suspected that Jill had a life-threatening condition, then the standard of care would have required him to explain his concerns and offer further treatment. Jill left the hospital early, so Jones did not have the opportunity to do further testing. There was no evidence to support that Jones should have performed tests for sepsis, and she did not have symptoms consistent with toxic shock syndrome, including a

documented fever, rash, or an infection site for bacteria. Ward testified that there were "a variety of different things that something could be at discharge" and that the standard of care did not require him "to go through each and every individual thing that may or may not be present."

¶ 54 Ward also testified that Connolly did not deviate from the standard of care as the physician in triage. Based on his review of Mercy's triage system and the responsibilities of the physician in triage, Connolly did not have to see Jill, as her time was divided between several areas. Her main role was to place orders on patients arriving in the emergency department to obtain information and expedite testing for the clinicians in the main emergency department. Connolly appropriately ordered a CT scan, CMP, and CBC. It was appropriate for Connolly to rely on the triage nurse's assessment. Connolly was not notified of any issues relating to Jill when Jill was in the waiting room. If an EKG had been performed on Jill in triage or the waiting room, it would have shown Jill had an elevated heart rate, which was a finding that was already known at that point. There was no evidence in the record that Jill deteriorated in the waiting room.

¶ 55 Ward testified that, at 10 p.m. on March 17, 2012, Arwindekar, as the attending physician, became responsible for Rodriguez's care of Jill. Rodriguez did not do anything wrong with Jill when Arwindekar was supervising him. There was nothing on the CT scan suggesting Jill had a life-threatening condition. The CT report's finding that there was "heterogenous density" that should be correlated clinically did not require Arwindekar to perform a vaginal exam on Jill and would have been "highly unusual," as she had gastroenteritis. Arwindekar's history and physical exam and opinion that she had a viral illness met the standard of care. Arwindekar's decision to admit Jill to the hospital met the standard of care, and he was not

required to transfer Jill to another section in the intensive care unit other than the observation unit.

¶ 56 Dr. Daniel Courtney, an emergency medicine physician, testified that the emergency medicine physicians who cared for Jill met the standard of care. Jill's underlying condition was viral gastroenteritis, a condition that gets better over time through the body's own immune process and should not be treated with antibiotics. The standard of care did not require the physicians to order antibiotics to treat a viral illness. Based on the record, there was nothing about Jill's condition that suggested she might have a condition that would cause an imminent death. He opined that Jill did not have toxic shock syndrome because she did not meet the CDC criteria for the syndrome. She did not have symptoms consistent with toxic shock syndrome, including a rash, fever, multiorgan failure, or hypotension.

¶ 57 It was Courtney's opinion that Jones met the standard of care with respect to his communication with Jill when she left the hospital against his recommendation. Asked if Jones was required to tell Jill she had a life-threatening condition, Courtney responded, "I don't think he thought that she had a life-threatening condition or knew or had any way to know that she had a life[-]threatening condition, so I would not say that he was required to say that to her." Based on his review of the records and laboratory findings, it was his opinion that Jill did not have a knowable life-threatening condition when she left the hospital. The record did not show evidence that Jones should have suspected that Jill had pulmonary embolism, a GI bleed, or sepsis. If Jones had suspected that Jill had a pulmonary embolism, GI bleed, or a life-threatening condition, the standard of care would have required him to tell Jill about these concerns before she left the hospital. There were no additional tests that Jones should have ordered before he spoke with Jill about leaving the hospital.

¶ 58 Dr. Robert Citronberg, a specialist in infectious disease, testified that Jill died of fulminant viral myocarditis, which meant "it came very quickly" and nothing could have been done to prevent her death. A virus can cause gastrointestinal symptoms. Jill did not have toxic shock syndrome because she did not have symptoms consistent with this condition, including a notable skin rash, low blood pressure, or high fever. There was no evidence in the record that Jill had a bacterial infection or sepsis. If she had bacterial sepsis, there would have been evidence of bacteria in one of her organs, which neither autopsy report identified. Before Jill coded, her white blood count did not indicate a patient who had systemic bacterial infection, and her kidneys were functioning properly.

¶ 59 Citronberg testified that Woertz's autopsy report indicated that she died of myocarditis due to sepsis, which was based on the MRSA that grew out of the postmortem blood sample. Jill experienced nine different codes, and as such, bacteria could have been introduced to the surface of Jill's skin during these codes. It is uncommon for a patient with toxic shock syndrome to have bacteria in her blood. If Jill had MRSA in her blood when she was alive, that finding would argue against the theory that she had toxic shock syndrome, as MSRA only shows up in the bloodstream in about five percent of the patients with staphylococcal toxic shock syndrome.

¶ 60 Dr. Gary Schaer, an interventional cardiologist, testified that Jill had a severe viral infection that caused nausea, vomiting, and diarrhea, which ultimately caused her to die of very rare fulminant myocarditis, meaning that it was progressive and injured her heart acutely. There was nothing about Jill's presentation in the emergency department that would have suggested that she had an imminent cardiac emergency or viral myocarditis. There was also nothing to suggest that she had a severe bacterial infection because her white blood count analysis did not

suggest she had an infection circulating in her bloodstream. There was nothing Jill's healthcare providers could have done to prevent her death.

¶ 61 Dr. Gregory M. Lewis, a cardiologist, testified that Jill died from a fulminant viral myocarditis. The autopsy reports showed no source of an infection or evidence that Jill's organs were damaged to raise the suspicion that she had a bacterial infection. The MRSA finding from Woertz's examination was most likely a contaminant that entered Jill's body when she was coding and experiencing various interventions. There was nothing the health care providers did or failed to do that contributed to her death.

¶ 62 Dr. Scott Denton, a forensic pathologist, testified that, based on his review of the microscope slides and autopsy reports, Jill died of acute myocarditis. Denton testified that the microscope slides and autopsy reports did not show evidence of bacteria and that Jill's coronary arteries were completely open, which was consistent with myocarditis. The clinical records showing gastritis was a preceding viral illness consistent with myocarditis. Denton saw no evidence of toxic shock syndrome because Jill did not have a rash, skin blotchiness, high fever, or source of MRSA.

¶ 63 Denton disagreed with Woertz's conclusion that Jill died of myocarditis due to bacterial sepsis. He disagreed because the autopsy reports showed no evidence of an infection, which must be present with a documented bacterial infection. He testified that results from postmortem microbiology, taking blood 24 hours after death, should be interpreted with caution. He opined that MRSA entered Jill's body when she was coding and being resuscitated, as there were various interventions that could have broken her skin and created areas for bacteria to enter her body. Based on the autopsy reports, it was Denton's opinion that Jill did not have a tampon

in her body at the time of death. If a tampon had been present during the autopsy, it would have been normal practice to document that finding in the report.

¶ 64 Dr. Richard Gore, a diagnostic radiologist, testified that the CT scan did not show the presence of a tampon and there was no evidence that Jill had an infection. Vahid Yaghmai, a diagnostic radiologist, testified that Jill's CT scan did not show a tampon and that the image identified by plaintiff's experts as a tampon was Jill's urethra.

¶ 65 With respect to Anderson, Laurie Carrol, a registered nurse with 40 years of experience, testified that the nurses involved in Jill's care met the standard of care. She testified that there are certain situations when an emergency medicine nurse will assess a patient's vital signs and be aware of them but will not document them in the patient's chart. It would have been custom and practice for Anderson to have been aware of Jill's vital signs throughout her admission in the emergency room even when she did not document them. She testified that nurses and physicians communicate with each other frequently, especially in the emergency room, and that patient care takes precedence over making sure everything is documented in the medical record. Carroll testified that, at 1:59 a.m. on March 18, 2012, Anderson documented Jill's vital signs, which were within normal ranges. At 4:28 a.m., Anderson documented a transfer form, noting that Jill's condition was stable, which would indicate that Anderson performed an evaluation at that time. The standard of care did not require Anderson to place Jill on a cardiac monitor or perform an EKG.

¶ 66 I. Dr. Arthur Reingold

¶ 67 Dr. Arthur Reingold, a physician and professor of epidemiology at the University of California, Berkley, testified as an expert about toxic shock syndrome. Following medical school and residency, he worked for one year as an emergency medicine physician, after which he

worked at the Centers for Disease Control (CDC) as a medical epidemiologist. In the 1970s and 1980s, there was a dramatic increase in toxic shock syndrome. In 1980, Reingold joined the CDC's toxic shock syndrome task force to study the disease. For five years, Reingold reviewed between 5000 and 10000 patient records to determine whether the patient fit the CDC clinical criteria for toxic shock syndrome. Reingold was an author of over two dozen articles on toxic shock syndrome and had worked with the CDC on a contractual basis since 1988. Reingold explained that toxic shock syndrome is caused by an infection with staphylococcus aureus, a bacteria that produces a toxin and can get into the vagina through the insertion of a tampon. Reingold had not worked in a clinical setting treating patients since 1980.

¶ 68 Reingold testified that menstrual toxic shock syndrome in a woman in her forties was extremely rare because individuals develop antibodies and immunity. The incidence of women having toxic shock syndrome in 2012 was one in one million. Based on his review of Jill's medical records, his work at the CDC, and his background and experience with utilization of the CDC's toxic shock syndrome criteria over 38 years, it was Reingold's opinion that Jill did not have toxic shock syndrome and did not meet the CDC case criteria for toxic shock syndrome. The requirements for toxic shock syndrome included a documented fever of 102 degrees or greater, a rash, desquamation, which is a shedding of skin layers, low blood pressure, and multisystem organ failure. Jill did not have a documented fever of 102 degrees Fahrenheit or greater, rash, or desquamation, and she only had two isolated systolic blood pressure readings below the acceptable levels. He did not see that anything on Jill's autopsies that supported "multi-system involvement" showing she had toxic shock syndrome.

¶ 69 He testified that, in the early course of toxic shock syndrome, autopsy findings showed that people who died of toxic shock syndrome had normal hearts. On cross-examination,

he acknowledged that the last time he examined a heart on a postmortem exam was in medical school. Asked whether he knew about any recent data regarding how a heart would appear on a postmortem exam with someone who died of toxic shock syndrome, he testified that he was unaware of any recent findings but believed that the findings from the early years would still apply.

¶ 70 J. Demonstrative Exhibit

¶ 71 Before Dr. Schaer testified, Mercy sought to use a demonstrative exhibit explaining that viruses can be airborne. Plaintiff objected, arguing that there was no evidence or testimony that Jill caught a virus from another person through an inhalation process. Defense counsel argued that the exhibit showed that Jill had a contagious virus, not that it was airborne. The court denied plaintiff's motion to prohibit the exhibit, noting that plaintiff's arguments were appropriate for cross-examination. Thereafter, during Schaer's testimony without objection from plaintiff, defense counsel introduced the exhibit and Schaer testified about the exhibit:

> "we have a patient who has a viral infection and many viruses spread from person to person via aerosol droplets. *** I believe that this unfortunate woman caught this viral infection, which initially presented with some flu-like symptoms *** and then began to also present most notably with severe abdominal pain, nausea, vomiting and diarrhea. So the virus initially involves some of the lungs *** and then the GI tract. "

¶ 72 K. Blood Culture

¶ 73 When Jill was coding, the medical record showed that one of Jill's physicians, Dharanipragada, ordered "pan cultures," which included blood, urine, and sputum. The results of the order were not in the medical record nor presented at trial. According to plaintiff's expert, Noto, there was nothing in the record to show why there were no results of the blood culture or

what happened to it. Noto testified that, had the blood culture that Dharanipragada ordered been analyzed, there would be an answer as to whether bacteria was in Jill's body before she died.

¶ 74 Defendants' expert Citronberg testified that, based on his review of the medical records, the blood culture order was discontinued and never sent to the laboratory. Citronberg also reviewed the deposition of Mercy's lab technician, Ruth Cryer. Cryer testified at her deposition that, if the laboratory did not receive a blood culture order, it would not do an analysis or generate a report. If an order is discontinued, that could mean the blood never made it to the lab, and it was possible the blood was never drawn.

¶ 75 L. Jury Instructions

¶ 76 The court denied plaintiff's request to give IPI Civil (2011) No. 105.07.01, which is the instruction on informed consent, and IPI Civil (2011) No. 5.01, which relates to when a party fails to introduce evidence or a witness. The trial court also refused to give a nonpattern jury instruction on the loss of chance doctrine.

¶ 77 M. Verdict and Posttrial Motions

¶ 78 The jury returned a verdict against plaintiff and in favor of all defendants. The trial court denied plaintiff's posttrial motion. This appeal followed.

¶ 79 II. ANALYSIS

¶ 80 On appeal, plaintiff contends that the trial court denied her a right to a fair trial and abused its discretion when it refused to give three jury instructions she requested: (1) IPI Civil (2011) No. 105.07.01, the instruction on informed consent; (2) IPI Civil (2011) No. 5.01, the instruction relating to missing evidence or witnesses; and (3) a nonpattern jury instruction on the loss of chance doctrine. Plaintiff further argues the trial court denied her a fair trial and abused its discretion when it permitted defendants' expert, Dr. Arthur Reingold, to testify and when it

allowed Mercy to use a demonstrative exhibit showing an individual contracting an airborne disease from another individual. Lastly, plaintiff claims that the jury's verdict was against the manifest weight of the evidence because she had a right to have the jury instructed on the issues presented and the law to be applied.

¶ 81 Initially, we note that defendants assert in their response briefs that plaintiff violated Illinois Supreme Court Rule 341(b)(1) (eff. May 25, 2018) because her brief exceeds the page limit and the certificate of compliance did not state that the brief contained fewer than 15,000 words. However, after defendants filed their response briefs, plaintiff filed a "motion for leave to withdraw brief and for leave to file *instanter* a correct brief of plaintiff-appellant in excess of the page limit." We granted plaintiff's motion and allowed her to withdraw her initial brief, correct the certificate of compliance, and file a corrected brief in excess of the page limit.

¶ 82 A. Illinois Pattern Jury Instructions

¶ 83 Plaintiff contends that the trial court denied her a right to a fair trial and abused its discretion when it refused to give IPI Civil (2011) No. 105.07.01, the jury instruction on informed consent, and IPI Civil (2011) No. 5.01, the jury instruction on failing to produce evidence or a witness.

¶ 84 Generally, "[a] party has a right to have the jury instructed on his or her theory of the case if the facts in evidence or a reasonable inference from those facts supports the theory." *Tsoukas v. Lapid*, 315 Ill. App. 3d 372, 377 (2000). A trial court must use an Illinois Pattern Jury Instruction when it is applicable unless the court determines that the instruction does not accurately state the law. *Schultz v. Northeast Illinois Regional Commuter R.R. Corp.*, 201 Ill. 2d 260, 273 (2002). The trial court has discretion in determining which instructions to give the jury. *Luye v. Schopper*, 348 Ill. App. 3d 767, 773 (2004). We will not disturb the trial court's decision

absent an abuse of discretion. *Id.* To determine whether the trial court abused its discretion, we will examine the jury instructions in their entirety, "to determine whether they fairly, fully and comprehensively informed the jury of the relevant law." *LaSalle Bank, N.A. v. C/HCA Development Corp.*, 384 Ill. App. 3d 806, 813 (2008). However, when the issue is whether the jury instructions accurately stated the law, our review is *de novo*. *Doe v. Bridgeforth*, 2018 IL App (1st) 170182, ¶ 66.

¶ 85 1. IPI Civil (2011) No. 105.07.01 Informed Consent—Duty and Definition—Professional Negligence

¶ 86 Plaintiff's first argument on appeal is that a single-line reference to informed consent in the jury instructions did not sufficiently convey the legal principles to be applied to the evidence of a negligence claim based on informed consent. Rather, plaintiff contends, IPI Civil (2011) No. 105.07.01 should have been given to the jury. Defendants maintain that the trial court appropriately denied plaintiff's request for the jury to be given IPI Civil (2011) No. 105.07.01.

¶ 87 IPI Civil (2011) No. 105.07.01 states as follows:

> "In providing medical [services] [care] [treatment] to [patient's name], a [insert appropriate medical professional] must obtain [patient's name]'s informed consent.
>
> When I use the expression 'informed consent' I mean a consent obtained from a patient by a [insert appropriate medical professional] after the disclosure by the [insert appropriate medical professional] of those [risks of] [and] [or] [alternatives to] the proposed treatment which a reasonably well-qualified [insert appropriate medical professional] would disclose under the same or similar circumstances. A failure to obtain informed consent is professional negligence.

> [The only way in which you may decide what (risks) (and) (or) (alternatives) the [insert appropriate medical professional] should have disclosed to [patient's name] is from expert testimony presented in the trial. You must not attempt to determine this from any personal knowledge you have.]"

¶ 88 The comments to the jury instruction state, "[t]his instruction differs from instructions based upon failure to obtain consent. Such actions are brought under a theory of battery. Informed consent is a negligence concept." IPI Civil (2011) No. 105.07.01, Comment. The notes on use also state that, "if the evidence shows that some other factor (i.e., the relative benefits or lack of benefits of alternative treatments) should have been disclosed, then the instruction may be modified accordingly." IPI Civil (2011) No. 105.07.01, Notes on Use.

¶ 89 Plaintiff's proposed jury instruction No. 11 based on IPI Civil (2011) No. 105.07.01 stated as follows:

> "The plaintiff claims that the defendant, Brett Jones, M.D. failed to inform Jill Milton-Hampton of the risks associated with pulmonary embolism, gastrointestinal bleed, infection and sepsis prior to being discharged the morning of March 17, 2012, which a reasonably careful emergency medicine physician would have disclosed under the same or similar circumstances;
>
> The plaintiff further claims that if the defendant had disclosed those risks, a reasonable person in Jill Milton-Hampton's position would not have left the hospital the morning of March 17, 2012; and
>
> The plaintiff further claims that Jill-Milton Hampton was injured, and that the defendant's failure to disclose the aforementioned risks was a proximate cause of her injury.

> The defendant denies that he failed to inform the plaintiff of those risks which a reasonable careful emergency medicine physician would have disclosed under the same or similar circumstances; denies that Jill Milton-Hampton was injured and denies any failure to disclose risks was a proximate cause of any harm or injury."

¶ 90 In objecting to this instruction, the defense argued that it was "highlighting one particular physician with respect to a consent issue on a jury instruction that deals more with battery and the request of administering medication without consent. It doesn't apply. It's not applicable in this case." The trial court, in refusing to give the instruction, stated:

> "I do think there's sufficient testimony about the—and there was testimony that the standard of care would have required the doctor to say certain things.
>
> I agree with the defense. I don't think a separate instruction is appropriate, but I'll *** permit you to add 'failed to adequately inform her'—you work on the language.
>
> ***
>
> So the objection—defendant's objection to Plaintiff's Proposed Jury Instruction No. 11 as a separate instruction is going to be sustained. The instruction will be refused.
>
> However, I will permit the plaintiff to add a line item in the issues instruction to talk about informed consent, okay?"

¶ 91 The jury instructions given to the jury stated, in part: "plaintiff claims that [decedent] was injured and sustained damage, and that the defendants were negligent in one or more of the following respects: *** Dr. Brett Jones failed to inform [decedent] of the risks of leaving the

hospital." Plaintiff maintains that it was error to give this one-line instruction on informed consent instead of the proposed instruction based on IPI Civil (2011) No. 105.07.01. We agree.

¶ 92 "The function of jury instructions is to convey to the jury the correct principles of law applicable to the submitted evidence and, as a result, jury instructions must state the law fairly and distinctly and must not mislead the jury or prejudice a party." (Emphasis omitted.) *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 507 (2002). The parties are entitled to have the jury instructed on the issues presented, the principles of law to be applied, and the necessary facts to be proven to support the jury's verdict. *Id.* at 505.

¶ 93 A plaintiff must prove four elements to prevail in a medical malpractice action under a theory of informed consent:

> "(1) the physician had a duty to disclose material risks; (2) he failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and (4) plaintiff was injured by the proposed treatment." (Internal quotation marks omitted.) *Crim v. Dietrich*, 2016 IL App (4th) 150843, ¶ 35.

¶ 94 Here, plaintiff submitted evidence on each of these four elements at trial. Plaintiff's expert, Dr. D'Ambrosio, testified that Jones had a duty to inform Jill of what could go wrong by leaving the hospital and that she could die. Defendant's expert, Dr. Ward, testified that, if Jones had suspected Jill had sepsis or a life-threatening condition, he should have explained his concerns and offered further testing. Defendant's expert, Dr. Courtney, testified that, if Jones had suspected that Jill had a pulmonary embolism, GI bleed, or a life-threatening condition, the standard of care would have required him to tell Jill about these concerns before she left the hospital. Jones acknowledged that he was concerned that Jill could have had certain life-

threatening conditions, as he testified that sepsis was a condition that could be life-threatening and it was one of the "main possibilities" he was concerned about. He also testified that Jill's persistent tachycardia "throws up red flags for any emergency physician," as it could be a sign of a pulmonary embolism, a blood clot in the lungs, or gastrointestinal bleeding, which are all life-threatening conditions. The trial court seemingly agreed about the standard of care, stating, "I do think there's sufficient testimony about the—and there was testimony that the standard of care would have required the doctor to say certain things." Jones also acknowledged that, when he discharged Jill, he did not inform her that she could have a blood clot in her lungs, gastrointestinal bleeding, or sepsis. As a result, Jill went home and did not receive treatment or further testing to determine her condition, and she ultimately died.

¶ 95 Accordingly, the trial court should have allowed plaintiff to submit her informed consent instruction based on IPI Civil (2011) No. 105.07.01 which would require the jury to assess whether a "reasonably well-qualified" doctor would have disclosed to Jill the risks of leaving the hospital under the same or similar circumstances. See IPI Civil (2011) No. 105.07.01. We emphasize that "[w]here IPI instructions accurately state the law applicable in a case and adequately charge the jury, they should be used exclusively." *Doe v. University of Chicago Medical Center*, 2014 IL App (1st) 121593, ¶ 80.

¶ 96 A plaintiff is entitled to have the jury instructed on his theory of the case, and the failure to do so may require a new trial. *Ellig v. Delnor Community Hospital*, 237 Ill. App. 3d 396, 405 (1992). A faulty jury instruction does not require reversal unless the error results in serious prejudice to the party's right to a fair trial. *Ramirez v. FCL Builders, Inc.*, 2014 IL App (1st) 123663, ¶ 164. To determine whether a party was prejudiced, we consider whether the

instructions, taken as a whole, were sufficiently clear so as not to mislead the jury. *Ellig*, 237 Ill. App. 3d at 408.

¶ 97 Here, the trial court erred in giving the one-line instruction on informed consent, as it was an inaccurate statement of the applicable law. It did not explain the elements of informed consent, including Dr. Jones's duty to disclose material risks. This resulted in prejudice to plaintiff because it "denied [her] right to have the jury instructed on [her] theory of the case." *Doe*, 2014 IL App (1st) 121593, ¶ 88.

¶ 98 Defendants maintain that a separate informed consent instruction was not applicable because it "contemplates securing informed consent *** in order to perform a test or procedure on a patient," which is different from wanting a patient to stay in the hospital "for further assessment and observation." However, defendants do not cite to any case law for this proposition, and we find none. IPI Civil (2011) No. 105.07.01 states that, in providing medical services, care, or treatment to the patient, the doctor must obtain informed consent, and the notes on use state that, "if the evidence shows that some other factor (i.e., the relative benefits or lack of benefits of alternative treatments) should have been disclosed, then the instruction may be modified accordingly." IPI Civil (2011) No. 105.07.01, Notes on Use. This instruction applies here because plaintiff alleges that, in providing care to Jill, Jones did not disclose that leaving the hospital could result in grave injury or death. Plaintiff contends that, as a result, Jill was not informed of the material risks of leaving the hospital and therefore could not give informed consent prior to being discharged. We therefore disagree with defendants' contention that IPI Civil (2011) No. 105.07.01 should not have been given.

¶ 99 2. IPI Civil (2011) No. 5.01—Failure to Produce Evidence or a Witness

¶ 100 Plaintiff argues that the trial court denied her a right to a fair trial and abused its discretion when it refused to give IPI Civil (2011) No. 5.01 with respect to the results of Jill's blood culture that was ordered when she was coding. She asserts that she established the necessary elements for the court to submit the missing evidence instruction to the jury, including that the results were under Mercy's control, the missing evidence was not equally available to her, Mercy would have produced the report if it was favorable to Mercy, and Mercy did not offer direct evidence to explain why the blood culture results were missing from the medical record.

¶ 101 A missing evidence instruction under IPI Civil (2011) No. 5.01 advises "the jury that, if a party fails to offer evidence that is within its power to produce, the jury may infer that this evidence would be adverse to that party." *Simmons v. Garces*, 198 Ill. 2d 541, 573 (2002). The court may give IPI Civil (2011) No. 5.01 when (1) the evidence was under the control of the party to be charged and could have been produced by reasonable diligence, (2) the evidence was not equally available to both parties, (3) a reasonably prudent person under the same or similar circumstances would have produced the evidence if she believed the testimony was favorable to her, and (4) there was no reasonable excuse for the failure to produce the evidence. *Nassar v. County of Cook*, 333 Ill. App. 3d 289, 298 (2002). Thus, the instruction is warranted only if " 'there was no reasonable excuse for failure to produce the evidence.' " *Simmons*, 198 Ill. 2d at 573 (quoting *Brown v. Moawad*, 211 Ill. App. 3d 516, 531 (1991)). It is within the trial court's discretion to give IPI Civil (2011) No. 5.01, and its decision will not be disturbed absent an abuse of that discretion. *Nassar*, 333 Ill. App. 3d at 298-99.

¶ 102 Here, when the court denied plaintiff's request for IPI Civil (2011) No. 5.01, it stated that there was "evidence to suggest that these tests were ordered" but "no evidence to suggest,—or no firm evidence that they were ever completed." The court explained that "this is not a

situation where he had the cultures drawn and tested and, somehow, someone lost the results, in which case the instruction would be more appropriate." We cannot find that the trial court abused its discretion when it refused plaintiff's request to give IPI Civil (2011) No. 5.01.

¶ 103 There was nothing in the record to show that Mercy possessed the blood culture results and failed to produce them. Rather, Mercy presented evidence that the blood culture order was not completed and, consequently, the blood culture results did not exist. The record showed that, when Jill was suffering multiple codes and the physicians were trying to resuscitate her, Dharanipragada ordered a blood culture. However, defendants presented evidence that this order was never completed, as Citronberg testified that the medical record showed that the blood culture order was discontinued, meaning it was never sent to the laboratory. When the blood culture was ordered, a "whole host" of other orders were also entered, and many of those orders were discontinued. This was not unusual because "all the attention diverts to managing the code and to keeping the patient alive" and "the secondary lab tests *** take a back seat to the more urgent ones." In fact, during argument on the instruction, plaintiff's counsel acknowledged that the order was never completed, as she stated, "[a]ll we know is that these were ordered and never done." Accordingly, the record shows that Mercy had a reasonable excuse for failing to produce the blood culture results, as the blood culture order was never completed and, consequently, the results did not exist.

¶ 104 Further, the record shows that Dharanipragada, who ordered the blood culture, was deposed. Plaintiff does not argue on appeal, and there is nothing in the record to show, that she was not equally available to plaintiff to call as a witness at trial. In addition, Mercy's lab employees, Ruth Cryer and Dean Christ, were also deposed before trial. There is nothing in the record to show that the deposition transcripts were not equally available to plaintiff.

¶ 105 Plaintiff was also not unfairly prejudiced because the court expressly stated that it would allow the parties to argue the evidence and whatever reasonable inferences one can conclude from the evidence. See *Simmons*, 198 Ill. 2d at 574 (concluding that court did not abuse its discretion when it refused Illinois Pattern Jury Instructions, Civil, No. 5.01 (3d ed. 1995) and noting that the plaintiffs "were not unfairly prejudiced, particularly in light of the fact that the court, while refusing the instruction, nevertheless allowed plaintiffs to argue whatever inferences they felt the jury should draw from defendant's failure to produce the record"). Accordingly, we cannot find that the trial court abused its discretion when it refused plaintiff's request to give the jury the instruction on missing evidence.

¶ 106 B. Nonpattern Jury Instruction on Loss of Chance Doctrine

¶ 107 Plaintiff argues that the trial court denied her a right to a fair trial and abused its discretion when it refused to give her nonpattern jury instruction on the loss of chance doctrine. She argues she presented some evidence on every essential element of the doctrine.

¶ 108 We conclude that plaintiff was denied a fair trial when the trial court refused her instruction on the loss of chance. As previously discussed, "[a] party has a right to have the jury instructed on his or her theory of the case if the facts in evidence or a reasonable inference from those facts supports the theory." *Tsoukas*, 315 Ill. App. 3d at 377. Plaintiff presented sufficient evidence to support her loss of chance theory of recovery. Under the loss of chance theory, a plaintiff may establish proximate cause "when the evidence presented shows to a reasonable certainty that defendant's negligent delay in diagnosis or treatment lessened the effectiveness of the treatment." *Sinclair v. Berlin*, 325 Ill. App. 3d 458, 465-65 (2001). A plaintiff establishes a *prime facie* case when she presents "some" evidence on every essential element. *Hemminger v. LeMay*, 2014 IL App (3d) 120392, ¶ 17.

¶ 109 Here, plaintiff submitted sufficient evidence to support her theory that defendants Heinrich, Jones, Connolly, and Arwindekar's negligent delay in diagnosis or treatment lessened the effectiveness of Jill's treatment. Plaintiff's experts testified that Jill's history, symptoms, and certain test and laboratory findings in the emergency room were consistent with toxic shock syndrome and sepsis, which ultimately caused her death. However, defendants Heinrich, Jones, and Arwindekar diagnosed Jill with viral gastroenteritis, not sepsis, during her first two admissions in the emergency room.

¶ 110 D'Ambrosio testified that Heinrich and Jones should have suspected that Jill had an infection when Jill's symptoms did not improve after she received two liters of fluids. He testified that Jones and Heinrich should have ordered additional testing to look for sepsis. Jones acknowledged that he suspected sepsis could be one of the "main possibilities" but that he did not order additional testing for sepsis, inform Jill, or document this suspicion in the record. D'Ambrosio testified that Arwindekar should have taken note that the CT results showed fluid in her lungs, as that could indicate an infection, and that he should have ordered a sepsis workup. Further, plaintiff's experts testified that a tampon caused Jill's infection, which was identified as the "heterogeneous density" in the CT report. Arwindekar had the CT finding during the time he cared for Jill, and he did not take any measures to determine whether a tampon was present. D'Ambrosio testified that the standard of care required Arwindekar to admit Jill to a higher level of intensive care unit rather than the observation unit. D'Ambrosio testified that Connolly, as the physician in triage, should have ordered additional testing and should have sent Jill quickly back to the main emergency room. Jill waited in the waiting room for four hours before she was sent back to the main emergency department.

¶ 111 Plaintiff's experts testified that a patient has a better outcome if sepsis is treated early with antibiotics. Dr. Noto, who testified that his opinions were made with a reasonable degree of medical certainty, specifically testified that each hour of delay from the time a patient presents with sepsis to the time she receives antibiotics increases the risk of death by about 7%. He testified that Jill's risk of dying increased when the physicians did not diagnose her with sepsis or administer an early treatment of antibiotics. Drs. Hudson and Jacob, who also testified that their opinions were made with a reasonable degree of medical certainty, both specifically testified that, if Jill had received the proper course of treatment, it was more probably true than not that she would have survived. Accordingly, plaintiff submitted sufficient evidence to support her loss of chance theory as it relates to her case against Heinrich, Jones, Connolly, Arwindekar, and EMP. However, plaintiff does not argue on appeal, and the record does not support, that she offered sufficient evidence to support her loss of chance theory against Anderson.

¶ 112 Plaintiff requested the court to submit a nonpattern jury instruction on the loss of chance, which stated as follows:

> "If you decide or if you find that plaintiff has proven that a negligent delay in the diagnosis and treatment of sepsis in Jill Milton-Hampton lessened the effectiveness of the medical services which she received, you may consider such delay one of the proximate causes of her claimed injuries or death."

We find that this instruction met the criteria for a nonpattern instruction, as it was simple, brief, impartial, and free from argument. See Ill. S. Ct. R. 239(a) (eff. Apr. 8, 2013). Thus, the trial court should have permitted plaintiff to submit her nonpattern jury instruction on the loss of chance, which would have required the jury to consider whether a negligent delay in the diagnosis and treatment of sepsis in Jill lessened the effectiveness of the medical services that

she received and was one of the proximate causes of her death. However, the court denied her request and only gave the long-form proximate causation instruction based on IPI Civil (2011) No. 15.01, which stated as follows:

> "When I use the expression 'proximate cause,' I mean a cause that, in the natural or ordinary course of events, produced the plaintiffs [*sic*] injury. It need not be the only cause, nor the last or nearest cause. It is sufficient if it combines with another cause resulting in the injury."

We find that plaintiff was denied a fair trial when the court refused her instruction on loss of chance and only gave IPI Civil (2011) No. 15.01.

¶ 113 In reaching our conclusion, we recognize this court's previous opinion in *Cetera v. DiFilippo*, 404 Ill. App. 3d 20 (2010). There, the trial court, as here, instructed the jury on proximate causation using Illinois Pattern Jury Instructions, Civil, No. 15.01 (3d ed. 1989) (hereinafter IPI Civil 3d) and refused the plaintiff's nonpattern jury instruction based on the loss of chance. *Cetera*, 404 Ill. App. 3d at 45. This court found that the trial court did not err, stating that this court has consistently affirmed a trial court's refusal to give a nonpattern jury instruction on the loss of chance because the proximate cause instruction provided in IPI Civil 3d No. 15.01 "properly states the law in lost chance medical malpractice cases." *Cetera*, 404 Ill. App. 3d at 45 (citing *Sinclair v. Berlin*, 325 Ill. App. 3d 458 (2001); *Lambie v. Schneider*, 305 Ill. App. 3d 421 (1999); *Henry v. McKechnie*, 298 Ill. App. 3d 268 (1998)). In finding no error, this court concluded that it found no reason to depart from our previous determinations. *Id.* We disagree.

¶ 114 Our supreme court has stated that, "[t]o the extent a plaintiff's chance of recovery or survival is lessened by the malpractice, he or she should be able to present evidence to a jury that the defendant's malpractice, to a reasonable degree of medical certainty, proximately caused the

increased risk of harm or lost chance of recovery." *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 119 (1997). Thus, under *Holton*, a plaintiff may submit evidence and recover on a loss of chance theory. However, the Illinois Pattern Jury Instructions do not provide an instruction on the loss of chance doctrine. If we continue to follow *Cetera* and the cases that have found no error where a trial court gives IPI Civil (2011) No. 15.01 and refuses to give a nonpattern instruction on the loss of chance, a plaintiff may never be able to submit an instruction explaining a loss of chance theory to the jury. As laypersons, juries "are not trained to separate issues and to disregard irrelevant matters. That is the purpose of jury instructions." *Dillon*, 199 Ill. 2d at 507. Thus, when a trial court refuses a loss of chance instruction, the jury is forced to understand a plaintiff's loss of chance theory argued at trial without an instruction to guide them on the law and how it should be applied to the general proximate causation concept described in IPI Civil (2011) No. 15.01. See *Dillon*, 199 Ill. 2d at 507 ("[t]he function of jury instructions is to convey to the jury the correct principles of law applicable to the submitted evidence"). Further, while a plaintiff may argue a loss of chance theory during argument, as here, the jury is instructed that arguments are not evidence, and therefore, the jury may not consider the theory when it considers the general proximate cause instruction in IPI Civil (2011) No. 15.01. However, if the trial court properly instructs the jury about the loss of chance theory, the theory will be properly before the jury, and the jury will likely give it more consideration.

¶ 115 We recognize that this court has previously held that the loss of chance theory is encompassed in the long form proximate cause instruction in IPI Civil (2011) No. 15.01, which was given here. However, "jury instructions must state the law fairly and *distinctly* and must not mislead the jury or prejudice a party." (Emphasis in original.) *Dillon*, 199 Ill. 2d at 507. The proximate cause instruction in IPI Civil (2011) No. 15.01 provides that the cause "need not be

the only cause, nor the last or nearest cause" but does not distinctly inform the jury about loss of chance, *i.e.*, that the jury may consider, as a proximate cause of a patient's injury, that a defendant's negligence lessened the effectiveness of the treatment or increased the risk of an unfavorable outcome to a plaintiff (see *Hemminger*, 2014 IL App (3d) 120392, ¶ 16 (loss of chance in medical malpractice is where the malpractice lessened the effectiveness of treatment or increased the risk of an unfavorable outcome)).

¶ 116 Accordingly, because plaintiff submitted sufficient evidence to support her loss of chance theory and because she was entitled to have the jury instructed on her theory of the case, she was denied a fair trial when the court refused her instruction on loss of chance. Thus, we reverse and remand the case for a new trial against Jones, Heinrich, Connolly, Arwindekar, and EMP.

¶ 117 We note that plaintiff asserts in her reply brief that EMP "waived any arguments on this issue" because it did not object to plaintiff's proposed loss of chance instruction at the jury instructions conference. Generally, "[i]ssues not raised at trial are waived and cannot be argued for the first time on appeal." *Amalgamated Bank of Chicago v. Kalmus & Associates, Inc.*, 318 Ill. App. 3d 648, 658 (2000). However, this rule does not apply to defendants because an "[appellee] may raise for the first time on appeal any legal issue to defend her judgment for which there was a factual basis in the trial court." *Tuftee v. County of Kane*, 76 Ill. App. 3d 128, 134 (1979).

¶ 118 C. Dr. Reingold's Testimony

¶ 119 Plaintiff asserts that the trial court erred when it allowed Reingold to testify as an expert because he was unqualified to testify about his opinion on the medical diagnosis, clinical condition, treatment of Jill, or conditions of Jill's heart on the postmortem exam. She asserts that,

when the court allowed Reingold to testify and denied her motion *in limine* on this issue, it prejudiced her and resulted in an unfair trial.

¶ 120 Defendants assert that plaintiff forfeited her argument that she was denied a fair trial when the court denied her motion *in limine* and allowed Reingold to testify because she did preserve the issue by objecting at trial. "A ruling on a motion *in limine* is a determination addressing an admissibility of evidence issue likely to arise at trial and is subject to reconsideration." *Sullivan-Coughlin v. Palos Country Club, Inc.*, 349 Ill. App. 3d 553, 561 (2004). "Whether granted or denied, a motion *in limine* itself does not preserve the issue for appellate review." *Id.* Rather, to preserve the issue for review, a party must object to the evidence at trial (*Schuler v. Mid-Central Cardiology*, 313 Ill. App. 3d 326, 333 (2000)) or make an offer of proof (*Sullivan-Coughlin*, 349 Ill. App. 3d at 561).

¶ 121 Here, plaintiff did not object to Reingold's testimony at trial when defendants called him as a witness. Plaintiff does not argue on appeal that she properly preserved her argument by objecting to Reingold's testimony at trial. We therefore find that plaintiff forfeited her argument that the court denied her a fair trial when it allowed Reingold to testify.

¶ 122 Nevertheless, even if we would find that plaintiff did not forfeit her argument, we would find that the trial court did not abuse its discretion. An individual is permitted "to testify as an expert if his experience and qualifications afford him knowledge that is not common to laypersons and where such testimony will aid the trier of fact in reaching its conclusions." *Unitrin Preferred Insurance Co. v. Dobra*, 2013 IL App (1st) 121364, ¶ 20. " 'There is no predetermined formula for how an expert acquires specialized knowledge or experience and the expert can gain such through practical experience, scientific study, education, training or research.' " *Thompson v. Gordon*, 221 Ill. 2d 414, 428-29 (2006) (quoting *People v. Miller*, 173

Ill. 2d 167, 186 (1996)). "An expert need only have knowledge and experience beyond that of an average citizen." *Id.* at 429. A trial court's ruling on a motion *in limine* and its decision to admit expert testimony are both reviewed under the abuse of discretion standard. *Davis v. Kraff*, 405 Ill. App. 3d 20, 28 (2010). The abuse of discretion standard is the most deferential standard of review and occurs when no reasonable person would agree with its decision. *Id.*

¶ 123 Here, Reingold testified as an expert on toxic shock syndrome and opined whether Jill met the criteria for the disease. With respect to Reingold's expertise and qualifications, Reingold testified that, following his medical training, he joined the CDC's task force on toxic shock syndrome in 1980, which was created as a response to the increase in toxic shock syndrome in the 1970s and 1980s. In this role, he studied the disease and reviewed between 5000 and 10000 medical records to determine whether the patients fit the CDC's definition for toxic shock syndrome. He authored about two dozen articles on toxic shock syndrome and had studied infectious diseases for 38 years. Accordingly, we find there was sufficient evidence to support that Reingold had sufficient experience and knowledge to testify about toxic shock syndrome and that his testimony helped aid the jury in understanding the disease and symptoms.

¶ 124 Further, plaintiff's counsel cross-examined Reingold on the weaknesses in his experience, qualifications, sincerity, and soundness of opinion. See *Karn v. Aspen Commercial Painting, Inc.*, 2019 IL App (1st) 173194, ¶ 16 ("On cross-examination, counsel may probe an expert witness's qualifications, experience and sincerity, the weaknesses in the basis of his opinions, the sufficiency of his assumptions, and the general soundness of his opinion."). Thus, the jury heard about any weaknesses or insufficiencies in his qualifications and had the opportunity to assign weight to his testimony. See *id.* ¶ 21 ("The weight to be assigned to an expert opinion is for the jury to determine in light of the expert's credentials and the factual basis

of his or her opinion."). Accordingly, we cannot find that the trial court abused its discretion when it permitted Reingold to testify.

¶ 125 D. Defendants' Demonstrative Exhibit

¶ 126 Plaintiff argues that the trial court erred when it allowed Mercy to use a demonstrative exhibit to the jury during the testimony of one of its experts, Dr. Schaer. She asserts that the exhibit showed an individual contracting an airborne disease from another individual and that there was no testimony or evidence presented that Jill contracted her illness from an airborne contaminant.

¶ 127 Defendants assert that plaintiff forfeited her argument because she failed to timely object to the exhibit at trial. As previously discussed, the trial court's "denial of a motion *in limine* does not preserve an objection to disputed evidence later introduced at trial." *Grauer v. Clare Oaks*, 2019 IL App (1st) 180835, ¶ 95. To preserve an argument for review, the party asserting the objection must object contemporaneously when the evidence is offered at trial. *Id.* Although the party need not repeat an objection each time similar evidence is offered at trial, the party must object to the evidence the first time it is introduced. *Id.*

¶ 128 Here, the record shows that, during a conference on April 29, 2018, the parties discussed plaintiff's objections with certain demonstrative exhibits, including the exhibit at issue. However, during Schaer's testimony on May 1, 2018, plaintiff did not object when Mercy's counsel introduced the exhibit. Therefore, because plaintiff did not object contemporaneously when defendants offered the exhibit at trial, she failed to properly preserve her objection.

¶ 129 Nevertheless, even if we would find that plaintiff did not forfeit her objection, we would find that the trial court did not abuse its discretion when it allowed Schaer to testify about the demonstrative exhibit. Demonstrative evidence serves as a visual aid to the jury in

comprehending the verbal testimony of a witness. *Cisarik v. Palos Community Hospital*, 144 Ill. 2d 339, 341 (1991). Demonstrative evidence is looked upon favorably by the courts because it allows the fact finder "to have the best possible understanding of the matters before it." *Sharbono v. Hilborn*, 2014 IL App (3d) 120597, ¶ 30. "The primary considerations in determining whether demonstrative evidence is admissible or may be used at trial are relevancy and fairness." *Yanello v. Park Family Dental*, 2017 IL App (3d) 140926, ¶ 31.

¶ 130 With respect to relevancy, the evidence " 'must actually be used to illustrate or explain the verbal testimony of a witness as to a matter that is relevant.' " *Id.* With respect to fairness, demonstrative evidence may still be excluded if " 'its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.' " *Id.* (quoting Ill. R. Evid. 403 (eff. Jan. 1, 2011)). The admission of an exhibit as demonstrative evidence is within the sound discretion of the trial court. *Kayman v. Rasheed*, 2015 IL App (1st) 132631, ¶ 66. A trial court abuses its discretion when the ruling is arbitrary, fanciful, or unreasonable or when no reasonable person would take the same view. *Id.*

¶ 131 Schaer testified that it was his opinion that Jill had a severe viral infection. He testified the virus caused nausea, vomiting, and diarrhea and ultimately injured her heart and caused fulminant myocarditis. During his testimony, Mercy's counsel used the demonstrative exhibit, which showed a diagram of how a virus can be transmitted from one individual to another individual through the air, causing the individual to experience flu-like symptoms, after which the virus attacks the GI system and then the heart. Schaer explained the exhibit:

> "we have a patient who has a viral infection and many viruses spread from person to person via aerosol droplets. *** I believe that this unfortunate woman caught this viral

> infection, which initially presented with some flu-like symptoms *** and then began to also present most notably with severe abdominal pain, nausea, vomiting and diarrhea. So the virus initially involves some of the lungs *** and then the GI tract. *** Then the process that led to her heart's injury and ultimately to her death."

Thus, Schaer used the exhibit to explain his opinion that Jill caught a viral infection that attacked her GI tract and then damaged her heart, which caused death due to viral myocarditis. Accordingly, we cannot find that trial court's decision to allow Schaer to testify about the demonstrative exhibit was so arbitrary or unreasonable such that no reasonable person would agree with its decision. Thus, the trial court did not abuse its discretion.

¶ 132 E. Jury's Verdict

¶ 133 Plaintiff lastly argues that the jury's verdict was against the manifest weight of the evidence. She argues that she had a right to have the jury instructed on the issues presented and principles of law to be applied and that the court denied her this right.

¶ 134 Having found reversible error with respect to the informed consent and loss of chance jury instruction issues, which relate to Jones, Heinrich, Connolly, Arwindekar, and EMP, we are remanding the case for a new trial against these defendants. Therefore, we need not address plaintiff's argument that the jury verdict against these defendants was against the manifest weight of the evidence.

¶ 135 Further, plaintiff only argues that the jury's verdict was against the manifest weight of the evidence because the court denied her the right to have jury instructions submitted on the issues presented and the law to be applied. Given our disposition that the jury instruction issues plaintiff raised do not relate to Anderson or Mercy, we cannot find that the jury's verdict finding

against plaintiff and in favor of Anderson and Mercy was against the manifest weight of the evidence. Thus, we affirm the verdict in favor of Anderson and Mercy.

¶ 136 III. CONCLUSION

¶ 137 The trial court erred when it refused to give plaintiff's proposed instruction on informed consent based on IPI Civil (2011) No. 105.07.01 and when it refused to give plaintiff's nonpattern instruction on the loss of chance doctrine. We reverse the jury's verdict finding against plaintiff and in favor of defendants Brett Jones, Scott Heinrich, Amit Arwindekar, Helene Connolly, and Emergency Medicine Physicians of Chicago, and remand for a new trial with respect to these defendants. We affirm the jury's verdict finding in favor of defendant Tara Anderson and Mercy Hospital and Medical Center and against plaintiff.

¶ 138 Affirmed in part and reversed and remanded in part.

No. 1-18-2702

Cite as:	*Bailey v. Mercy Hospital & Medical Center*, 2020 IL App (1st) 182702
Decision Under Review:	Appeal from the Circuit Court of Cook County, No. 2013-L-8501; the Hon. Thomas V. Lyons II, Judge, presiding.
Attorneys for Appellant:	Vivian Tarver-Varnado, of AMB Law Group, LLC, and Robert Allen Strelecky, both of Chicago, for appellant.
Attorneys for Appellee:	Patricia S. Kocour, Catherine Basque Weiler, and Elizabeth Bruer, of Swanson Martin & Bell, LLP, of Chicago, for appellees Mercy Hospital & Medical Center and Tara Anderson. Michael T. Walsh and Nicholas J. Alsaka, of Kitch, Drutchas, Wagner, Valittuti & Sherbrook, of Chicago, for other appellees.

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

JILL M. BAILEY, as Independent Representative of the Estate of JILL M. MILTON-HAMPTON, Deceased, and JILL M. BAILEY, Individually,	)	
Plaintiff,	)	
v.	)	No. 2013 L 008501
MERCY HOSPITAL AND MEDICAL CENTER, an Illinois Corporation, *et al*.	)	The Honorable Thomas V. Lyons, II Judge Presiding

NOTICE OF APPEAL

Notice is hereby given that Plaintiff-appellant, Jill M. Bailey, hereby appeal to the Illinois Appellate Court, First District from (1) the May 3, 2018, judgment on the jury's verdict in favor of Defendants, Mercy Hospital and Medical Center, Tara Anderson, RN, Scott Heinrich, M.D., Brett Jones, M.D., Helene Connolly, M.D., Amit Arwindekar, M.D. and Emergency Medicine Physicians of Chicago, LLC and against Jill M. Bailey (Exhibit "A"); and (2) the November 27, 2018 order denying Jill M. Bailey's post-trial motion (Exhibit "B").

By this appeal, Plaintiff-appellant, Jill M. Bailey will ask the Court for the following relief:

1. To set aside and vacate the jury' verdict and judgment dated May 3, 2018 in favor of Defendants, Mercy Hospital and Medical Center, Tara Anderson, RN, Scott Heinrich, M.D., Brett Jones, M.D., Helene Connolly, M.D., Amit Arwindekar, M.D. and Emergency Medicine Physicians of Chicago, LLC, and against plaintiff-appellee.

2. Alternatively, to set aside the jury's verdict and the judgment thereon and to grant Jill

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APPEAL TO THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT
FROM THE CIRCUIT COURT OF THE COOK JUDICIAL CIRCUIT
COOK COUNTY, ILLINOIS

JILL M. BAILEY, ET AL.
Plaintiff/Petitioner

Reviewing Court No: 1-18-2702
Circuit Court No: 2013L008501
Trial Judge: THOMAS V. LYONS,II.

v.

MERCY HOSPITAL AND MEDICAL CENTER, ET AL.
Defendant/Respondent

E-FILED
Transaction ID: 1-18-2702
File Date: 4/12/2019 1:39 PM
Thomas D. Palella
Clerk of the Appellate Court
APPELLATE COURT 1ST DISTRICT

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Plaintiff's Proposed Jury Instruction #8:

If you decide or if you find that the plaintiff has proven that a negligent delay in the diagnosis and treatment of sepsis in Jill Milton-Hampton lessened the effectiveness of the medical services which she received, you may consider such delay one of the proximate causes of her claimed injuries and death.

(Non-IPI (Holton v. Memorial Hospital, 176 Ill.2d 95 (1997); Hajian v. Holy Family Hospital, 273 Ill.3d 932 (1st. Dist. 1995); Dillion v. Evanston Hospital, 199 Ill.2d 483 (2002).

D OBJ.

Given ___
Given as Modified ___
Refused ✓
Withdrawn ___

7

Plaintiff's Proposed Jury Instruction #11:

The plaintiff claims that the defendant, Brett Jones, M.D. failed to inform Jill Milton-Hampton of the risks associated with pulmonary embolism, gastrointestinal bleed, infection and sepsis prior to being discharged the morning of March 17, 2012, which a reasonably careful emergency medicine physician would have disclosed under the same or similar circumstances;

The plaintiff further claims that if the defendant had disclosed those risks, a reasonable person in Jill Milton-Hampton's position would not have left the hospital the morning of March 17, 2012; and

The plaintiff further claims that Jill Milton-Hampton was injured, and that the defendant's failure to disclose the aforementioned risks was a proximate cause of her injury.

The defendant denies that he failed to inform the plaintiff of those risks which a reasonable careful emergency medicine physician would have disclosed under the same or similar circumstances; denies that Jill Milton-Hampton was injured and denies any failure to disclose risks was a proximate cause of any harm or injury.

Source: IPI Civil No. 105.07 (c)

D OBJ.

Given ___
Given as Modified ___
Refused ✓
Withdrawn ___