2024 IL App (4th) 230893-U

NO. 4-23-0893

IN THE APPELLATE COURT

OF ILLINOIS

FOURTH DISTRICT

FILED
December 27, 2024
Carla Bender
4th District Appellate
Court, IL

KIRK GULLIKSON, Individually and as Independent Administrator of the Estate of Sheila Gullikson, Deceased, Plaintiff-Appellee, v. WILLIAM MINORE, M.D.; HOWARD WEISS, M.D.; MEDICAL PAIN MANAGEMENT SERVICES, LTD.; and DANIEL GREEN, DNP, NP-C, Defendants-Appellants.	)	Appeal from the Circuit Court of Winnebago County No. 20L235 Honorable Ronald Anthony Barch, Judge Presiding.

JUSTICE LANNERD delivered the judgment of the court.
Justices Steigmann and Grischow concurred in the judgment.

ORDER

¶ 1 *Held*: The appellate court affirmed, concluding (1) defendants were not entitled to a judgment notwithstanding the verdict, (2) the jury's verdict was not against the manifest weight of the evidence, and (3) defendants were not prejudiced by plaintiff's counsel's comments during closing arguments or plaintiff's children's improper financial testimony.

¶ 2 Defendants (William Minore, M.D. (Dr. Minore); Howard Weiss, M.D. (Dr. Weiss); Medical Pain Management Services, Ltd. (MPMS); and Daniel Green, DNP, NP-C (NP Green)) appeal from a Winnebago County jury verdict entered in favor of plaintiff, Kirk Gullikson, individually and as independent administrator of the Estate of Sheila Gullikson. At trial, the jury found defendants liable for medical negligence connected to their treatment of Sheila and awarded plaintiff $4 million in damages.

¶ 3 On appeal, defendants present three arguments. First, defendants contend NP Green and MPMS are entitled to a judgment notwithstanding the verdict (judgment *n.o.v.*). Next, defendants argue the jury's verdict was against the manifest weight of the evidence and they are therefore entitled to a new trial. Finally, defendants argue they are entitled to a new trial because plaintiff's counsel's comments during closing arguments and plaintiff's children's testimony regarding finances both violated the trial court's *in limine* orders and were unfairly prejudicial to defendants. Plaintiff responds no errors occurred, defendants NP Green and MPMS are not entitled to judgment *n.o.v.*, and neither plaintiff's counsel's comments during closing arguments nor plaintiff's children's testimony were so prejudicial as to warrant a new trial.

¶ 4 We affirm.

¶ 5 I. BACKGROUND

¶ 6 A. Sheila Gullikson's Care

¶ 7 The present litigation arises from the medical treatment and lack of treatment Sheila received from defendants. A timeline of the uncontested facts leading to the litigation follows.

¶ 8 Dr. Minore and MPMS began treating Sheila for pain management in July 2012. Dr. Minore diagnosed her with complex regional pain syndrome in her right arm and hand. She remained under Dr. Minore's and MPMS's care for years due to various issues related to her complex regional pain syndrome and pain associated with various subsequent injuries to her foot, groin, and knee. Over time, Sheila also developed arthritis of the bones in her spine and degenerative disc disease.

¶ 9 To address her chronic pain, Sheila received several treatments and had been prescribed a variety of medications, including significant quantities of oral opioids. However, Sheila still suffered from severe pain that negatively impacted her daily activities.

¶ 10 Following discussions and testing, on February 14, 2019, Dr. Minore implanted an intrathecal pump into Sheila, who was 51 years old. The intrathecal pump is a medical device which, following insertion, delivers pain medication directly to the patient's cerebrospinal fluid (CSF). The procedure involved puncturing her lumbar dura and inserting a catheter into her CSF. The goal of the procedure was to more efficiently and directly administer Sheila's pain medication to reduce overall dosage and alleviate side effects associated with higher doses of opioids. During the procedure, Dr. Minore made an inch incision in Sheila's lower back over the spine, inserted a needle through layers of tissue and into the spinal canal, threaded the catheter through the needle into the spinal canal, then removed the components of the needle. Dr. Minore reported that the incision was "atraumatic," meaning there was no presence of blood cells following the puncture of the dural sac. Dr. Minore applied Dermabond, Steri-Strips, and wound dressings to protect the incision.

¶ 11 Over the course of the next several weeks, Sheila reported to her treatment team she was experiencing excessive drainage from her back incision. At Sheila's February 19, 2019, follow-up appointment with Dr. Minore, Dr. Minore noted minimal drainage to the posterior dressing (*i.e.*, the back incision) and no erythema or tenderness, and he observed symptoms consistent with opioid withdrawal, such as excessive sweating. Dr. Minore recommended a four-week follow-up appointment unless she experienced significant drainage, chills, fever, or a pus-like symptom oozing from the wound.

¶ 12 Sheila returned to MPMS on February 21, 2019, where NP Green examined her. NP Green began working as a registered nurse (RN) in 2006 and earned his doctorate in nursing in August 2016. MPMS hired NP Green in May 2016, where he began as an RN before transitioning to an NP position upon completing his degree. During the February 21, 2019,

appointment, Sheila informed NP Green her "wounds" were open, although the Steri-Strips remained in place. She also reported "straw colored drainage" from her back incision the previous day. NP Green found no active drainage and normal approximation (*i.e.*, the process of bringing together the edges of a wound to help it heal) of the back incision, except for one corner. Sheila told NP Green she was experiencing sweating, nausea, headaches, and dizziness. NP Green found the symptoms to be consistent with opiate withdrawal and instructed her to follow up in four weeks. NP Green did not inform his supervising physician that day, Dr. Kothawala, of Sheila's worsening condition.

¶ 13 On February 28, 2019, Sheila saw NP Green at MPMS after reporting that her back incision drained enough to saturate through her top. NP Green examined Sheila and observed that her back incision had dehisced—meaning the previously approximated wound edges had separated—leading to Sheila's catheter being visible inside the incision. NP Green referred her to Dr. Weiss. The visibility of the catheter inside the incision concerned Dr. Weiss due to the possible risk of infection and meningitis. Sheila was then admitted to OSF Saint Anthony Medical Center. Upon being admitted, Sheila was seen by Dr. Allan Ong, whose notes indicated as follows:

> "She does have on and off headaches ***. History actually started 2 weeks prior to admission, when she underwent pain pump placement ***. Postprocedure, apparently she had some CSF leakage. She has continued to have off and on leakage from the surgical site ever since the surgery. On occasion, it would stop, but after repositioning, she states that the drainage would just be copious again."

¶ 14 Dr. Weiss noted Sheila's post-operative progress had been complicated by serous drainage suggestive of a possible CSF leak in the days immediately after the procedure. Because Sheila reported feeling "normal," Dr. Weiss did not suspect a CSF leak. Specifically, Sheila had

not reported experiencing positional headaches, which are severe headaches that tend to worsen while sitting or standing. Positional headaches are a key symptom of a CSF leak. Dr. Weiss concluded most of any fluid leaking from the wound was interstitial fluid (ISF)—*i.e.*, fluid found in spaces around cells—and not CSF.

¶ 15 The next day, Dr. Weiss performed Sheila's catheter removal surgery. Generally, with conservative therapy following this type of surgery, the patient's dura will fully heal within a few weeks, which was Dr. Weiss's expectation for Sheila. To encourage the entire wound to heal, Dr. Weiss elected to apply a wound vacuum ("wound vac"), a device placed on top of a wound to remove fluid and help the wound dry, facilitating healing and closure. A sponge is first placed over the wound, and the wound vac is placed atop the sponge. As fluid soaks into the sponge, it is then extracted by the vacuum. Dr. Weiss expected it would pull out ISF.

¶ 16 Following application of the wound vac, the cannister to which it was connected filled with fluid and, by the morning of March 3, 2019, it stopped working. Dr. Weiss elected to remove the wound vac and instead work with the hospital's wound service regarding a more effective dressing. Sheila was discharged and returned home March 5, 2019.

¶ 17 The next day, Sheila continued to experience headaches, and her home health care nurse contacted MPMS to address them. Sheila was prescribed Toradol, an anti-inflammatory, and was advised to continue bed rest and to consume fluids and caffeinated beverages. Sheila's home health care nurse again contacted MPMS the following day regarding Sheila's pain. The home health care nurse inquired with NP Green about a "blood patch," a procedure in which a physician draws the patient's blood then injects it into the epidural space in an attempt at forcing the blood to clot over and plug any dural leak. NP Green communicated the request to Dr. Weiss, who advised a blood patch would not be a proper course of treatment in this case due to the risk of

infection. The same discussion occurred again the next day, and NP Green refilled the Toradol prescription. During Sheila's next in-person evaluation on March 14, 2019, NP Green noted Sheila's worsening headaches and ongoing drainage from the back incision. NP Green did not participate in Sheila's care after that date.

¶ 18 Dr. Minore evaluated Sheila on March 19, 2019, and March 26, 2019. At the first visit, Dr. Minore noted Sheila may have an internal, not external, CSF leak. However, he recommended continuing the conservative treatment plan, expecting it would resolve on its own within a few weeks. At the second appointment, Sheila again reported worsening headaches and drainage from the back incision. She also reported tenderness in her neck, but Dr. Minore noted no focal deficit or photophobia. At this point, Dr. Minore referred Sheila to a neurosurgeon, Dr. Todd Alexander, for consult. Dr. Minore did not believe Sheila's condition was deteriorating, but he suspected she still had CSF draining internally from the dural puncture where the catheter had been removed.

¶ 19 On April 1, 2019, Sheila went to the OSF Saint Anthony Medical Center emergency department. Sheila had fallen while walking up the stairs and hit her head. The treating physician noted Sheila's back incision appeared to be healing normally with no evidence of infection, pus, or CSF. Sheila was discharged after computerized tomography (CT) scans of her brain appeared normal.

¶ 20 On April 3, 2019, Dr. Alexander's nurse practitioner visited Sheila and noted no active drainage on her wound dressing. Dr. Alexander also evaluated Sheila, and two days later, he performed a lumbar diversion drain procedure to alleviate her symptoms. The procedure involved inserting a needle between the lumbar 5 and sacral 1 vertebrae, securing a catheter above the lumbar 2 and lumbar 3 vertebrae into a small hole, which then diverts the flow of fluid from

the dura, decompresses the opening of the dura, and allows the wound to heal. Dr. Alexander noted that upon inserting the needle, there was a "brisk return of clear spinal fluid."

¶ 21 At some point between April 1 and April 7, 2019, Sheila developed a blood clot in her transverse venous sinus in her brain. On April 8, 2019, Sheila died after the clot caused a large right brain stroke.

¶ 22 B. Complaint

¶ 23 On June 30, 2020, plaintiff filed a 10-count complaint against Drs. Minore, Weiss, and Alexander; MPMS; and Rockford Orthopedic Associates Ltd. NP Green was named a respondent in discovery, along with Dr. Leslie P. Edgecomb, with plaintiff asserting wrongful death and survival claims. In January 2021, plaintiff filed an amended complaint adding NP Green as a defendant. In September 2021, plaintiff voluntarily dismissed the claims against Dr. Alexander and Rockford Orthopedic Associates. We therefore discuss only those portions of the amended complaint on which the parties proceeded to a jury trial in May 2023.

¶ 24 In count I of the amended complaint, plaintiff alleged Dr. Minore caused Sheila to suffer a dural tear when he performed the intrathecal pump procedure. Specifically, plaintiff alleged Dr. Minore caused significant damage to the dura while implanting her intrathecal pump on February 14, 2019; caused a CSF leak; failed to take appropriate steps to investigate a post-operative CSF leak; failed to take appropriate steps for the timely diagnosis and treatment of her CSF leak; failed to promptly refer Sheila to a neurosurgeon for treatment; failed to communicate to Dr. Alexander that OSF Saint Anthony Medical Center was the location of her treatment; and/or was otherwise negligent. The complaint claimed, as a direct and proximate result of the deviations from the standard of care, Sheila suffered serious injuries that ultimately resulted in her death.

¶ 25 In count II, plaintiff alleged Dr. Weiss failed to take appropriate steps to investigate Sheila's post-operative CSF leak; failed to take appropriate steps for the timely diagnosis and treatment of Sheila's post-operative CSF leak; failed to promptly refer Sheila to a neurosurgeon for treatment of her post-operative CSF leak; and/or was otherwise negligent. Plaintiff again alleged this negligence caused serious injuries to Sheila, resulting in her death.

¶ 26 In count III, plaintiff alleged NP Green failed to communicate (1) Sheila's abnormal post-operative complications to Dr. Minore; (2) Sheila's abnormal post-operative complications to any physician on February 21, 2019; and (3) Sheila's abnormal post-operative complications to any physician on March 14, 2019. Plaintiff also alleged NP Green failed to take appropriate steps for the timely diagnosis and treatment of Sheila's post-operative CSF leak and/or was otherwise negligent.

¶ 27 In count IV, plaintiff alleged MPMS, by and through its agents and employees, was negligent based on facts set forth *supra* ¶¶ 24, 26, under a theory of vicarious liability.

¶ 28 Count V alleged institutional negligence against MPMS. Specifically, plaintiff alleged MPMS failed to (1) appropriately train NP Green to recognize signs and symptoms of a CSF leak, (2) appropriately train NP Green to notify the patient's surgeon about abnormal post-operative complications, (3) properly review and supervise NP Green's care and treatment of Sheila, and (4) develop or comply with internal policies.

¶ 29 In counts VIII to XII, plaintiff alleged mirror image survival claims against Dr. Minore, Dr. Weiss, NP Green, and MPMS (vicarious liability and institutional negligence), respectively.

¶ 30 C. Jury Trial

¶ 31 The trial court conducted a jury trial over two weeks beginning May 3, 2023.

¶ 32 1. *Motions in Limine*

¶ 33 Prior to trial, the parties submitted motions *in limine* for the trial court's consideration. As relevant to the issues presented in this appeal, plaintiff's motion *in limine* No. 9 sought to bar "appeals to sympathy by the defense," including comments intended to "improperly appeal to the sympathy and passions of the jury." Additionally, plaintiff's motion *in limine* No. 12 similarly sought to bar "improper comment or suggestion concerning how much money the plaintiff or his children need to live comfortably or what they will do with the money." The court granted motion *in limine* No. 9 in part, emphasizing that appeals for sympathy to the jury are improper and "go[ ] both ways. The plaintiff is not able to do it either."

¶ 34 Defendants' motion *in limine* No. 10 sought to bar plaintiff from introducing evidence related to "safety," "protection," or "best treatment" as a standard of care. Plaintiff did not object, and the trial court granted the motion. Additionally, plaintiff's motion *in limine* No. 8 sought to bar "improper argument that the jury should place itself in the shoes of the defendants." Defendants did not object, and the court granted the motion, specifying it would be applicable to both sides.

¶ 35 2. *Plaintiff's Case*

¶ 36 Plaintiff's central theory of the case was as follows. First, Dr. Minore caused a dural defect during the February 14, 2019, intrathecal pump procedure leading to an external CSF leak. Next, Dr. Weiss negligently applied the wound vac after the March 1, 2019, surgery removing the catheter. NP Green then failed to communicate Sheila's post-operative symptoms to a physician. Additionally, Drs. Minore and Weiss negligently failed to refer Sheila to a neurosurgeon for evaluation and treatment of the external CSF leak. Finally, MPMS failed to adequately train NP Green.

¶ 37 a. Expert Witnesses

¶ 38 i. *Dr. Adam Carinci*

¶ 39 Dr. Adam Carinci, a board-certified pain management anesthesiologist, testified as an expert witness on the issue of standard of care. Dr. Carinci testified, in his expert opinion and based on his review of Sheila's medical records, Dr. Minore caused a tear in Sheila's dura when placing the catheter during the February 14, 2019, procedure. According to Dr. Carinci, after the February 14, 2019, surgery, CSF was leaking from a tear in her dura through the tissues to the external wound, which is a very rare issue. Dr. Carinci opined Dr. Minore should have been concerned about the volume of drainage from the wound in the days after the procedure and during late March 2019 because the ongoing leak created a risk of infection and brain herniation. Without enough CSF pressure to hold the brain in place, Dr. Carinci testified, it could sag inside the skull. Further, when a patient has less CSF in her system, her blood becomes thicker and more prone to clotting.

¶ 40 According to Dr. Carinci, there are four ways to address a CSF leak: a blood patch, conservative care, direct surgical repair, or placement of a dural drain. Dr. Carinci conceded that a blood patch would be inappropriate in this case. He opined the volume of fluid leaking from Sheila's wound was so significant that conservative care would not be effective. He further maintained the standard of care required a referral to a neurosurgeon to decide whether to directly repair the dura in the operating room or to insert a drain.

¶ 41 Dr. Carinci had no criticisms of Dr. Weiss's removal of the catheter on March 1, 2019, but he nonetheless opined Dr. Weiss deviated from the standard of care by applying the wound vac after the procedure. Specifically, Dr. Carinci believed it accelerated the removal of CSF from Sheila's system and issues related to intracranial hypotension. Dr. Carinci further opined

the standard of care required Dr. Weiss to consult with neurology after the March 1, 2019, procedure. According to Dr. Carinci, if Sheila had been referred to a neurosurgeon at any time between February 19 and March 19, 2019, or emergently referred to a neurosurgeon on March 26, 2019, she would have survived.

¶ 42 On cross-examination, Dr. Carinci conceded there was no direct evidence of any dural tear occurring during the February 14, 2019, procedure. He acknowledged, in the days following that procedure, many of Sheila's symptoms were consistent with opioid withdrawal. He further agreed there was no noted drainage from her back incision from February 21, 2019, until February 27, 2019. Dr. Carinci testified had Drs. Weiss and Minore ordered a timely consult with a neurosurgeon, they would have complied with the standard of care.

¶ 43 Dr. Carinici also testified on the standard of care applicable to NP Green and MPMS. Regarding NP Green, Dr. Carinci maintained a reasonably careful NP would be trained to understand the potential complications of the intrathecal pump procedure and monitor post-operative patients accordingly. Dr. Carinci opined NP Green deviated from the standard of care on February 21, 2019, when he failed to advise Dr. Minore of Sheila's complaints of a fluid leak and symptoms including headache, nausea, and dizziness. Similarly, Dr. Carinci opined NP Green deviated from the standard of care on March 14, 2019, when he did not communicate Sheila's complaints and symptoms to Dr. Weiss. Regarding MPMS, Dr. Carinci testified it failed to properly supervise NP Green on March 14, 2019. In both situations, if NP Green had advised Dr. Weiss or Dr. Minore of Sheila's symptoms, a reasonably careful anesthesiologist would have referred her for surgical intervention. According to Dr. Carinci, these failures contributed to causing Sheila's death.

¶ 44 ii. *Dr. Richard Fessler*

¶ 45 Dr. Richard Fessler testified he is a board-certified neurosurgeon and professor at Rush University Medical Center (Rush). Dr. Fessler opined Sheila had an external CSF leak and a reasonably careful physician who operates on a patient's spine and causes a CSF leak should refer that patient to a neurosurgeon to stop the leak. Dr. Fessler added that he believed a neurosurgeon informed of Sheila's CSF leak would have worked to seal the leak in a timely manner, either by operating on the dura to repair the leak or by placing a diversion drain. On cross-examination, Dr. Fessler acknowledged the possibility that "if the dural leak had been remedied on or before April 4th that there would have been almost an immediate correction of the CSF volume and the stroke would have been prevented."

¶ 46 iii. *Dr. Gordon Sze*

¶ 47 Dr. Gordon Sze testified he was a board-certified neuroradiologist. In his expert opinion and based on the CT scans taken on April 1, 2019, and April 7, 2019, Sheila had a CSF leak that caused her to experience intracranial hypotension, which caused a blood clot and stroke. Specifically, Dr. Sze observed, in the April 1, 2019, CT scan, Sheila's brain stem was sagging, which was an indicator of low CSF volume and intracranial hypotension. Dr. Sze explained intracranial hypotension is a clinical diagnosis and imaging can only rule intracranial hypotension *in*—it cannot necessarily rule it *out*. Furthermore, a patient's CSF volume cannot be measured from a simple CT scan; it can only be assessed accurately by performing a special research sequence with magnetic resonance imaging, which was never performed in Sheila's case. On cross-examination, Dr. Sze acknowledged that no stroke was visible in Sheila's April 1, 2019, CT scan. Instead, the stroke became visible in her April 7, 2019, CT scan—meaning the stroke occurred between those days. Dr. Sze also acknowledged intracranial hypotension is not always

visible in CT scans.

¶ 48 iv. *Dr. Edwin Amos III*

¶ 49 Dr. Edwin Amos III testified he was a board-certified neurologist. In his expert opinion, Sheila experienced a chronic loss of CSF leading to chronically decreased intracranial pressure. This caused the venous sinuses in Sheila's brain to clot and the clot, Dr. Amos testified, caused Sheila's fatal stroke. However, Dr. Amos also acknowledged the CT scan of Sheila's brain showed a normal amount of CSF as of April 1, 2019. At that point, he agreed, her basal cisterns were filled with CSF and appeared normal. Similarly, as of April 1, 2019, there was no evidence of venous thrombosis, bleeding, intracranial hypotension, or hemorrhagic stroke. Dr. Amos opined:

> "[I]f someone had corrected the spinal fluid leak somehow before the *** first few days of April, I think it's probable that the continuum, the ongoing clotting that we have talked about for all the reasons we mentioned, that would have been forestalled, it would have been stopped, and you wouldn't have had this tragic outcome."

Dr. Amos expanded upon this opinion further during the following colloquy:

> "Q. You would agree with me, would you not, Doctor, that if the physicians who were treating Mrs. Gullikson on April 1st, April 2nd, April 3rd, April 4th, or April 5th were able to normalize the pressure within her brain, in other words, stop the leak and normalize the pressure in her brain, she would not have had a stroke?
>
> A. So if I understand your question, you are asking me hypothetically if somehow they could have resolved that problem—
>
> Q. Right.

A. —would it have prevented her stroke? I would believe it would have."

According to Dr. Amos, it was not too late on April 1, 2019, probably not too late on April 2 or April 3, 2019, and potentially not too late on April 4, 2019, to resolve any CSF-related issues and stabilize Sheila's condition.

¶ 50 b. Plaintiff's Children's Testimony

¶ 51 Plaintiff and Sheila's children testified for plaintiff. Their daughter, Jacqueline Shipman, testified on direct examination as follows:

"Q. When you were feeling down, did your mom do special things to help uplift you?

A. Oh, yeah. She would—anytime I felt like, you know, upset or anything, my mom would always take me—at the time, you know, obviously raising kids, I didn't have a lot of money. So she would—

MS. DeFALCO [Defense counsel]: I object, your Honor, and move to strike and ask the jury to be instructed to disregard. Wealth and poverty, your Honor.

THE COURT: Overruled for now.

[The Witness]: She would take me to get my hair done, my nails done, you know, things like that just to make me feel better."

Plaintiff and Sheila's son Jesse Gullikson also testified, wherein the following exchange occurred:

"Q. Did your mom do things to encourage and support your sister Jacqueline?

A. Of course. Her and Jacqueline were best friends; and obviously Jacqueline lived at home much longer than me, and those two were basically inseparable. She was my mini mom. You know, they were shopping buddies, her

and my grandma and Jacqueline. That's what they would do and take the kids out and, you know, go shopping [and] have fun. She supported her, you know, obviously financially at times, you know, helping her out with being able to get established and get things going. I mean, emotional, I mean, obviously, you know, Jacqueline had gone through things in relationships and different things like that, my mom was always there for.

* * *

Our relationship was just really getting to that, like, blossoming stage where finally I was also like, financially secure, so we could do more things together again.

MS. DeFALCO: Objection, your honor. Move to strike.

THE COURT: Sustained. Ladies and gentlemen of the jury, you have heard a reference to finances twice. You are to ignore those comments.

Q. Jesse, how did your mom show you love and affection?

A: *** Again, you know, obviously within times, my mom would show me love and support by helping me in other ways, like, financially at times."

¶ 52 Following this exchange, the trial court called a recess and directed plaintiff's counsel to advise Jesse not to make any references to wealth or poverty during his testimony per plaintiff's motion *in limine*. The court found the issue had not risen to the level of a mistrial but emphasized the elicited responses were improper under plaintiff's motion *in limine*.

¶ 53 c. Motion for Directed Finding

¶ 54 At the close of plaintiff's case-in-chief, defendants moved for a partial directed finding on the claims against NP Green and institutional negligence claims against MPMS. The

trial court denied the motion.

¶ 55 3. *Defendants' Case*

¶ 56 The defendants' central theory of the case can be summarized as follows. First, there were no issues with the intrathecal pump implantation surgery. Next, defendants properly provided consistent and appropriate conservative care to Sheila throughout the course of her treatment. Furthermore, Sheila's CSF levels and pressure were all normal as of April 1, 2019. Finally, Sheila's stroke was not related to their care.

¶ 57 a. Defendants' Experts

¶ 58 i. *Dr. Timothy Lubenow*

¶ 59 Dr. Timothy Lubenow testified he is board-certified in both anesthesiology and pain management. Currently, he is the chair of Pain Management at Rush, as well as an anesthesiologist with University Anesthesiologists at Rush. According to Dr. Lubenow, both Drs. Minore and Weiss complied with the standards of care in this case. In his expert opinion and based on his review of Sheila's medical records, the February 14, 2019, procedure proceeded normally. There was no documentation suggesting any issues with the procedure, including a dura tear. Sheila did not demonstrate excessive drainage during her February 19, 2024, follow-up appointment, and Dr. Lubenow agreed the fluid described was likely interstitial fluid, not CSF. At that point, Dr. Lubenow reasoned, there was no reason for Dr. Minore to refer Sheila to a neurosurgeon. Additionally, Dr. Lubenow opined Dr. Weiss did not deviate from the standard of care in applying a wound vac after the March 1, 2019, procedure. He explained the wound vac would not have had enough pressure to cause fluid to leak through the fascia. Moreover, the wound vac had been discontinued within two days of placement—more than a month before Sheila's stroke, and therefore did not cause intracranial hypotension.

¶ 60 Dr. Lubenow explained on average, there are approximately 150 cubic centimeters (ccs) of CSF in the body. Each day, the body naturally produces between 500 to 600 ccs of CSF, which is continually replaced and recirculated. Dr. Lubenow reasoned Sheila was consistently replacing the CSF in her body based on these facts and the April 1, 2019, CT scan, which showed a "normal" CSF volume. Dr. Lubenow claimed this was confirmed again on April 5, 2019, when Dr. Alexander placed the diversion drain and noted a brisk return of spinal fluid. According to Dr. Lubenow, Sheila could maintain homeostasis within her brain and spinal column at that time.

¶ 61 Regarding the period after the March 1, 2019, procedure, Dr. Lubenow conceded it was difficult to tell whether there was a small internal CSF leak following the removal of the catheter. Regardless, it was within the standard of care for both Drs. Minore and Weiss to continue with conservative management of Sheila's wound throughout the time of their care, meaning there was no need for an urgent referral to a neurologist on either March 19, 2019, or March 26, 2019.

¶ 62 ii. *Dr. Gregory Zweig*

¶ 63 Dr. Gregory Zwieg testified he is board-certified in both radiology and neuroradiology. In his expert opinion and based on his review of Sheila's medical records, Sheila's April 1, 2019, CT scan was normal. He explained there was no evidence of (1) diminished CSF in the brain, (2) intracranial hypotension, or (3) brain sagging. However, Dr. Zwieg acknowledged intracranial hypotension is not always visible in CT scans and cannot always be ruled out by review of the patient's CT scans.

¶ 64 iii. *Dr. Jerry Bauer*

¶ 65 Dr. Jerry Bauer testified he is a board-certified neurosurgeon. In his expert opinion and based on his review of Sheila's medical records, there was no indication of an external CSF leak from February 14 to February 28, 2019. Specifically, there was no evidence of positional

headaches and therefore no reason to seek consult from a neurosurgeon. According to Dr. Bauer, Dr. Weiss properly removed the catheter after noting the wound dehiscence on February 28, 2019, and there was no need to consult with a neurosurgeon regarding the catheter removal process. Dr. Bauer did not believe the wound vac applied after the March 1, 2019, procedure had any effect on Sheila's transverse sinus thrombosis or hemorrhagic infarct.

¶ 66 Furthermore, Dr. Bauer agreed it was appropriate to proceed with conservative treatment after the catheter removal procedure to allow the dura time to heal. Dr. Bauer reasoned a neurosurgeon would not have proceeded differently between the March 1, 2019, procedure and Dr. Minore's decision to refer Sheila to a neurosurgeon on March 26, 2019. There was no reason for the March 26, 2019, referral to be made on an emergent basis. Moreover, a neurosurgeon would never perform a direct repair of the dura for a needle puncture.

¶ 67 Dr. Bauer opined Sheila's April 7, 2019, stroke was not related to a CSF leak or intracranial hypotension. Instead, Ms. Gullikson's stroke resulted from a clot that developed because of a combination of three issues around the time of her April 2019 hospitalization: dehydration caused by a bacterial infection in her colon; low blood pressure; and the discontinuation of her use of a blood thinner, Lovenox, in anticipation of the diversion drain procedure.

¶ 68 b. Fact Witnesses

¶ 69 i. *Dr. Minore*

¶ 70 Defendant Dr. Minore testified on his own behalf. According to Dr. Minore, Sheila did not require a neurosurgical consult at any point while in his care before March 26, 2019. NP Green's notes were very good, and there was nothing NP Green failed to tell him that would have changed anything about Dr. Minore's care, assessment, or treatment of Sheila.

¶ 71 ii. *Dr. Weiss*

¶ 72 Defendant Dr. Weiss also testified on his own behalf. According to Dr. Weiss, nothing NP Green might have communicated to Dr. Weiss would have changed Dr. Weiss's directed conservative course of treatment.

¶ 73 4. *Closing Arguments*

¶ 74 During closing arguments, plaintiff's counsel made several references to the concepts of "protection," safety," and "accountability" as follows:

> "The law protects everyone from those who negligently cause harm, whether it's the Gullikson family or anyone else. What happened to this family could happen to anyone, and the law is our protection for those who violate safety standards and cause harm.
>
> * * *
>
> *** We cannot let them get away with this. So that's what we're asking for more than anything else is accountability. They refused to take responsibility.
>
> * * *
>
> So now it's up to you to enforce the law and hold them accountable.
>
> * * *
>
> Don't let them get away with this. What happened to Sheila, could happen to any of us."

At this point, defendants' counsel objected, and the trial court sustained the objection. Additionally, the court sustained defendants' counsel's objection after plaintiff's counsel posed the following rhetorical question: "So let's start with loss of society. What's the value of a life?" Finally, the court overruled defendants' objection to plaintiff's counsel's presentation of a

PowerPoint slide titled "The Law," which read, the law states "[t]hose who negligently cause harm to others are compensating the injured person for the harm they caused with an amount of money equal to the amount of harm." After the objection, plaintiff's counsel took down the slide.

¶ 75 Prior to deliberations, the trial court instructed the jury, in relevant part, as follows:

> "It is your duty to resolve the case by determining the facts based on the evidence and following the law given in these instructions. Your verdict must not be based on speculation, prejudice, or sympathy.
>
> * * *
>
> The opening statements which were given at the start of the trial were what the attorneys expected the evidence to be. The closing argument which you just heard was given at the conclusion of the case, were a summary of what the attorneys contend the evidence has shown. If any statement or any argument of any attorney is not supported by the law or the evidence, you should disregard that statement or comment."

¶ 76 5. *Jury Verdict and Posttrial Motion*

¶ 77 On May 23, 2023, the jury returned its verdict in favor of plaintiff, awarding $4 million in damages. Defendants timely filed their posttrial motion, raising the same arguments as those in their partial motion for directed finding and including the argument defendants NP Green and MPMS were entitled to judgment *n.o.v.* After briefing and argument, the trial court denied the motion.

¶ 78 This appeal followed.

¶ 79 II. ANALYSIS

¶ 80 On appeal, defendants present three arguments. First, defendants contend NP Green

and MPMS are entitled to judgment *n.o.v.* Next, defendants argue the jury's verdict was against the manifest weight of the evidence and, therefore, they are entitled to a new trial. Finally, defendants argue they are entitled to a new trial because plaintiff's counsel's comments during closing arguments and plaintiff's children's testimony violated the trial court's *in limine* orders and were unfairly prejudicial to defendants. Plaintiff responds no errors occurred, defendants NP Green and MPMS are not entitled to judgment *n.o.v.*, and neither plaintiff's counsel's comments during closing arguments nor plaintiff's children's testimony regarding finances were so prejudicial as to warrant a new trial.

¶ 81 A. Judgment *N.O.V.*

¶ 82 We first address defendants' argument the trial court erred when it denied their posttrial motion asserting defendants NP Green and MPMS were entitled to judgment *n.o.v.* In support of this argument, defendants claim there was no evidence "that anything NP Green did (or did not do) would have changed [Sheila]'s care and treatment by Drs. Minore and Weiss; and the evidence showed as of the start of Ms. Gullikson's April 1, 2019[,] hospitalization, she could still have been stabilized and survived."

¶ 83 1. *Standard of Review*

¶ 84 In *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 37, the Illinois Supreme Court explained the concept of a judgment *n.o.v.* as follows:

> "A motion for judgment *n.o.v.* should be granted only when all of the evidence, when viewed in its aspect most favorable to the opponent, so overwhelmingly favors [a] movant that no contrary verdict based on that evidence could ever stand. [Citation.] In other words, a motion for judgment *n.o.v.* presents a question of law as to whether, when all of the evidence is considered, together

with all reasonable inferences from it in its aspect most favorable to the plaintiffs, there is a total failure or lack of evidence to prove any necessary element of the [plaintiff's] case. [Citation.] The standard for entry of judgment *n.o.v.* is a high one and is not appropriate if reasonable minds might differ as to inferences or conclusions to be drawn from the facts presented. [Citation.] When the trial court has erroneously denied a motion for judgment *n.o.v.*, we will reverse the verdict without a remand. [Citation.] Although motions for directed verdicts and motions for judgments *n.o.v.* are made at different times, they raise the same questions and are governed by the same rules of law. [Citation.] Our standard of review is de novo. [Citation.]" (Internal quotation marks omitted.)

¶ 85 2. *Applicable Law*

¶ 86 In a medical negligence case, the plaintiff must establish the following: "(1) proper standard of care against which the professional's conduct must be measured; (2) negligent failure to comply with the standard; and (3) the injury had as one of its proximate causes the negligence of the professional." *Mengelson v. Ingalls Health Ventures*, 323 Ill. App. 3d 69, 74 (2001). Here, defendants claim NP Green and MPMS are entitled to judgment *n.o.v.* on the grounds plaintiff failed to prove the third element—proximate causation.

¶ 87 "The term proximate cause encompasses two distinct requirements: cause in fact and legal cause." (Internal quotation marks omitted.) *City of Chicago v. Beretta U.S.A. Corp.*, 213 Ill. 2d 351, 395 (2004). In *Beretta*, the Illinois Supreme Court explained these requirements as follows:

"The first requirement, cause in fact, is present when there is a reasonable certainty that a defendant's acts caused the injury or damage. [Citation.] In deciding this

> question, we first ask whether the injury would have occurred absent the defendant's conduct. [Citation.] In addition, when, as here, there are multiple factors that may have combined to cause the injury, we ask whether defendant's conduct was a material element and a substantial factor in bringing about the injury. [Citation.]
>
> The second requirement, legal cause, is established only if the defendant's conduct is so closely tied to the plaintiff's injury that he should be held legally responsible for it. [Citation.] *** The proper inquiry regarding legal cause involves an assessment of foreseeability, in which we ask whether the injury is of a type that a reasonable person would see as a likely result of his conduct." (Internal quotation marks omitted.) *Id.*

¶ 88 To establish proximate causation in a medical negligence case, the plaintiff must offer expert testimony establishing "that defendant's breach of the applicable standard of care is more probably than not the cause of plaintiff's injury." *Mengelson*, 323 Ill. App. 3d at 74. That testimony cannot be "contingent, speculative or merely possible but, rather, must be shown by a degree of probability as to amount to a reasonable certainty that such a nexus exists." *Scardina v. Nam*, 333 Ill. App. 3d 260, 271 (2002). In the "absence of expert testimony that an act by the defendant could have, within a reasonable degree of medical certainty, caused the plaintiff's injuries, it would be impossible for a jury verdict in plaintiff's favor to stand." *Mengelson*, 323 Ill. App. 3d at 74-75.

¶ 89 Proximate cause is generally a question of fact within the province of the jury. *Lee v. Chicago Transit Authority*, 152 Ill. 2d 432, 455 (1992) (citing W. Keeton, Prosser & Keeton on Torts § 41, at 267 (5th ed. 1984)). However, "the lack of proximate cause may be determined by

the court as a matter of law where the facts alleged do not sufficiently demonstrate both cause in fact and legal cause ([citation]).” *Beretta*, 213 Ill. 2d at 395-96.

¶ 90 Both plaintiff and defendants rely on *Snelson v. Kamm*, 204 Ill. 2d 1, 46 (2003), which this court also finds instructive. The First District aptly summarized that case in *Buck v. Charletta*, 2013 IL App (1st) 122144, ¶ 66-68, as follows:

> “In *Snelson*, *** our supreme court held that a plaintiff did not establish that the nurses’ failure to inform his treating physician about his pain was the proximate cause of his injury, since the physician himself testified that he was aware of the pain. [Citation.] In that case, the plaintiff had undergone a procedure called a translumbar arteriogram. [Citation.] Because of a complication in the procedure, however, he experienced a blood clot, which ultimately caused much of the tissue in his large and small intestines to die due to lack of blood flow to the intestines. [Citation.] Although the plaintiff complained of abdominal pain immediately after the procedure and continued to complain of it throughout the night, his treating physician did not diagnose the problem until the following day. [Citation.] At trial, the plaintiff’s expert witness testified that the delay in diagnosis was the proximate cause of the loss of so much intestinal tissue. [Citation.]
>
> While the plaintiff was recovering, throughout the night, nurses charted his vital signs and complaints of abdominal pain, and generally kept his treating physician informed of the plaintiff’s condition. [Citation.] However, the nurses failed to tell the physician: (1) that they had placed a catheter in the patient at 3 p.m. and (2) that the plaintiff continued to complain of abdominal pain after the physician left for the day at 6 p.m. The plaintiff alleged that these omissions

constituted a breach of the standard of care applicable to the nurses. [Citation.]

The trial court granted a [judgment *n.o.v.*] in favor of the nurses and our supreme court affirmed. [Citation.] In doing so, the supreme court noted that the physician had testified that he had access to the nurses' notes on their care of the patient and that therefore he must have been aware when he examined the patient in the evening that the catheter had been placed at 3 p.m. [Citation.] The physician also testified that the nurses had provided him with all the information that he needed. [Citation.] Our supreme court also noted that 'there was no indication *** that [the physician] would have taken a different course of action had he been informed that [the patient] had some pain after [he] left at 6 p.m.' [Citation.] As our supreme court explained, the physician must have been aware that the plaintiff was experiencing pain and 'clearly anticipated' that the plaintiff's pain would continue throughout the night because he increased the dosage of the pain medication the patient was receiving. [Citation.] Based on the aforementioned facts, the court recognized that since the physician already knew that the patient was in pain, there was no causal connection between the hospital nurses' failure to provide the physician with that information and the physician's late diagnosis:

> 'That [the physician] knew about [the patient's] pain and yet was unconcerned about it beyond his ordering of [pain medication] means that the nurses' conduct on this matter could not have been the proximate cause of [the patient's] injury even if there had been testimony that they deviated from the standard of care in failing to advise of pain.' [Citation.]"

Additionally, the supreme court disagreed with the plaintiff's argument that it would be impossible "for a plaintiff to prove causation where the doctor testifies that 'he would not have acted differently regardless of what information could have been given him' " by the nurses. *Snelson*, 204 Ill. 2d at 45. Instead, the supreme court found this argument to be a "red herring" for two reasons: (1) the plaintiff "mistakenly assume[d] that a doctor will not be willing to tell the truth about whether the conduct of hospital nurses affected his decisionmaking ability" and (2) a plaintiff in a medical negligence case may "present expert testimony as to what a reasonably qualified physician would do with the undisclosed information and whether the failure to disclose the information was a proximate cause of the plaintiff's injury in order to discredit a doctor's assertion that the nurse's omission did not affect his decisionmaking." *Id.* at 45-46.

¶ 91 Defendants also rely on *Wilcox v. Advocate Condell Medical Center*, 2024 IL App (1st) 230355. In that case, a jury found the defendant hospital liable for the wrongful death of the decedent, Scott Wilcox, on separate theories of both institutional negligence and vicarious liability for the professional negligence of the health care providers who treated him. *Id.* ¶ 1. The evidence at trial showed Scott had previously been paralyzed in an accident, after which a pump was implanted into his abdomen that administered an antispasmodic drug, baclofen, into the intrathecal space of his spinal canal via a catheter. *Id.* ¶ 3. According to expert testimony, such pumps require periodic replacement, and if not working properly, the patient can experience baclofen withdrawal. *Id.* On the evening of Friday, July 28, 2017, Scott began experiencing symptoms of baclofen withdrawal and was seen by Dr. Senno, who managed the pump. *Id.* ¶ 5. After determining the pump was not functioning, Dr. Senno admitted Scott into the hospital to monitor the withdrawal symptoms and contacted neurosurgeon Dr. Bagan, who informed him Scott's pump could be replaced the following Monday, although the surgery was not immediately scheduled. *Id.* ¶¶ 5-6.

By Sunday afternoon, Scott's visiting family members noticed his condition was declining in the form of increased heart rate and blood pressure, forgetfulness, speech mistakes, and pronounced spasms. *Id.* ¶¶ 17-19. During the period between 4 p.m. Sunday and 7 a.m. Monday, nurses Carol Tenant, Karen Roque, and Lauren Yonan were responsible for Scott's care. *Id.* ¶ 19. Scott's neurologist, Dr. Samuels, testified he was never informed by nursing staff that Scott was experiencing global aphasia—*i.e.*, difficulty speaking and receiving information—despite all nurses noting the condition between 4 p.m. and midnight, which Dr. Samuels considered to be a significant change in Scott's mental status. *Id.* A concerned family member left Dr. Bagan a voicemail around 11:30 p.m. requesting immediate action, and around 12:30 a.m. on Monday, Dr. Bagan entered orders for Scott to be prepared to have surgery later the same day. *Id.* ¶ 22. Around 7:30 a.m., Dr. Bagan informed operating room staff that Scott's surgery would be added to the schedule for 1 p.m. *Id.* ¶ 23. At 1 p.m., Dr. Bagan was informed that the representative from the pump manufacturer would not arrive with the device until 1:30 p.m., and the requisite amount of baclofen would not arrive from another hospital for another 1-2 hours. *Id.* ¶ 26. The pharmacy director for the hospital testified the orders for baclofen were not received until 1 p.m. on Monday. *Id.* ¶ 27. Around 3 p.m., Scott suffered a code event involving multiorgan failure and resulting in brain damage but was eventually stabilized for surgery, which took place with no complications around 5:30 p.m. *Id.* ¶¶ 28-29. Scott never woke after the code event and died after several weeks on life support. *Id.* ¶ 29. Dr. Bagan testified that had he been made aware of Scott's fluctuating heart rate, blood pressure, and global aphasia sooner than the 11:30 p.m. phone call Sunday night, he may have begun "the process" of preparing Scott for surgery sooner, but expressed uncertainty about the timing as follows:

> "It's hard to say, you know, depending on the conversation, what would have

changed as far as the timing goes. Perhaps, I would have started the process of trying to plan the case earlier; but, again, ultimately, it wasn't a situation where it would be something that we would do in the middle of the night necessarily. And so, therefore, I think that, you know, timing-wise, the next morning is when I would have found out when exactly I could do the surgery." *Id.* ¶ 89.

¶ 92 The administrator of Scott's estate filed a multicount complaint against the defendant hospital and other health care providers, but only the claim against the defendant hospital proceeded to a jury trial. See *id.* ¶¶ 30-31. With respect to the vicarious liability claim, the jury was instructed as follows:

> "[T]he plaintiff was claiming that Advocate, acting by and through its agents, was negligent in that (1) Yonan failed to adequately monitor Scott on Sunday evening through Monday morning, (2) either Yonan or Tenant failed to adequately and timely advise neurosurgical staff and/or other physicians of Scott's worsening symptoms of intrathecal baclofen withdrawal, (3) Yonan failed to educate herself about Scott's intrathecal baclofen withdrawal, (4) Tenant failed to communicate her concerns about Scott's intrathecal baclofen withdrawal at the end of her shift on Sunday, (5) Yonan failed to advocate for Scott in that she did not notify the neurosurgical service of his worsening condition, and/or (6) Tenant failed to advocate for Scott in that she did not advise the family that surgery could be done over the weekend." *Id.* ¶ 32.

The jury found the defendant hospital liable on both theories and awarded plaintiff $42.4 million in damages. *Id.* ¶ 33.

¶ 93 On appeal, the hospital argued, *inter alia*, it was entitled to a judgment *n.o.v.* or a

new trial on grounds the plaintiff failed to establish the element of proximate cause. *Id.* ¶ 97. With respect to the vicarious liability claim, the hospital argued plaintiff failed to establish that Scott's nurses' negligence in failing to communicate his condition was a proximate cause of the delay in procuring the necessary baclofen for surgery at or near the time of Scott's 1 p.m. scheduled surgery. *Id.* More specifically, Dr. Bagan's testimony that Scott's procedure would not have been scheduled or performed until Monday—regardless of whether information about Scott's condition had been communicated to him earlier on Sunday evening—negated plaintiff's causation argument and warranted reversal under *Snelson*. *Id.* The First District agreed with the hospital, concluding that Dr. Bagan's testimony he may have been able to start "the process" for surgery sooner had Scott's condition been communicated was simply too contingent, speculative, and vague to support plaintiff's claim. *Id.* ¶¶ 103-04. The First District concluded there was no evidence indicating that entering the orders to begin preparing Scott for surgery earlier Sunday evening would have resulted in the pharmacy being notified that baclofen was required for surgery the following day. *Id.* ¶ 104. Ultimately, the First District affirmed after concluding the jury's verdict could nonetheless be sustained on the theory of institutional negligence. *Id.* ¶ 107.

¶ 94 3. *This Case*

¶ 95 Here, the jury was asked to resolve whether (1) NP Green negligently failed to "adequately communicate Ms. Gullikson's worsening post-operative symptoms to a physician" and (2) MPMS negligently failed to "adequately train [NP Green] to notify a physician about a patient's worsening postoperative complications." NP Green and MPMS concede that the testimony at trial was sufficient to create an issue of fact as to whether they deviated from the standard of care described by plaintiff's experts. The crux of defendants' argument is there was no evidence presented establishing that any of those alleged deviations from the standard of care

proximately caused Sheila's injuries. Specifically, defendants point to (1) Dr. Minore's testimony nothing NP Green said (or did not say) following the February 21, 2019, appointment would have caused Dr. Minore to order a consult with a neurosurgeon prior to Dr. Minore leaving town, because Dr. Minore found nothing out of the ordinary in Sheila's post-surgical course; (2) Dr. Weiss's testimony that nothing NP Green might have communicated to him would have caused Dr. Weiss to change his directed conservative course of treatment after the March 1, 2019, procedure; and (3) Dr. Minore's testimony he reviewed NP Green's notes before Dr. Minore evaluated Sheila on March 19, 2019, and Dr. Minore still determined the appropriate course of treatment would be a conservative one, without a referral to a neurosurgeon at that time. Furthermore, because plaintiff's own expert Dr. Amos testified Sheila's stroke could have been prevented as late as April 1, 2019, with intervention, NP Green's failure to communicate symptoms to a supervising physician could not have been a proximate cause of Sheila's stroke and death.

¶ 96 We conclude the trial court properly denied defendants' motion for a judgment *n.o.v.* with respect to NP Green and MPMS because plaintiff's experts presented sufficient evidence to create a factual question on the issue of whether NP Green's failure to communicate Sheila's worsening symptoms proximately caused Sheila's intracranial hypotension leading to her stroke and death. First, the evidence at trial showed Sheila returned to MPMS mere days after her pain pump procedure complaining of nausea, headache, and dizziness. Dr. Minore had specifically instructed Sheila to return to MPMS if she experienced these symptoms. Sheila further reported significant "straw-colored drainage" from her back incision. Although NP Green included these symptoms in Sheila's patient notes, he failed to communicate them with his supervising physician that day. NP Green also failed to inquire about the nature of Sheila's headaches—an inquiry which could have revealed the primary symptom indicating a CSF leak, *i.e.*, positional headaches. Dr.

Carinci testified, in his expert opinion, this failure to communicate Sheila's symptoms to the supervising physician constituted a deviation from the standard of care and a reasonably prudent anesthesiologist hearing said information would have referred Sheila for neurosurgical intervention. Dr. Carinci also testified MPMS did not train NP Green to recognize these symptoms and failed to adequately supervise him in accordance with the standard of care. Furthermore, in his expert opinion, NP Green and MPMS's deviations from the standard of care contributed to causing Sheila's death. We acknowledge Dr. Amos testified Sheila's death could have been avoided with intervention as late as the first few days of April—two weeks after NP Green was last involved in Sheila's care—and that Drs. Weiss and Minore were aware of Sheila's worsening symptoms even after NP Green had failed to communicate them immediately. However, this does not negate Dr. Carinci's expert testimony that NP Green's failure to communicate Sheila's symptoms, and MPMS's failure to train NP Green to recognize them, nonetheless contributed to her death. Under *Snelson*, and viewing the evidence in the light most favorable to plaintiff, Dr. Carinci's testimony was sufficient to discredit Drs. Weiss's and Minore's conflicting testimony and create a factual question for the jury to resolve. See *Snelson*, 204 Ill. 2d at 45-46.

¶ 97 Furthermore, the facts in this case are distinguishable from *Wilcox*. Defendants claim that similar to *Wilcox*, plaintiff's assertion that had NP Green communicated Sheila's worsening symptoms to the supervising physician (Dr. Kothawala) on February 21, 2019, she would have been timely referred to a neurosurgeon is simply too vague and speculative to constitute a proximate cause of Sheila's eventual stroke and death. We agree that this argument, standing alone, would be too speculative to establish proximate cause because Dr. Kothawala did not testify at trial what actions he would have taken if presented with this information on February 21, 2019. However, as noted immediately above, this is not the only theory of causation relied

upon by plaintiff. Unlike *Wilcox*, where Scott's condition deteriorated over the course of a mere weekend and earlier intervention by just a few hours could have prevented Scott's death, Sheila's condition worsened over the course of over a month, wherein there were multiple opportunities for life-saving intervention. Furthermore, Dr. Bagan's testimony in *Wilcox* was equivocal and did not definitively establish he would have been able to perform surgery at 1 p.m. before Scott's code event but for the nurses' failures to communicate his worsening symptoms earlier Sunday. In contrast, plaintiff provided ample support for the theory that had NP Green communicated Sheila's worsening symptoms to Dr. Minore even as late as the March 14, 2019, appointment when Dr. Minore was supervising, a reasonably prudent pain management anesthesiologist complying with the requisite standard of care would have referred her to a neurosurgeon. Again, despite Dr. Minore's testimony this information would not have impacted his treatment decisions, the jury was permitted to disbelieve this testimony based on Dr. Carinici's testimony regarding the standard of care. Accordingly, the trial court properly denied defendants' motion for a judgment *n.o.v.* with respect to NP Green and MPMS.

¶ 98 B. Jury's Verdict

¶ 99 We next address defendants' argument the jury's verdict in favor of plaintiff was against the manifest weight of the evidence and they are therefore entitled to a new trial. Defendants argue, even assuming *arguendo* they deviated from the standard of the care as alleged by plaintiff, the manifest weight of the evidence established these deviations did not proximately cause Sheila's death. Instead, defendants' argument continues, the evidence showed as of April 1, 2019, Sheila had normal CSF and her stroke could not have occurred because of diminished CSF pressure. Plaintiff responds the jury's verdict was supported by ample evidence and the trial court did not abuse its discretion when it denied defendants' motion for a new trial.

¶ 100 This court may only reverse a jury's verdict if it is against the manifest weight of the evidence. *Snelson*, 204 Ill. 2d at 35. A jury verdict is against the manifest weight of the evidence when the opposite conclusion is clearly evident or the findings of the jury are unreasonable, arbitrary, or not based on the evidence. *Id.* Because the jury's role as factfinder is to weigh the evidence, assess the credibility of the witnesses, and resolve conflicts in the expert testimony, this court cannot substitute its own judgment on questions of fact fairly submitted, tried, and determined from the conflicting evidence. *Maple v. Gustafson*, 151 Ill. 2d 445, 452-53 (1992). Moreover, this court will not reverse the trial court's denial of a motion for new trial unless it finds the trial court abused its discretion. *Snelson*, 204 Ill. 2d at 36. "In determining whether the trial court committed an abuse of discretion, reviewing courts consider whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial." *Henry v. McKechnie*, 298 Ill. App. 3d 268, 273 (1998).

¶ 101 Here, plaintiff presented ample evidence, in the form of multiple expert witnesses' testimony, that defendants' deviations from the standard of care proximately caused Sheila's intracranial hypotension leading to her stroke and death. Even accepting as true defendants' assertion Sheila's CSF appeared "normal" as of April 1, 2019, this does not foreclose plaintiff's theory Sheila suffered a stroke because of a CSF leak. Specifically, Dr. Sze testified Sheila's April 1, 2019, CT scans showed evidence of intracranial hypotension—a condition which he opined resulted from a CSF leak. Specifically, Dr. Sze observed from the CT scans that Sheila's brain stem was sagging, which indicated low CSF volume. Moreover, Dr. Sze clarified that without a special research sequence with magnetic resonance imaging—which was never performed on Sheila—there was no way to accurately discern, from CT scans alone, how much CSF was present. Furthermore, Dr. Amos testified Sheila exhibited multiple symptoms to support an intracranial

hypotension diagnosis prior to April 1, 2019, including severe headaches and dizziness, which was indicative of a CSF leak. Dr. Amos opined these symptoms were present almost immediately after the pain pump procedure. Even if there was no sign of depletion of CSF in Sheila's basal cisterns, a reasonable juror could nonetheless still infer Sheila began leaking CSF externally after the pain pump procedure despite maintaining a normal level of CSF *production*. Plaintiff's experts collectively testified if defendants urgently referred Sheila to a neurosurgeon consistent with the standard of care required for each encounter between February 19 and March 26, 2019, the CSF leak could have been repaired before the blood clot formed between April 1 and 7, 2019, and Sheila would have lived. This evidence, if believed, was sufficient to sustain the plaintiff's theory of the case. Because the jury's verdict was not against the manifest weight of the evidence, the trial court's denial of defendants' motion for a new trial on those grounds was not an abuse of discretion.

¶ 102 C. Closing Arguments and Financial Testimony

¶ 103 Defendants' final argument is that they are entitled to a new trial because they were unfairly prejudiced by plaintiff's counsel's improper comments during closing arguments and plaintiff's children's testimony regarding finances. Defendants argue these comments and testimony both violated the trial court's previous *in limine* orders. Specifically, defendants challenge, during closing argument, plaintiff's counsel's (1) use of a PowerPoint slide, which purportedly misstated applicable law, (2) references to "safety" and "accountability," (3) statement "[w]hat happened to Sheila, could happen to any of us," and (4) posing of a rhetorical question regarding the value of a life. Defendants further challenge plaintiff's children's testimony Sheila financially supported her daughter Jacqueline. Plaintiff responds no prejudicial errors occurred and the court properly denied defendants' posttrial motion for new trial. We agree with plaintiff.

¶ 104 1. *Closing Argument*

¶ 105 We first address defendants' claim they are entitled to a new trial because they were prejudiced by plaintiff's counsel's allegedly improper statements during closing argument.

¶ 106 As stated above, "The determination of whether a new trial should be granted rests within the sound discretion of the trial court, whose ruling will not be reversed unless it reflects an abuse of that discretion." *Snelson*, 204 Ill. 2d at 36. Accordingly, this court "will not reverse a court's ruling on a motion for new trial unless it is affirmatively shown that the trial court clearly abused its discretion." (Internal quotation marks omitted.) *Steed v. Rezin Orthopedics & Sports Medicine, S.C.*, 2021 IL 125150, ¶ 44.

¶ 107 Under Illinois law, "[a]ttorneys are afforded wide latitude during closing argument and may comment and argue on the evidence and any inference that may be fairly drawn from that evidence." *Zickuhr v. Ericsson, Inc.*, 2011 IL App (1st) 103430, ¶ 72. "Improper closing arguments require reversal *only* when the comments resulted in substantial prejudice to the opposing party." (Emphasis added.) *Id.* ¶ 75. "Substantial prejudice" occurs when, but for the improper comments during closing argument, the outcome of the trial would have been different. *Ittersagen v. Advocate Health & Hospitals Corp.*, 2020 IL App (1st) 190778, ¶ 87. "[I]f the trial was fair as a whole and the evidence was sufficient to support the jury's verdict, a case will not be reversed upon review." *Bresland v. Ideal Roller & Graphics Co.*, 150 Ill. App. 3d 445, 454 (1986). Furthermore, prejudice from an improper remark may be cured if the court sustains an appropriate objection and properly instructs the jury. See *Ittersagen*, 2020 IL App (1st) 190778, ¶ 87.

¶ 108 The First District aptly discussed what constitutes improper closing arguments in *Ittersagen* as follows:

> "[W]hen arguing to the jury, attorneys should not unfairly appeal to its emotions. [Citation.] The jury must decide the case based on the evidence and issues presented at trial unencumbered by appeals to [its] passion, prejudice or sympathy. [Citation.] One line of argument that this court has repeatedly found to improperly elicit passion, prejudice, or sympathy from the jury is asking it to place itself in the position of either the plaintiff or the defendant. [Citations.] The alleged improper comments must be viewed not in isolation, but within the context of the entire closing argument. [Citation.] As a result, some golden rule arguments, while technically improper, may not elicit passion, prejudice, or sympathy from the jury. [Citation.]" (Internal quotation marks omitted.) *Id.* ¶ 83.

¶ 109 We first conclude defendants were not prejudiced by plaintiff's counsel's statement during closing argument "what happened to Sheila, could happen to any of us" or the rhetorical question regarding the value of a life. Although we agree with defendants both statements were improper, the trial court promptly sustained defendants' objections. Furthermore, because the former comment was the last sentence in plaintiff's counsel's rebuttal argument, the court immediately advised the jury that it must determine the facts based only on the evidence and inferences to be drawn therefrom, and that its verdict must not be based on "speculation, prejudice, or sympathy." We acknowledge in addition to sustaining the objection to the rhetorical question, the court should have also directed the jury to disregard it. However, when viewed in the context of plaintiff's counsel's entire closing argument—which lasted over two hours—counsel immediately moved on after posing the question and also repeatedly reminded the jury it should make its decision based solely on the evidence and the law.

¶ 110 Next, we agree with plaintiff that defendants have forfeited any claim they were

prejudiced by plaintiff's counsel's references to "safety" and "standards" when they failed to timely object. Although the trial court previously granted defendants' motion *in limine* No. 10, which sought to bar plaintiff from introducing evidence related to "safety," "protection," or "best treatment" as a standard of care, *in limine* rulings are considered "interlocutory" in nature and "remain subject to reconsideration throughout trial." (Internal quotation marks omitted.) *Arkebauer v. Springfield Clinic*, 2021 IL App (4th) 190697, ¶ 60. Consequently, the granting or denial "of a motion *in limine* does not in itself preserve an objection to disputed evidence that is introduced later at trial." *Simmons v. Garces*, 198 Ill. 2d 541, 569 (2002). Accordingly, and despite the previous *in limine* ruling, defendants were nonetheless required to contemporaneously object in the event such evidence or argument was improperly introduced. Our review of the record shows defendants failed to object at any mention of safety standards, and they make no attempt to argue in their reply brief their forfeiture should be excused. Instead, they point to their separate objections to the PowerPoint slide, the statement "what happened to Sheila, could happen to any of us," and the posing of the rhetorical question about valuing a life. These separate objections were not specific to the mentioning of safety standards and therefore not sufficient to preserve the issue for appeal. See *Snowstar Corp. v. A&A Air Conditioning & Refrigeration Service, Inc.*, 2024 IL App (4th) 230757, ¶ 83 (explaining the grounds for an objection must be specifically stated). We therefore honor defendants' forfeiture and decline to review this issue for error.

¶ 111 Finally, we similarly find defendants were not prejudiced by plaintiff's counsel's use of a PowerPoint slide that purportedly misstated the applicable law. Although the trial court found, on review of defendants' posttrial motion, the slide improperly "paraphras[ed]" the law, it also determined the jury was nonetheless properly instructed, and we agree. The jury was instructed that arguments are not evidence, and it was to base its verdict solely on the evidence

and the law. Defendants do not argue the law provided to the jury in the instructions was incorrect. In the absence of any indication the jury misunderstood or misapplied the law due to plaintiff's counsel's PowerPoint slide, we conclude the instructions provided to the jury cured any impropriety associated with it.

¶ 112 In sum, we conclude defendants were not prejudiced, individually or cumulatively, by any alleged errors stemming from plaintiff's counsel's closing arguments.

¶ 113 2. *Plaintiff's Children's Testimony*

¶ 114 Finally, defendants argue they are entitled to a new trial because plaintiff's children repeatedly testified Sheila assisted Jacqueline financially despite the trial court's *in limine* order barring such testimony. Plaintiff responds any error was cured by the court sustaining defendants' objections and instructing the jury. We agree with plaintiff.

¶ 115 We find this court's decision in *Kutchins v. Berg*, 264 Ill. App. 3d 926, 930 (1994), instructive here. In *Kutchins*, the plaintiff accountant alleged his former firm and its president defamed him by informing one of his former clients he improperly accepted money from another client that should have been regarded as compensation to the firm and informing another client the plaintiff was involved in " 'highly irregular activities.' " *Id.* at 929. Prior to trial, the trial court granted the defendants' motion *in limine* to bar any reference to (1) the fact the plaintiff's 8-year-old daughter suffered from a terminal illness and ultimately died and (2) an alleged conversation plaintiff had with his daughter in which she claimed, at a birthday party, the firm president's daughter told her plaintiff had been caught stealing from his firm. *Id.* at 929-30. During trial, the plaintiff attempted to testify about the conversation on direct examination. *Id.* at 930. On redirect examination, the plaintiff's counsel specifically asked him who had told his daughter about his reason for leaving the firm. *Id.* Finally, during closing argument, the plaintiff's counsel claimed

plaintiff testified the firm's president's daughter told plaintiff's daughter at a birthday party that plaintiff had been caught stealing from the firm. *Id.* In each of these instances, the court sustained the defendants' objections. *Id.* The defendants moved for a mistrial based on the repeated violations of the *in limine* order and filed a motion for a new trial on the same grounds; the court denied both motions. *Id.* On appeal to the First District, the defendants argued the court abused its discretion when it denied these motions. *Id.* at 929.

¶ 116 The First District reversed and remanded for a new trial. *Id.* at 929-30. In its decision, the First District explained the effect of *in limine* orders as follows:

> "A motion *in limine* allows a litigant to obtain a pre-trial order which excludes inadmissible evidence and bars any questioning of witnesses regarding such evidence. [Citation.] In this way, the moving party safeguards against the prejudicial impact possibly resulting from asking questions and making objections regarding the inadmissible evidence before the jury. [Citation.] Where a litigant clearly violates an *in limine* order which was specific in its terms, and the violation denied the opposing party a fair trial, a new trial should be granted. [Citation.]" *Id.* at 930.

The First District concluded plaintiff and his counsel's repeated and flagrant violations of the *in limine* order deprived the defendants of a fair trial. *Id.* at 930-31. Specifically, even after the court sustained the defendants' first objection during the plaintiff's direct examination, counsel again attempted to elicit the same improper testimony from the plaintiff on redirect examination. *Id.* at 931. Most significantly, the plaintiff's counsel argued plaintiff testified his daughter came home from a birthday party where the firm president's daughter stated that he stole money from the firm—testimony the First District concluded was never admitted into evidence. *Id.* Citing

Gilson v. Gulf, Mobile & Ohio R.R. Co., 42 Ill. 2d 193, 200 (1969), the First District held "[a]ttempts to offer and argue incompetent evidence before the jury after it has been ruled inadmissible constitute prejudicial error." *Id.* Accordingly, the First District reversed and remanded the case for a new trial.

¶ 117 Here, we conclude plaintiff's repeated violation of the *in limine* order did not rise to the level of denying defendants a fair trial. First, we find the facts here are distinguishable from those in *Kutchins* that warranted a new trial. In *Kutchins*, the objectionable testimony regarding the conversation with the plaintiff's daughter was both improperly designed to appeal to the sympathy of the jury *and* went to the heart of the defamation case: whether the defendant firm and its president defamed the plaintiff by untruthfully claiming he accepted money from a client that belonged to the firm. In contrast, while the objectionable testimony here was also an improper appeal for sympathy, it was not related to the central issue of whether defendants negligently caused Sheila's death. Furthermore, the *Kutchins* court noted plaintiff's counsel *directly* elicited the improper testimony. Here, in contrast, plaintiff's counsel's questions were not clearly designed to elicit the barred financial testimony; each question that eventually elicited the improper responses were all open-ended questions relevant to the loss of society claim, such as how Sheila "encouraged," or "uplifted" Jesse and Jacqueline or how Sheila showed them "affection." Most importantly, the plaintiff's counsel in *Kutchins* argued facts not in evidence in the closing argument. Here, plaintiff's counsel did not mention, during closing arguments, Sheila's children's testimony about their mother's financial support. Moreover, the trial court sustained each of defendants' counsel's objections to the financial testimony, directed the jury to disregard the statements immediately after, and admonished plaintiff's counsel during a brief recess. Finally, as noted above, the court instructed the jury its verdict must only be based on facts in evidence and

it should not rely on "speculation, prejudice, or sympathy."

¶ 118 In sum, we conclude none of the alleged errors, individually or cumulatively, would have changed the result of the trial. Our review of the record shows the two-week trial was conducted fairly, and as explained *supra* Section II.B., the jury's verdict in favor of plaintiff was supported by ample evidence. Accordingly, the trial court's denial of defendants' motion for a new trial was not arbitrary or unreasonable and, therefore, did not constitute an abuse of discretion.

¶ 119 III. CONCLUSION

¶ 120 For the reasons stated, we affirm the trial court's judgment.

¶ 121 Affirmed.