No. 128651

In the Supreme Court of Illinois

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Plaintiff/Appellant,

v.

SIU HEALTHCARE, INC., CHARLENE YOUNG, F. N.P., ABDULLAH AL SAWAF, M.D., and ASHLEY KOCHMAN, et al, Defendants,

and

MOUHAMAD BAKIR, M.D., Respondent in Discovery/Appellee.

On Appeal from the Illinois Appellate Court,
Fourth Judicial District, No. 4-21-0284

There on Appeal from the Circuit Court of the Seventh Judicial Circuit,
Sangamon County, Illinois, Cause No. 2019-L-32
Honorable Raylene Grischow, Judge Presiding

BRIEF OF RESPONDENT IN DISCOVERY/APPELLEE, MOUHAMAD BAKIR, M.D.

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SUPPLEMENTAL STATEMENT OF FACTS AND PROCEDURAL HISTORY

This appeal involves the Illinois Appellate Court's affirmance of an order from the circuit court denying Plaintiff, Carol Cleeton's, Motion to Convert Mouhammad Bakir, M.D. from a respondent in discovery to a defendant (C 916-932). Dr. Bakir is an internist and pulmonary medical specialist who is a part of SIU Healthcare. (C 295, 322-323). Dr. Bakir provided care and treatment to Donald Cleeton ("Cleeton") in the intensive care unit at Memorial Medical Center over several hours on October 30, 2017. (*Id.*)

CLEETON'S TIME AT MEMORIAL MEDICAL CENTER

Donald Cleeton arrived at the emergency department at Memorial Medical Center at approximately 8:15 p.m. on October 29, 2017 (C 610). On arrival, Cleeton complained of abdominal pain and headache (C 610). Cleeton also suffered from quadriplegia stemming from an accident when he was 17.

Cleeton was seen by Dr. Richard Austin, the emergency room physician (C 605-613). Dr. Austin found Cleeton to be alert and oriented (C 608). Various tests were run and blood work and blood cultures were ordered (C 605-613). Dr. Austin's emergency room note contained a diagnosis/impression of sepsis and acute urinary tract infection (C 611). A urine sample collected that evening was positive for Klebsiella pneumoniae bacteria indicative of a urinary tract infection (C 596).

While Cleeton was in the emergency department, Medtronic was contacted about a Medtronic Baclofen pump which had been implanted in Cleeton several years earlier. *See Cleeton v. SIU Healthcare, Inc.*, 2021 Il App. (4th) 200490. The pump had been refilled a few days earlier by defendants Charlene Young, N.P. and Ashley Kochman, R.N. (C 621). Cleeton's mother reported that the refill was more difficult than usual. (*Id.*) A

representative from Medtronic came to the emergency room and interrogated the pump (*Id.*). The Medtronic representative determined that the pump was working properly and distributing the proper dosage of Baclofen (C 624). Cleeton was admitted to the hospital (C 597). When admitting Cleeton,, Dr. Austin spoke with Dr. Nichole Mirocha, a physician on the hospital floor (C 611).

On the morning of October 30, Dr. Mirocha phoned the intensive care unit and spoke with Dr. Bakir (C 295, 383, 621). Dr. Mirocha gave Dr. Bakir with Cleeton's history from his visit, stating that Cleeton had been seen in the emergency department for complaints of abdominal pain, headache and leukocytosis, an elevation in white blood cell count (C 295, 384-385). Dr. Mirocha stated that while in the emergency department, Cleeton had been seen by a "pump specialist" from Medtronic because of a concern that his Baclofen pump was not functioning properly (*Id.*). Dr. Mirocha told Dr. Bakir that the pump was interrogated and the pump was found to be functioning properly (*Id.*). According to Dr. Mirocha, Cleeton was then admitted from the emergency room to the medical floor for IV antibiotics to treat sepsis from a urinary tract infection (*Id.*). Dr. Mirocha advised Dr. Bakir that Cleeton was being seen by the neurology service and the cardiology service (C 296, 383-385, 918). She also stated that a rapid response had been called and Cleeton was being transferred to the intensive care unit (C 296, 621, 918).

Cleeton arrived in the intensive care unit around 10:00 a.m. on October 30, 2017 (C 296, 363-364, 918). Before Cleeton's arrival another urine sample had not been collected for testing (C 596). Dr. Bakir did not have the results of any blood cultures available during the time Cleeton was in the intensive care unit (C 390-393, 595).

Dr. Hannah Purseglove, a resident physician working with Dr. Bakir, obtained a history of Cleeton being a 25-year-old male with quadriplegia since 2009 who presented to the emergency department the prior day with complaints of muscle spasms in his abdomen (C 296, 618). She learned that Cleeton had a Baclofen pump managed by the SIU Neurology group, the pump had recently been refilled, that a Medtronic representative had interrogated the pump while Cleeton was in the emergency department, and the Medtronic representative concluded the pump was working properly and at the correct dose (*Id*.). Dr. Purseglove noted that Cleeton had a history of recurrent urinary tract infections and had been followed by the SIU Infectious Disease Department for this condition (*Id.*). At the time, Cleeton had an elevated white blood cell count of 24.5, a lactic acid level of 2.5 and a urinalysis specimen that was positive for a urinary tract infection (*Id.*). Dr. Purseglove wrote that Cleeton had a decreased level of consciousness and a heart rate in the 190s on the medical floor (*Id.*).

Dr. Bakir examined Cleeton and spoke with his mother (C 296-297, 621). Dr. Bakir confirmed placement of the Baclofen pump in 2014 and that the pump had been programmed periodically by Charlene Young at the SIU Neurology clinic (*Id.*). He learned that the most recent pump refill was on October 25, that it was a more difficult refill and since the refill, Cleeton was having more spasms which were worse over the preceding days (*Id.*). Dr. Bakir arrived at a differential diagnosis for Cleeton which included:

- Septic shock secondary to urosepsis;
- Possible Baclofen withdrawal/pump malfunction;
- Elevated troponin - possibly secondary to severe tachycardia versus sepsis versus myocarditis versus pulmonary embolus;
- Decubitus ulcers with questionable osteomyelitis; and
- Cardiac Arrest (C 297, 617; SC 39).

Dr. Bakir knew that Cleeton's elevated white blood cell count and lactic acid levels were not caused by Baclofen withdrawal (C 297, 395, 400-401). Sepsis could cause an increase in these levels (*Id.*).

Based on Cleeton's presentation, Dr. Bakir requested consultations from other team members including specialists in cardiology and neurology (C297, 621). In addition, he requested assistance from Medtronic and the neurology staff who managed the pump (*Id.*).

Dr. Siddique, a cardiologist, responded and ordered a stat CT of the chest to investigate a possible pulmonary embolism and an echocardiogram to investigate an elevated troponin level (*Id.*).

Dr. Abdullah Al Sawaf, a neurologist, and Dr. Shilpa Chaku, a neurology resident, saw and examined Cleeton in the intensive care unit at 11:15 a.m. (C 297, 621, 628, 632-636). The history included that Cleeton had presented to the emergency department the evening before with leukocytosis and lactic acidosis. (C 298-299, 628, 632.) Cleeton's urinalysis was positive for a urinary tract infection, but he did not have a fever (*Id.*). These physicians found Cleeton on examination to be awake, alert, and able to answer questions appropriately (C 298-299, 305, 621, 635; CI 86-88, 116). Cleeton followed commands (*Id.*). Cleeton was not rigid throughout his body nor having spasms in his back (C 157, 192-193, 227, 305, 334, 381, 398; CI 83-90). Cleeton appeared to be having abdominal spasms (*Id.*) The fact that Cleeton had abdominal spasms did not mean that he was in Baclofen withdrawal (CI 89). Rather, Dr. Chaku believed that the abdominal spasms were associated with the urinary tract infection (CI 48, 85, 89).

Cleeton had an episode of his eyes rolling back and fluttering, but he was able to respond to verbal coaching from his mother (C 289-299, 621, 635). The physicians did not

believe these findings to be altered mental status indicative of Baclofen withdrawal syndrome (C 635; CI 87, 115-116). The history included Cleeton having autonomic instability (a fluctuation in heart rate and/or blood pressure), but that he also had this at baseline (C 906-907; CI 71-77). The physicians noted that the Baclofen pump had been checked in the emergency department and was found to be functioning properly (C 621, 635).

Dr. Al Sawaf's differential diagnosis was mild-moderate Baclofen withdrawal versus sepsis (C 299-300, 628). Dr. Al Sawaf believed that Cleeton's normal tone argued against Baclofen withdrawal, but the timeline of events and dysautonomia supported that possibility (*Id.*). Dr. Al Sawaf noted that sepsis could present similarly (*Id.*). He advised to administer high dose IV Ativan versus intrathecal Baclofen for symptomatic support (*Id.*).

Dr. Al Sawaf directed Charlene Young from the neurology clinic to interrogate the pump to rule out failure (*Id.*). Dr. Al Sawaf ordered that the sepsis work up continue (*Id.*). The episodes of Cleeton's eyes rolling were not seizures but likely a dysautonomia phenomenon and Dr. Sawaf noted they should be evaluated with an EEG (*Id.*).

After Dr. Al Sawaf's examination, he spoke with Dr. Bakir at Cleeton's bedside regarding the Baclofen pump and a seizure work up (C 240, 300; SC 43). Dr. Bakir asked Dr. Al Sawaf if he believed that Cleeton was experiencing Baclofen withdrawal (C 243, 255, 300). Dr. Al Sawaf testified that he informed Dr. Bakir it was unlikely Cleeton was experiencing Baclofen withdrawal based on his examination (*Id.*). Among other things, Cleeton had normal tone (*Id.*).

Dr. Bakir also requested assistance from Medtronic and the neurology staff who had been involved in the management of the pump (C 300, 355, 402, 621). At 11:05, the Medtronic pump representative was paged for interrogation of the pump (C 300, 558). At approximately 10:44 a.m. Medtronic had faxed to Memorial Medical Center a document entitled Medtronic Emergency Procedures for Baclofen withdrawal syndrome (C 654-655, 874-875). That document was not provided to Dr. Bakir during his care and treatment of Cleeton and the document was not imported into the electronic medical record until 6:44 pm (C 332, 350-351, 365-366, 880).

After Dr. Bakir obtained consultations from cardiology and neurology and paged the Medtronic representative, Cleeton became less responsive and developed a labile blood pressure (C 300, 402). At that point, Dr. Bakir focused on a diagnosis of sepsis as being the most likely condition to explain Cleeton's presentation (*Id.*). According to Dr. Bakir, Cleeton had multiple sources of infection which could have caused sepsis including a urinary tract infection and decubitus ulcers at stage IV (C 300, 418). The diagnosis of sepsis was supported by the high lactic acid level (*Id.*).

Dr. Bakir spoke with all services including neurology, neurosurgery, and the Baclofen pump team about what to do if Cleeton was in fact in Baclofen withdrawal (C 300, 402; SC 43). Dr. Bakir needed to confirm the Baclofen withdrawal since administering Baclofen to a patient not in Baclofen withdrawal could lead to Baclofen overdose (C 300, 402-403).

At approximately 12:07 Cleeton went into cardiac arrest and a code was called (C 300, 669). During the code, Dr. Bakir relied on all teams involved in Cleeton's care for their areas of expertise (C 301, 404-405). The pump was interrogated again by Charlene

Young and determined to be working properly (C 301, 405-406). Dr. Bakir also asked the neurosurgery team to determine if Cleeton should be given Baclofen (C 301, 407, 414, 422, 424-425, 621). During the code, the neurosurgery team ordered that intrathecal Baclofen be administered to provide Cleeton every chance to recover even if Baclofen withdrawal was a remote possibility (*Id.*). Neurosurgery directed that an anesthetist assist with the administration with Baclofen (C 407, 409).

The Code was terminated at approximately 3:06 p.m. at which time Cleeton was pronounced deceased (C 301, 613, 669). An autopsy was performed and the pathologist concluded that given Cleeton's complex clinical history and the results of the autopsy, Cleeton died as a result of the sequelae of quadriplegia due to remote cervical spine fracture (C 301, 594). The autopsy report found: (1) a brain with mild chronic meningitis and focal, mild perivascular chronic inflammation; (2) sacral decubitus ulcers with exposed bone; and (3) evidence of resuscitative efforts (C 590, 939). The autopsy did not include Baclofen withdrawal syndrome as a final autopsy diagnosis (C 590, 594).

PLAINTIFF'S SECTION 2-402 MOTION TO CONVERT

On February 13, 2019, Plaintiff filed a lawsuit for the alleged wrongful death of her son (C 37-55). Plaintiff originally included claims against SIU Healthcare, Charlene Young, F.N.P., and Abdullah Al Sawaf, M.D. (C 37-49). She later named Ms. Kochman, a nurse from the SIU Neurology department who was involved in the pump refill as a defendant.

Attached to the Complaint was an affidavit of Cleeton's attorney and a Certificate of Merit from Dr. William Minore (C 916). Dr. Minore is a board-certified anesthesiologist who specialized in pain management (C 580). In his original certificate, Dr. Minore stated

that he reviewed the medical records from the SIU Medicine Department of Neurology, Memorial Medical Center, the autopsy report for Cleeton, two sets of records obtained from Medtronic regarding the Baclofen pump and catheter, and the studies and testing done on the catheter which purportedly revealed operator-related puncture holes (C 917). Dr. Minore concluded that there existed a reasonable and meritorious cause of action against the named defendants (*Id.*).

In her Complaint, Plaintiff also designated several individuals as Respondents in Discovery, including Dr. Bakir (C 37, 52, 917). On September 20, 2019, more than 6 months later, Plaintiff moved to extend the respondent in discovery status of Dr. Bakir (C 56-59). Dr. Bakir filed a Motion to Terminate his status as a respondent in discovery on September 27, 2019, stating that Plaintiff had not acted within the six month window set forth in 735 ILCS 5/2-402 (C 63-66, 67-70). Plaintiff filed a second motion to extend the respondent in discovery status on November 1, 2019 (C 72-75). Dr. Bakir responded explaining the lack of discovery which had occurred since the complaint had been filed (C 88-92). Dr. Bakir had agreed to appear for his deposition on October 25, 2019, but Plaintiff cancelled that deposition even though the Court had imposed a November 13, 2019 deadline for Plaintiff to move to convert Dr. Bakir to a defendant (C 90).

On November 13, 2019, Plaintiff filed her Motion to Convert Dr. Bakir from a Respondent in Discovery to a Defendant (C 117-120). In support of her Motion, Plaintiff attached another attorney affidavit, a "Certificate of Merit of Dr. Stephen Minore, M.D." dated November 12, 2019 (C 93-114) and two proposed counts against Dr. Bakir, one for wrongful death and one for a survival action claim (C 121-126). No other evidence was submitted at that time (C 93-126).

In his November 12, 2019 certificate of merit, Dr. Minore did not identify any additional materials he had reviewed since his certificate attached to the original Complaint (C 112-114, 917). Nor did Dr. Minore review Dr. Bakir's deposition, as Dr. Bakir was not deposed until September 24, 2020, more than 10 months later (*Id.*). In the certificate of merit, Dr. Minore concluded that Dr. Bakir deviated from the standard of care and that there was a reasonable and meritorious case for filing a lawsuit against him (*Id.*). Dr. Minore stated that he reviewed the records from Memorial Medical Center and created a timeline for the care and treatment provided by Dr. Bakir (C 112, 917). The timeline included:

> Dr. Bakir is a critical care specialist and was in charge of the diagnosis and treatment of Donald Cleeton when he was transferred to the Intensive Care Unit at 12:01 p.m. on October 30, 2017. From Dr. Bakir's records, Medtronic representatives and SIU Neurology clinic staff were contacted. At approximately 10:44 a.m., Memorial Medical Center received the faxed Emergency Procedure documents for Baclofen Withdrawal Syndrome. Inside those documents is language of the Emergency Procedure for Intrathecal Baclofen being administered. The records reflect that Dr. Bakir was notified of the elevated Troponin levels at 11:14 a.m. (C112-113, 917-918).

Dr. Minore then stated:

> Based upon a review of the tests performed, the presentation of symptoms and the Emergency Procedures faxed by the Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome. Intrathecal Baclofen was not ordered until 13:39 and not administered until 14:17. By the time the Intrathecal Baclofen had been administered, it was too late and Donald Cleeton died as a result of Baclofen Withdraw Syndrome (*Id.*).

According to Dr. Minore,

> based upon a review of the medical records provided by Memorial Medical Center, that Mouhammad Bakir, M.D., deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at

> approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner (C *Id.*).

Dr. Minore's Certificate of Merit also reserved the right to modify his opinions based on discovery:

> My opinions may be modified based upon additional evidence, including the discovery deposition of Dr. Mouhammad Bakir and review of further evidence and testimony of the witnesses (C 113, 917).

In her proposed counts against Dr. Bakir, Plaintiff alleged that Medtronic representatives were contacted and they faxed the Emergency Procedure documents regarding Baclofen withdrawal syndrome to Memorial Medical Center (C 123, 901-902). According to the proposed complaint, these procedures "include Medtronics [sic] recommended emergency procedure for the Intrathecal Baclofen being administered" (C 123, ¶ 14). Plaintiff alleged that the Emergency Procedure documents indicate the "[s]ymptoms of Baclofen withdrawal; and [s]uggested treatment for intrathecal Baclofen underdose or withdrawal" (*Id.*). Plaintiff then alleged that at 11:14, Dr. Bakir was notified by a nurse that Cleeton's troponin levels were elevated, an indication for Baclofen withdrawal syndrome (*Id.*, ¶ 15). Plaintiff then tracked the language of Dr. Minore's certificate to allege that "based upon a review of the tests performed, the presentation of symptoms and the Emergency Procedures faxed by the Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome" (C 123, ¶ 16).

Specifically with respect to Dr. Bakir, Plaintiff alleged that there existed a "duty on the part of the Defendant, Bakir, to provide adequate medical care, diagnosis, and treatment to his patients . . . within the standard of care of a reasonably careful critical care physician" (C 124, ¶ 20). Plaintiff then alleged that Dr. Bakir was guilty of one or more of the

following negligent acts or omissions: failed to timely recognize the differential diagnosis of Baclofen withdrawal syndrome; failed to order treatment consistent with the Medtronic, the pump manufacturer, Emergency Procedures [faxed to and] received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017; and failed to order the administration of Intrathecal Baclofen in a timely manner (C 124, ¶ 21). Plaintiff also alleged that as a direct and proximate result of the negligent acts and omissions of Dr. Bakir, Cleeton sustained a lethal Baclofen withdrawal which ultimately caused his death (C 124, ¶ 22).

On February 22, 2021, after Dr. Bakir was deposed and other discovery occurred, Dr. Bakir filed an Objection to Plaintiff's Motion to Convert (C 293-314). In support of his Objection, Dr. Bakir filed and relied upon the medical records (C 451-560, 583-873), his deposition (C 315-450), and the deposition of Dr. Abdullah Al Sawaf (C 129-292). In his Objection, Dr. Bakir explained how the discovery conducted since November 2019 when Plaintiff moved to convert Dr. Bakir refuted the assumptions and conclusions reached by Dr. Minore in his certificate of merit and thus, there was no basis to convert Dr. Bakir from a respondent in discovery to a defendant (C 293-314).

On March 15, 2021, Plaintiff filed a Reply to Dr. Bakir's Objection to her motion (C 884-888, 933-1075). In her reply, Plaintiff for the first time claimed that there was "clear evidence" that Cleeton's infectious process had improved, if not resolved, prior to his transfer to the intensive care unit and Dr. Bakir deviated from the standard of care by relying on a diagnosis of sepsis (C 920-921, 946). Plaintiff argued that in the absence of a reasonable basis to conclude sepsis was the cause of Cleeton's presentation, Dr. Bakir must have deviated from the standard of care by failing to diagnose and treat Baclofen

withdrawal syndrome (C 921, 946). Plaintiff did not support this argument with expert opinion testimony or a revised certificate from Dr. Minore (C 891, 921, 945-946). The analysis came from plaintiff herself (*Id.)*. Dr. Minore is barely mentioned in Plaintiff's Reply Memorandum (C 933-951; SC 4-21).

Dr. Bakir filed a Response to Plaintiff's Reply on April 5, 2021 (C 890-915). In his response, Dr. Bakir set forth the history of Cleeton's urinary tract infection based on the medical records which had previously been submitted (C 894-897). Dr. Bakir also informed the court that Plaintiff's interpretation of the medical records was not supported by a certificate of merit from Dr. Minore or anyone else (C 894). In addition, Dr. Bakir filed the deposition of neurologist Dr. Shilpa Chaku (neurologist),which was taken on March 12, 2021 to address Plaintiff's argument that Cleeton was suffering the signs and symptoms of Baclofen withdrawal (CI 4-133).

TRIAL COURT ORDER

On April 12, 2021, the trial court held a hearing on Plaintiff's Motion to Convert (R. 2-63). The parties outlined the evidence submitted and presented argument (*Id.)* On May 3, 2021, the trial court entered a written order denying Plaintiff's Motion to Convert and terminating Dr. Bakir's status as a respondent in discovery (C 916-932). The trial court found that Plaintiff's evidence was not sufficient to (1) set forth the standard of care against which Dr. Bakir's conduct was to be measured and (2) establish that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir was guilty of an unskilled or negligent failure to comply with the applicable standard of care (C 925, 929).

In reaching her decision, the trial court was "mindful of those cases which hold the plaintiff's burden under section 2-402 is a 'low threshold' and does not require a high degree of likelihood of success" (C 929 (citations omitted)). The trial court acknowledged her role as a "gatekeeper" under Section 2-402 and the requirement that she determine if probable cause existed for conversion (C 929).

The trial court evaluated the evidence in the context of a medical malpractice case and what a plaintiff is required to plead (C 930-932). The trial court found that Plaintiff "had failed to establish an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the standard of care" (C 930). She noted that Dr. Bakir had considered the diagnosis of Baclofen Withdrawal Syndrome and Cleeton's presentation of symptoms (C 930). The tests which were performed in the hospital did not reveal that the pump was malfunctioning (C 930-932). Dr. Bakir had a working diagnosis that Cleeton was suffering from sepsis resulting from a urinary tract infection (C 932). Dr. Bakir also consulted with specialists who considered other possible explanations for Cleeton's illness, including Baclofen Withdrawal Syndrome (C 932). The specialists advised Dr. Bakir that they did not believe Cleeton was suffering from Baclofen Withdrawal Syndrome (C 932). The trial court denied Plaintiff's motion to convert and terminated Dr. Bakir's status as a respondent in discovery (C 932).

APPELLATE COURT ORDER

The Fourth District Appellate Court applied a *de novo* standard of review, finding that it could address the merits of Plaintiff's appeal on uncontested evidence in the record. *Cleeton v. SIU Healthcare, Inc.*, 2022 IL App (4th) 210284-U, ¶ 21 ("*Cleeton*"). The Appellate Court set forth the Section 2-402 probable cause standard as meaning that "the

evidence necessary to establish the requisite probable cause need only be such as would lead a person of ordinary caution and prudence to believe or entertain an honest and strong suspicion that his injury was the proximate result of the tortious conduct of the respondent in discovery." *Cleeton*, ¶ 24 (citations omitted). The Appellate Court acknowledged the low threshold for such evidence and that the trial court serves as "gatekeeper." *Id.*

The Appellate Court then reviewed the evidence submitted regarding the applicable standard of care by which Dr. Bakir's conduct could be measured. The Appellate Court found that in the certificate of merit, Dr. Minore did not expressly set forth the standard of care for a pulmonary critical care specialist treating a critically ill patient who had a baclofen pump and where the physician had consulted multiple specialists regarding the patient's care. *Id*, ¶ 29. The Appellate Court agreed with the trial court that the Medtronic Emergency procedures did not establish the standard of care. *Id.*, ¶ 30. The Appellate Court found that while Dr. Minore had attempted to state how Dr. Bakir purportedly deviated from the standard of care, including by failing to order care consistent with the Medtronic procedures, he had not set forth the actual standard of care by which Dr. Bakir's conduct could be measured. *Id.*, ¶ 31. The Appellate Court rejected Plaintiff's argument that Dr. Bakir's knowledge of Baclofen withdrawal syndrome was sufficient to establish the standard of care. *Id.*, ¶ 32. The Appellate Court affirmed, concluding that the trial court had properly found that Plaintiff failed to establish probable cause. *Id.*, ¶ 33.

ARGUMENT

I. THE PLAINTIFF HAS THE BURDEN OF PRESNTING EVIDENCE DISCLOSING THE EXISTENCE OF PROBABLE CAUSE TO CONVERT A RESPONDENT IN DISCOVERY TO A DEFENDANT.

A. The Respondents in Discovery Statute.

This case involves application of the Illinois respondents in discovery statute, 735 ILCS 5/2-402. The statute provides:

> The plaintiff in any civil action may designate as respondents in discovery in his or her pleading those individuals or other entities, other than the named defendants, believed by the plaintiff to have information essential to the determination of who should properly be named as additional defendants in the action.
>
> Persons or entities so named as respondents in discovery shall be required to respond to discovery by the plaintiff in the same manner as are defendants and may, on motion of the plaintiff, be added as defendants if the **evidence discloses the existence of probable cause** for such action.
>
> A person or entity named a respondent in discovery may upon his or her own motion be made a defendant in the action, in which case the provisions of this Section are no longer applicable to that person.

735 ILCS 5/2-402 (emphasis added). The plain language of the statute requires a plaintiff filing a motion to convert to submit evidence disclosing the existence of probable cause. A plaintiff's compliance with the filing requirements alone does "not justify the granting of a section 2-402 motion." *Froehlich v. Sheehan*, 240 Ill. App. 3d 93, 98, 100 (1st Dist. 1992).

The trial court considering the motion is required to make an "evidentiary determination" based on all the evidence submitted of whether the plaintiff has met his burden under the statute. *Id.*, 240 Ill. App. 3d at 102. The trial court serves as "gatekeeper." *McGee v. Heimburger*, 287 Ill. App. 3d 242, 247-248 (4th Dist. 1997). Indeed, the trial court must find that evidence from "all sources" shows adequate grounds for the conversion

of a respondent in discovery to a defendant. *Browning v. Jackson Park Hosp.*, 163 Ill. App. 3d 543, 549 (1st Dist. 1987). The trial court must also "ensure that plaintiffs file only meritorious medical malpractice actions." *Williams v. Medenica*, 275 Ill. App. 3d 269, 272 (1st Dist. 1995). Eliminating "frivolous" lawsuits is one purpose of the statute. *Coyne v. St. Bernard's Hosp.*, 281 Ill .App. 3d 587, 592 (1st Dist. 1996); *Williams*, 275 Ill. App. 3d at 272.

Thus it is the judicial branch, not a plaintiff or an expert, who determines whether there is probable cause for conversion. Allowing a plaintiff to have the "unilateral" say of whether the evidence submitted is sufficient could have "absurd" results. *Torley v. Foster G. McGaw Hosp.*, 116 Ill. App. 3d 19, 23 (1st Dist. 1983). As held in *Torley*, "[i]t would be equally absurd to construe this provision as permitting plaintiff to make the unilateral judgment that such probable cause does indeed exist without court authorization." *Torley*, 116 Ill. App. 3d at 23.

B. A finding of probable cause requires evidence that leads a person of ordinary caution and prudence to believe or entertain a strong suspicion that his injury was proximately caused by the respondent in discovery.

According to Plaintiff, this appeal "questions the proper evidentiary standard required to establish probable cause pursuant to Section 2-402." (Pl. Brief, p. 5.) Dr. Bakir believes this appeal involves whether Plaintiff met her evidentiary burden as set forth in the applicable case law for converting him from a respondent in discovery to a defendant.

The Appellate Courts of Illinois have consistently held that the "probable cause" requirement is met when all of the evidence "lead[s] a person of ordinary caution and prudence to believe or entertain an honest and strong suspicion that his injury was the proximate result of the tortious conduct of the respondent in discovery." *E.g. Williams v.*

Medenica, 275 Ill. App. 3d 269, 272 (1st Dist. 1995). *See also Cleeton v. SIU Healthcare, Inc.*, 2022 IL App (4th) 210284-U, ¶ 24; Pl. Brief, p. 19. While appellate courts have held that the threshold of evidence is not a high one and need not rise to the level of evidence necessary to defeat a motion for summary judgment or to make a *prima facie* case against the respondent in discovery, this does not mean that every plaintiff's motion is rubber stamped. *McGee*, 287 Ill. App. 3d at 248; *Williams*, 275 Ill. App. 3d at 272. The requirements of 735 ILCS 5/2-402 are not "hoop jumping" or "empty formalism." *Froehlich*, 240 Ill. App. 3d at 103 (noting that the statute gives plaintiff the right to discovery to support her motion).

What evidence is sufficient to establish probable cause is dependent on the nature and complexity of the case. *Medjesky v. Cole*, 276 Ill. App. 3d 1061, 1065 (4th Dist. 1995); *Cleeton*, at ¶ 25. In a case alleging medical malpractice, as compared to other cases, "a significantly greater amount of 'evidence' may be required" than just a proposed amended complaint setting forth the involvement of the respondent in discovery. *Id.*

Courts also consider the evidence submitted in light of the elements of the cause of action the moving plaintiff intends to plead and prove. *Ingle v. Hospital Sisters Health System*, 141 Ill. App. 3d 1057, 1062 (4th Dist. 1986). In a medical malpractice action, a plaintiff must allege: the proper standard of care against which the physician's conduct is to be measured; an unskilled or negligent failure to comply with the applicable standard of care; and a resulting injury proximately caused by the physician's negligence or want of skill or care. *Mayer v. Braiser*, 147 Ill. App. 3d 159, 155 (4th Dist. 1986) (citing *Purtill v. Hess*, 111 Ill.2d 229, 242-243 (1986)). In medical malpractice cases these elements, including the standard of care, are proved through expert testimony. *E.g. Advincula v.*

United Blood Services, 176 Ill.2d 1, 24 (1996); *Addison v Whittenberg*, 124 Ill.2d 287, 297 (1988).

Plaintiff implies that the trial court should not look at the elements of the cause of action in considering the motion. That contention ignores the case law incorporating the elements of the cause of action into the Section 2-402 analysis. A plaintiff must plead the elements in her cause of action so why should those elements not be used in the Section 2-402 context so frivolous lawsuits are precluded.

Accordingly, when considering a Section 2-402 motion to convert in the medical malpractice context a circuit court may grant the motion to convert "only if a plaintiff presents evidence that would engender, in an ordinarily cautious and prudent person, an honest and strong suspicion that the respondent's alleged breach of the applicable standard of care was the factual and legal cause of the plaintiff's injury." *Froehlich*, 240 Ill. App. 3d at 102. *See also Ingle*, 141 Ill. App. 3d at 1062. In doing so, the court must consider all of the evidence submitted. *Moscardini v. Neurosurg, S.C.*, 269 Ill. App. 3d 329, 339 (2nd Dist. 1994); *Medjesky*, 276 Ill. App. 3d at 1065. This necessarily includes any evidence submitted by the respondent in challenging the motion.

II. A SECTION 2-622 CERTIFICATE OF MERIT IS ONE PIECE OF EVIDENCE A COURT CAN CONSIDER IN EVALUATING A SECTION 2-402 MOTION TO CONVERT.

Plaintiff spends a significant portion of her brief discussing the Healing Arts Malpractice Act, 735 ILCS 5/2-622, and comparing that statute to Section 2-402. Plaintiff contends that "the evidentiary burden required by section 2-402 is the same or similar to the requirement a physician certify the merit of the case pursuant to section 2-622." (Pl. Brief, p. 24.) Essentially, Plaintiff is arguing that if she submits some 2-622 certificate,

even if it is not accurate or complete, then the motion to convert must be granted. The purpose of the statute in deterring frivolous lawsuits, however, would be thwarted by a bright line rule which deems a plaintiff's 2-622 certificate of merit sufficient to grant the motion to convert.

A. The Trial Court, Not The Plaintiff, Determines Compliance With Section 2-402 And With Section 2-622.

A comparison of both Section 2-402 and Section 2-622 shows that it is the court, not the plaintiff, who determines if the statute has been complied with. Section 2-402 can be "be read as requiring the **court** to which the motion is addressed to make such a finding on whatever evidence may be presented." *Torley*, 116 Ill. App. 3d at 23 (emphasis added); *Froehlich*, 240 Ill. App. 3d at 99 ("a court may rule on the merits"). Similarly, this Court held in determining a challenge to Section 2-622

> [t]he **judge** presumably takes the medical report into account in determining the sufficiency of the complaint. However, the **judge alone** has power to dismiss the cause if he finds the complaint to be insufficient.

McAlister v. Schick, 147 Ill.2d 84, 93 (1992) (emphasis added). *See also Murneigh v. Gainer*, 177 Ill.2d 287, 302 (1997) (the "judicial function" involves "interpreting and applying laws in specific cases"). Similarly, as enunciated by this Court in *DeLuna v. St. Elizabeth's Hosp.*, 147 Ill.2d 57, 68, 72 (1992), a health professional who submits a 2-622 certificate "does not exercise a judicial power." If a plaintiff or the author of the certificate of merit had the "unilateral" say on whether a respondent could be converted, the results could be "absurd." *Torley*, 116 Ill. App. 3d at 23.

B. The Purpose Of The Statutes Reflects A Requirement That The Court Consider All Of The Evidence Presented.

Section 2-402 and Section 2-622 share a similar purpose – to deter frivolous lawsuits. "[T]he benefits of preventing frivolous suits outweigh the burden on the plaintiff" in complying with the statute. *McAlister*, 147 Ill.2d at 98 (interpreting Section 2-622). Section 2-402 should not be interpreted narrowly simply because an evidentiary submission which does not meet the standards of Section 2-402 or Section 2-622 may result in a dismissal of a potential party. *See DeLuna*, 147 Ill.2d at 73 (discussing the dismissal of a lawsuit when a plaintiff fails to comply with Section 2-622).

Section 2-402 can have an added benefit to plaintiffs – the extension of the statute of limitations by six months or more as applied to the respondent in discovery. *Froehlich*, 240 Ill. App. 3d at 103. *See also* 735 ILCS 5/13-202. This added benefit requires "[s]crupulous adherence to the requirements of section 2-402 [to be] a condition precedent to the plaintiffs right to seek a remedy" against individuals or entities named as respondents in discovery. *Knapp v. Bulun*, 392 Ill. App. 3d 1018, 1024 (1st Dist. 2009). The added benefit to plaintiff from the longer statute of limitations can come with additional requirements.

In reality, a plaintiff's submission of a 2-622 certificate of merit in support of a motion to convert is one piece of evidence a trial court may review in considering the motion. Given that a plaintiff has a unilateral right to conduct discovery against a respondent in discovery, it is not unreasonable in certain cases to require a plaintiff to submit an accurate and complete 2-622 certificate or more evidence than just a 2-622 certificate in support of the motion to convert. Each case is case specific depending on the evidence submitted to the trial court.

A trial court need not accept or adopt only the certificate of merit when considering a plaintiff's motion to convert. If that were the case, a respondent could never challenge the evidence submitted even if it were wrong or did not make sense. Just looking at the Minore certificate itself, the certificate has the time of Cleeton's arrival in the intensive care unit incorrect and also relies at length on the Medtronic procedures which Dr. Bakir never received. The trial court must be allowed to consider the certificate of merit in addition to other evidence submitted.

The cases cited by Plaintiff support this principle. For example, in *Moscardini,* the issue was whether an unverified physician's report could be considered *at all* by the trial court in support of the motion to convert. The trial court had ruled that it could not. In ruling that the report could be considered as one piece of evidence, the appellate court acknowledged that the moving plaintiff had also submitted deposition testimony from the respondents in discovery which the physicians who authored the certificates had reviewed. *Moscardini*, 269 Ill. App. 3d at 338. The *Moscardini* court reversed the trial court's decision and remanded "so that the trial court may consider the physicians' letters, plaintiff's attorney's affidavit, and the deposition transcripts in determining whether there [was] probable cause." *Id.* at 339. In other words, the court remanded so that the trial court could consider all of the evidence presented.

In *Ingle*, the plaintiff supported her motion with an affidavit from a physician, discovery depositions, x-rays which had been interpreted by the two respondents in discovery, and the respondents' reports on the x rays to the treating physician. *Ingle,* 141 Ill. App. 3d at 1062. The court highlighted how in the depositions one of the respondents testified that the purpose of a radiologist's report is to provide information on which the

treating physician could rely. Both respondents testified in their depositions that they did not make any report to the treating physician that the x-rays gave any indication that a catheter might be in an improper position, although they agreed that it might be difficult to see the tip of the catheter and that the possibility existed that the catheter could be outside of an acceptable position. The deposition testimony was accompanied by a physician's affidavit stating that the affiant physician had reviewed the x rays in question and that it was possible to discern that the tip of the catheter could be in the wrong position.

The appellate court acknowledged the elements of a cause of action for medical malpractice, including "(1) the proper standard of care against which the professional's conduct must be measured; (2) a negligent failure to comply with the standard; and (3) that the injury for which the suit is brought had as one of its proximate causes, the negligence of the professional." *Id.*, 141 Ill. App. 3d at 1064. The court looked at the "totality of the matter" in rendering its decision. *Id.* The court found that the deposition testimony was sufficient to indicate the standard of care against which the conduct of the respondents in discovery was to be measured – that the respondents in discovery had a duty through the standard of care to report to the treating physician anything about x-rays which would be significant. *Id*. The appellate court noted that the totality of the matter before it would also require a reasonable person to have a strong and honest suspicion that any failure on the part of the respondents to properly advise the treating physician of significant matters about the x-rays was a proximate cause of the ultimate injury to the plaintiff. *Id.* The appellate court stated that the "difficult question" was whether there was a strong enough showing that the respondents in discovery failed to give necessary information to another physician to require the court to have found that probable cause existed for conversion. *Id.*

Ultimately, the appellate court found the affidavit of the plaintiff's proposed expert was corroborated by the deposition testimony of the respondents in discovery and the plaintiff had established the requirements of Section 2-402. *Id.,* 141 Ill. App. 3d at 1064-65.

Ingle shows how a plaintiff can use a certificate of merit, the events that occurred and the deposition testimony to establish the applicable standard of care, proximate cause and probable cause for a motion to convert. The case also shows how the trial court is obligated to review all of the evidence submitted by the plaintiff.

As shown, a certificate of merit is just one piece of evidence which a court can consider in ruling on a motion to convert. A plaintiff's statement that she has met the certificate of merit requirement is not controlling. A court is also permitted to consider whether a certificate of merit is accurate and complete in light of other evidence submitted.

Likewise, a plaintiff's statement that she has met the Section 2-402 requirement is not controlling. A plaintiff is simply not allowed to act as the judge and usurp the role of the judiciary. Rather, as explained above, a court considering a motion to convert is required to consider all of the evidence submitted to determine if it meets the probable cause requirement.

Here, both the trial court and the Appellate Court found that Plaintiff failed to submit evidence establishing the proper standard of care against which Dr. Bakir's conduct could be measured. *Cleeton*, ¶¶ 28-32; C 925-926. The trial court further reviewed all of the evidence submitted by both Plaintiff and Dr. Bakir and additionally found that she could not "conclude that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard of care. Nor can the Court conclude Mr. Cleeton died as a result

of any act or omission on Dr. Bakir's part." (C932; 926-930.) The appellate court likewise fully considered the evidence that Plaintiff submitted on the standard of care, including the Minore certificate. Despite the hyperbole in Plaintiff's Brief, it is clear both the trial court and the appellate court complied with the applicable legal standards in their rulings. Their decisions should be affirmed.

III. PLAINTIFF FAILED TO PRESENT EVIDENCE OF THE STANDARD OF CARE SUFFICIENT TO ESTABLISH PROBABLE CAUSE AS REQUIRED BY SECTION 2-402.

A. The Minore Certificate Does Not Set Forth The Applicable Standard Of Care.

The trial court and the Appellate Court both considered the certificate of merit from Dr. Minore and the other evidence presented. What each court found after thoroughly analyzing all of the evidence was that Plaintiff had not set forth the applicable standard of care by which Dr. Bakir's conduct could be measured. The courts did not overlook the certificate. Rather, they found that the certificate and other information submitted by Plaintiff did not set forth the standard of care owed by Dr. Bakir to Cleeton and the evidence was not sufficient to establish that a man of ordinary caution and prudence would entertain an honest and strong suspicion that the purported negligence of the respondent in discovery was a proximate cause of plaintiff's injury. (*Cleeton*, ¶ 32; C 925-926.)

As noted by the Appellate Court, Dr. Minore in his certificate did not expressly set forth the standard of care of Dr. Bakir. *Cleeton*, ¶ 29. Nor has Plaintiff in her brief specifically identified where the standard of care is set forth in her evidentiary submission. Plaintiff now states that the standard of care should have been whether a "reasonable pulmonology critical care physician should have reasonably recognized that Donald was suffering from baclofen withdrawal syndrome and provided appropriate and timely

treatment for such condition." (Pl. Brief, p. 32.) But as determined by both the trial court and the appellate court there was no evidence submitted by Plaintiff on this matter. And, as shown below, the standard of care was not even "implicit" in the Dr. Minore certificate, assuming "implicit" matters are even evidence.

Before the trial court, Plaintiff through Dr. Minore, attempted to establish the standard of care through the following statement:

> Based upon a review of the tests performed, the presentation of symptoms and the Emergency Procedures faxed by Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome (C 925).

Cleeton, ¶ 30. Plaintiff also argues that the standard of care is set forth in the certificate of merit through the following:

> based upon a review of the medical records . . . Mouhammad Bakir, MD deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 am on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner.

(Pl. Brief, p. 26 (citing C113).) Plaintiff then proceeds through her own interpretation of the medical records from Memorial Medical Center. (Pl. Brief, p. 27-29.)

First, Plaintiff's reliance on the Medtronic Emergency procedures is not sufficient to establish the standard of care. Plaintiff includes a reference to those procedures in both the Minore certificate and in her proposed amended complaint. (C 123, ¶ 14, 16.) The procedures were faxed to the hospital, but never provided to Dr. Bakir during his treatment of Cleeton. *Cleeton,* ¶ 30; C 925. They were not incorporated into Cleeton's chart and available to Dr. Bakir until after Cleeton's death. (*Id.*) The instructions themselves do not set forth the standard of care. (C 654-655, 874-875.) Thus, those procedures could not

form the standard of care of Dr. Bakir. Plaintiff actually appears to have abandoned parts of her arguments relating to these procedures by only briefly mentioning them in her discussion of the standard of care. (Pl. Brief, p. 26-27.)

Second, plaintiff contends that Dr. Minore relied on Cleeton's "signs and symptoms, as well as the studies performed, as set forth in the Memorial Medical Center records, to determine the standard of care required Bakir to diagnose baclofen withdrawal syndrome." (Pl. Brief, p. 26-27.) Yet, "signs and symptoms" are missing from the Dr. Minore certificate and there are no indications about how the "signs and symptoms" relate to the standard of care owed by Dr. Bakir to Cleeton. (C 112-113.) Plaintiff appears to be focused on her interpretation of what Dr. Minore did not set forth in his certificate or things that are allegedly "implicit" from what he set forth as compared to what he actually set forth. (*See* Amicus Brief, pp 5-6.) Implications are not evidence. The lack of statements by Dr. Minore does not create evidence of the standard of care.

In addition, while Dr. Minore's Certificate does reference "the tests performed," and the "presentation of symptoms" there is no discussion of those matters other than the elevated troponin level. There are no statements of how the elevated troponin level is indicative of the standard of care, Baclofen withdrawal syndrome, sepsis or some other cardiac issue. Nor is there an assertion by Plaintiff that the standard of care required Dr. Bakir to perform or order some test which was not performed or ordered.

While Dr. Bakir was familiar with Baclofen Withdrawal Syndrome, being familiar with a condition does not establish the standard of care. *Cleeton*, ¶ 32. While a plaintiff can use testimony from a party physician to establish the applicable standard of care, there still must be some testimony about what the standard of care is or requires. *See e.g. Walski*

v. Tiesenga, 72 Ill.2d 249, 259-260 (1978); *Okic v. Fullerton Surgery Center, Ltd.*, 2019 Ill. App. (1st) 181074, ¶¶ 73-74. The appellate court agreed. *Cleeton,* ¶¶ 31, 32.

Plaintiff has not cited any testimony from Dr. Bakir, or anyone else, about the standard of care. Plaintiff did not ask, and Dr. Bakir did not testify, about what the standard of care was or what the standard of care required. *Compare Ingle*, 141 Ill. App. 3d at 1062 (finding that the respondents testified in their discovery depositions about reporting the results of an x ray). In addition, Dr. Minore did not incorporate any part of Dr. Bakir's deposition testimony into a certificate of merit, which he reserved the right to do. There is simply no evidence of the standard of care of a critical care physician under the circumstances at hand.

B. Plaintiff's Interpretation Of The Medical Records Is Misplaced And Does Not Disclose The Standard Of Care Or Probable Cause.

Plaintiff's discussion and interpretation of the medical records and Cleeton's symptoms in her Brief does not create evidence of the standard of care, proximate cause or probable cause for that matter. Before the Appellate Court, Plaintiff's arguments regarding Cleeton's symptoms focused more on the "proximate result of the tortious conduct" portion of the Section 2-402 probable cause analysis than standard of care. In addition, Plaintiff's statements about Cleeton's symptoms are just that – her own interpretations, not evidence of the standard of care. The Minore certificate is silent on the symptoms of Baclofen withdrawal. The courts were not required to rely on Plaintiff's conclusions from the evidence she submitted. *See Torley,* 116 Ill. App. 3d at 22-23.

i. Altered mental status – Plaintiff cites portions of the deposition testimony of Dr. Bakir in an attempt to show that Cleeton had altered mental status consistent with baclofen withdrawal syndrome. There was no evidence that the condition observed in

Cleeton was consistent with Baclofen withdrawal or that these symptoms somehow established the applicable standard of care. Dr. Minore is silent about Cleeton's purported altered mental status. His certificate does not state that he was experienced in Baclofen therapy such that he could determine the level of altered mental status in a patient he had never seen. His certificate actually only states that he "was well versed in the care and treatment of patients who have undergone Baclofen pump implantations." (C 112.) These are not the same.

Dr. Bakir, unlike Dr. Minore, saw Cleeton. Dr. Bakir also consulted with the care team to determine the significance of Cleeton's symptoms. (SC 81, p. 61.) The neurologists (Dr. Al Sawaf and Dr. Chaku) who examined Cleeton and with whom Dr. Bakir consulted did not state or opine that Cleeton had "altered mental status" upon which a diagnosis of Baclofen withdrawal syndrome could be made. (C 305, 635, 905, 926-927; CI 86-88, 116.) In fact, the other physicians found Cleeton to be awake, alert and able to answer questions appropriately. (C 305, 635, 905; CI 86-88, 116.) There was no correlation by Dr. Minore, or Plaintiff, of altered mental status and patients suffering from Baclofen withdrawal syndrome.

ii. Increased spasticity - Plaintiff also claims that increased spasticity is a sign of Baclofen withdrawal syndrome as admitted by Dr. Bakir. Again, there is no discussion from Dr. Minore regarding this symptom. Dr. Bakir testified that Cleeton did not have muscle rigidity which is a symptom of Baclofen withdrawal. (C 304, 3345-337, 341, 398.) Dr. Al Sawaf found that while Cleeton had decreased tone, he was not spastic in his upper or lower extremities consistent with Baclofen Withdrawal Syndrome (C 157,

192-193, 227, 305). Dr. Chaku testified that Cleeton's spasticity was consistent with his urinary tract infection. (C 905-906; CI 48, 83-90.)

iii. Increased spasms following a difficult pump refill – Plaintiff cannot link this temporal relationship fact to the standard of care. The reason why is evident – courts have held that a temporal association alone is not sufficient to "infer" causation, let alone establish the standard of care. *See e.g. Hussung v. Patel*, 369 Ill. App. 3d 924, 933-934 (2ns Dist. 2007) (discussing the temporal relationship a the summary judgment stage, but also noting that timing alone cannot be used to infer causation since that would shift the burden of proof from plaintiff to defendant). Plaintiff contends that this proposition of law should be ignored at this stage of the litigation, but that ignores the trial court's role as gatekeeper. Allowing a plaintiff to rely on something in her evidentiary submission that the plaintiff cannot later rely on does not deter frivolous lawsuits, but rather, encourages their filing.

In addition, Dr. Bakir paged the Medtronic representative and consulted with the SIU neurology department about the pump. Ms. Young reported that Cleeton's baclofen pump was working as expected. (*Cleeton*, ¶ 32.) This information was important to Dr. Bakir as administering baclofen in a situation where a patient was not going through baclofen withdrawal could result in a baclofen overdose with significant consequences. (C 300, 402-403). Moreover, that later testing after Cleeton's death may have purportedly shown that there could have been holes in the catheter does not establish the standard of care (or proximate cause) sufficient to meet the requirements of section 2-402. Any testing was not known to Dr. Bakir, or any other provider, while Cleeton was at the hospital.

iv. Autonomic dysreflexia – Despite Plaintiff's statements, the presence of this symptom does not relate to the standard of care. This condition is an overreaction of the involuntary (autonomic) nervous system which is commonly caused by spinal cord injury and can result in a change in heart rate and blood pressure. *See* *https://medlineplus.gov/ency/article/001431.htm* (last accessed on December 19, 2022). Again, Dr. Minore's certificate does not cite the medical record, use the phrase "autonomic dysreflexia" or describe Cleeton's heart rate or blood pressure. Cleeton had automatic dysreflexia at baseline and he had a urinary tract infection which can trigger this condition. (C 906-907; CI 71-77.)

v. Improvement of the infectious process – Plaintiff makes a claim that there was "clear evidence" that Cleeton's infectious process was improving. (Pl. Brief, p. 31; C 946.) It is not clear how this argument relates to the standard of care. This argument was first raised in Plaintiff's Reply to Dr. Bakir's Objection to her motion to convert. (C 945-946.) Notably absent from Plaintiff's Reply was any discussion by Dr. Minore, or any other medical provider, relating to improvement in Cleeton's condition or the standard of care relating to the same. (C 921.) In responding to this argument, Dr. Bakir pointed out that Plaintiff's own interpretation of the medical records was not logical or supported by the medical records themselves. (C 391, 596, 895-897.) For example, Plaintiff claims that the blood cultures did not show any infectious growth, but those cultures were not returned during Cleeton's time in the hospital and were taken after antibiotics had been given. (C 701, 703, 895.) The fact that the cultures later showed no growth could not form a basis for the standard of care or for Dr. Bakir to rule out sepsis while Cleeton was in the intensive care unit. (C 897.) Plaintiff's infectious disease process statement is a creation of her own.

Plaintiff's interpretation of the medical records does not establish the standard of care, proximate cause, or probable cause. Her interpretation is not evidence. Plaintiff did not file an affidavit stating that she had consulted and reviewed these facts with a qualified reviewing health professional who concluded that Cleeton's sepsis or infectious disease process had resolved by the time Cleeton was admitted to the intensive care unit or that this set the standard of care. Nor was a letter or certificate from a medical professional included.

Plaintiff's own interpretation of Cleeton's presentation is no different than a plaintiff just filing a motion to convert without any evidence of probable cause. There is no modicum of reliability. Plaintiff's interpretation is even less reliable than the unsworn, unsigned and undated letter from an internist which was rejected as evidence in *Froehlich*. *See Froehlich,* 240 Ill. App. 3d at 103. If Plaintiff's arguments were accepted, Section 2-402 would have no threshold as compared to a low one and the word "evidence" as used in the statute would be rendered meaningless.

The trial court undertook its role as gatekeeper in considering the medical records, the certificate of Dr. Minore, and the deposition testimony. (C 926-932.) This is what she was required to do by the statute and applicable case law. The trial judge did not step into the role of a juror or the trier of fact. Rather, she undertook her judicial authority to consider the motion to convert on all of the evidence submitted by the parties. Her determination that Plaintiff had not only failed to establish the applicable standard of care, but also proximate cause, was not an abuse of discretion or erroneous.

In summary, Plaintiff's analysis of the signs and symptoms that Cleeton presented in the intensive care unit does not establish the standard of care, proximate cause or

probable cause. Dr. Minore's certificate is particularly silent. Plaintiff did not disclose evidence to meet the requirements of Section 2-402. The appellate court should be affirmed.

C. Illinois Pattern Jury Instructions Are Not Evidence Of The Standard Of Care.

The *amicus*, citing the introductory language to Chapter 105 of the Illinois Pattern Jury Instructions, attempts to argue that a plaintiff need not present evidence on the standard of care in support of a Section 2-402 motion because an Illinois Pattern Jury Instruction is given to a jury about standard of care. This argument ignores that jury instructions are designed to instruct the jury on the correct principles of law. *Hana v. Illinois State Medical Inter-Insurance Exchange Mut. Ins. Co.*, 2018 IL App. (1st) 162166, ¶ 36; *People v. Grant*, 2016 IL App. (5th) 130416, ¶ 29. Jury instructions are not evidence. *Id.* In addition, in medical malpractice actions a plaintiff bears the burden of establishing the applicable standard of care by which a medical provider's conduct is to be measured through the use of expert testimony. *Advincula*, 176 Ill.2d at 24. A plaintiff cannot solely use a jury instruction setting forth the law to establish the standard of care. A party's recitation of a pattern jury instruction is simply not "evidence" of the standard of care allegedly breached by a respondent in discovery.

D. Plaintiff Chose When And How To Proceed On Her Motion To Convert.

Plaintiff having chosen to use the respondent in discovery process was required to comply with the statute. Plaintiff had additional time to conduct discovery before the motion to convert was heard. She chose not to submit a supplemental certificate of Dr. Minore, even though Dr. Minore reserved the right to do so. Any claim by Plaintiff's that Minore's certificate may not have been as artfully crafted as it could have been is of her

own doing, not that of Dr. Bakir. Nothing precluded Plaintiff from submitting a revised or supplemental certificate.

When Plaintiff did submit additional matters in support of her motion to convert, she provided no expert analysis of those matters and instead relied upon her own interpretation of the depositions and medical records. Neither the trial court nor the appellate court were bound to accept Plaintiff's unilateral statements about the Minore certificate or her interpretation of the depositions and medical records. To hold otherwise would usurp the judiciary's role in considering Section 2-402 motions to convert and could lead to an absurd result. The trial court (and the appellate) court could not make a finding of an "honest and strong" suspicion that Dr. Bakir deviated from the standard of care when there was no evidence to establish the applicable standard of care. Dr. Bakir requests that the Appellate Court's decision be affirmed.

E. The Trial Court And The Appellate Court Did Not Exceed Their Authority.

After setting forth her own interpretation of the evidence submitted, Plaintiff goes back to the case law cited earlier and claims that her evidence was equivalent to what was submitted in those cases. Plaintiff also claims that the trial court acted as a trier of fact, not the judge. Yet, neither the trial court, nor the appellate court, exceeded its authority in evaluating the medical records, the Minore certificate or the deposition testimony. The trial court was required to consider all of the evidence in rendering its decision, not just one piece of evidence. The trial court noted that Dr. Minore's certificate contained "conclusions," not evidence. The trial court further found that the evidence which did exist refuted the basis upon which Dr. Minore relied. This is not the trial court (or the appellate court) substituting its judgment for the ultimate trier of fact, bur rather pointing out the

insufficiency of the materials Plaintiff presented in support of her own burden of proof. The trial court did not exceed its authority in determining that there was no evidence of the applicable standard of care or that Cleeton's signs and symptoms were not consistent with Baclofen withdrawal syndrome. Considering Dr. Minore's certificate alone and in a vacuum would have been an abuse of discretion.

Plaintiff also claims that the evidence supported a finding that Dr. Bakir's breach of the standard of care caused or contributed to Cleeton's death. Dr. Bakir would be remiss in failing to point out that the only evidence that supports that Cleeton passed from Baclofen withdrawal syndrome was Dr. Minore's conclusory statement in his certificate. The autopsy did not reveal baclofen withdrawal syndrome as the cause of death. (C 301, 590, 594.)

The fact that Dr. Bakir knew that baclofen withdrawal syndrome could cause certain symptoms simply does not establish the applicable standard of care, particularly in light of the fact that Dr. Bakir consulted with other physicians on the team. Dr. Al Sawaf even told Dr. Bakir that he did not believe Cleeton was suffering from Baclofen withdrawal syndrome. (C 240, 243, 255, 300.) Plaintiff did not submit evidence on the standard of care or for that matter proximate causation such that the evidence disclosed probable cause. There was not sufficient evidence "that would engender, in an ordinarily cautious and prudent person, an honest and strong suspicion that the respondent's alleged breach of the applicable standard of care was the factual and legal cause of the plaintiff's injury." *Froehlich*, 240 Ill. App. 3d at 102.

Mere argument, unsupported allegations and jury instructions are not "evidence" which can establish that a man of ordinary caution and prudence would entertain an honest

and strong suspicion that Dr. Bakir deviated from the applicable standard of care in his treatment of Cleeton. Plaintiff failed to meet the requirements of Section 2-402. The fact that Plaintiff does not accept the decisions of the lower courts does not mean that they went too far in their analysis. The appellate court's decision should be affirmed.[1]

F. The Trial Court And The Appellate Court Did Not Erroneously Apply Case Law.

Plaintiff spends part of her brief arguing that the trial and appellate courts erroneously applied caselaw addressing the proof required to establish the elements of a medical malpractice case at later stages of litigation. (Pl. Brief, p. 29.) In raising this argument, plaintiff ignores that Section 2-402 is also designed to deter frivolous lawsuits. Thus, a 2-402 motion to convert should be analyzed in terms of the elements of the cause of action the plaintiff is attempting to assert. *See also, DeLuna*, 147 Ill.2d at 73 (noting that the 2-622 requirements are "no different from the parallel requirement . . . that the plaintiff . . . present expert testimony to demonstrate the applicable standard of care and its breach"). Plaintiff later admits this when she agrees that the 2-402 burden requires evidence of purported negligence, breach of the applicable standard of care and proximate cause. (Pl. Brief, p. 19, 24.) Before the trial court, Plaintiff also agreed that probable cause must exist for the cause of action the plaintiff proposes to assert against the respondent in discovery and set forth the elements of a claim for medical malpractice. (C 943-944.)

[1] Should this Court determine that Plaintiff did in fact submit sufficient evidence of the applicable standard of care, Dr. Bakir respectfully requests that this matter be remanded to the appellate court for the appellate court to consider the remainder of the trial court's decision – that plaintiff has otherwise failed to establish that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard of care and proximate cause. (C. 926-932.) This issue was not decided by the appellate court, although briefed before it.

Plaintiff claims that her "expert" is not required to provide a direct statement of the applicable standard of care. (Pl. Brief, p. 32.) Plaintiff's citation to the case of *Williams v. Medenica*, confirms that evidence of the applicable standard of care is required: plaintiff must show that the evidence "would engender, in an ordinary and prudent person, an honest and strong suspicion that the respondents in discovery breached the **applicable standard of care** and that their breach proximately resulted in injury to the plaintiff." *Williams,* 274 Ill. App. 3d at 273 (emphasis added). While the standard of care can come from deposition testimony of the respondents in discovery themselves or other medical providers or other evidence, it must come from somewhere. A plaintiff cannot set forth the standard of care on her own volition in her motion to convert or in her appellate briefing.

The courts' decisions here are consistent with the decisions cited by Plaintiffs. For example, in *Moscardini*, the appellate court found that "[t]he physicians who wrote the letters opining that respondents had been negligent based their opinions on these depositions" and that the "factual assertions contained in the letters can be **corroborated** by respondents' depositions." *Moscardini*, 269 Ill. App. 3d at 338 (emphasis added). The same is not true in this case.

Plaintiff further contends that no appellate court considering a trial court's denial of a 2-402 motion to convert has ever affirmed the trial court.[2] Plaintiff's argument needs to be placed into context. First, when a motion to convert is allowed by the trial court and a respondent in discovery is converted into a defendant, there is no avenue for the

[2] Plaintiff's statement should be revised to reflect that no published decision has affirmed the trial court's denial of a motion to convert. Dr. Bakir refers the Court to the case *Cincinnati Ins. Co. v. A-Square Mfg., Inc.*, 2015 IL App (2d) 141032-U, an unpublished decision whose citation is governed by Illinois Supreme Court Rule 23. Dr. Bakir cites that case here to correct Plaintiff.

respondent to appeal, other than perhaps a certified question pursuant to Illinois Supreme Court Rule 308. Only when the motion to convert is denied can the Illinois Supreme Court Rule 304 process be used to bring the trial court's order denying the motion to convert before the appellate court. Thus, the Section 2-402 cases proceeding on appeal are already limited. In addition, several of the appellate cases discussing Section 2-402 in the appellate process have done so in the context of the procedure being used as compared to the evidence which was presented. Even in *Williams* discussed at length in Plaintiff's Brief, there was a full remand directing the trial court to consider all of the evidence presented, not just a reversal of the order denying the motion to convert. *Id.*

In summary, the trial court was correct (as affirmed by the appellate court) in finding that there was not an honest and strong suspicion that Dr. Bakir deviated from the standard of care and that the deviation proximately caused Cleeton's death. Dr. Bakir himself considered several diagnosis and asked other specialists to evaluate Cleeton to determine if he was suffering from Baclofen withdrawal and to determine if the pump was working properly. Dr. Bakir did what a reasonable and careful critical care physician would do under the circumstances. – he treated Cleeton and consulted with the members of the team. To accept Plaintiff's arguments, unsupported conclusions and assumptions would essentially tell physicians that they cannot rely on the statements of a specialist in evaluating a patient. Rather, your medical practice is controlled by a third party, hired by the plaintiff who never saw the patient and who has not set forth all of the salient matters. Dr. Minore's certificate was insufficient and contradicted by the records and deposition testimony.

IV. ACCEPTING PLAINTIFF'S PUBLIC POLICY ARGUMENT WOULD NEGATE THE TRIAL COURT'S ROLE AS GATEKEEPER.

Plaintiff spends the last two pages of her brief raising public policy type arguments and creating a series of what ifs without any factual or legal support. Plaintiff's panic stricken language attempts to create a dooms day scenario with respect to use of the respondent in discovery statute. What Plaintiff is really attempting to accomplish is to encourage this Court to create a new rule applicable to Section 2-402 motions that any one piece of "evidence" submitted by a plaintiff on a motion to convert should be sufficient. Plaintiff's rule would prevail whether or not the submitted evidence was sufficient, correct, or contrary to other facts.

Courts, however, are not required to take a plaintiff's word for it. Plaintiffs are not the arbiter of whether a statutory provision has been complied with. A plaintiff cannot usurp the judicial function. *See Deluna*, 147 Ill.2d at 68, 72. If Plaintiff's one piece of evidence theory is sufficient (no matter how accurate, complete or correct that evidence is), then a respondent in discovery would never have an opportunity to challenge a motion to convert. Frivolous lawsuits would proceed and the purpose of the statute would be thwarted.

CONCLUSION

Plaintiff chose what evidence to present on her Section 2-402 motion to convert Dr. Bakir from a respondent in discovery to a defendant. She chose when to proceed with the hearing on her motion. The trial court acted in its role as gatekeeper in reviewing all of the evidence submitted and making a determination of whether Plaintiff had satisfied the probable cause requirement of Section 2-402. The evidence from all sources did not disclose adequate grounds for converting Dr. Bakir from a respondent in discovery to a defendant. The evidence did not show the applicable standard of care or that a man of ordinary caution and prejudice would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard of care which was a proximate cause of plaintiff's injury. The Fourth District Appellate Court agreed that Plaintiff had failed to establish the applicable standard of care by which Dr. Bakir's conduct could be judged. In doing so, the Appellate Court correctly followed the case law interpreting Section 2-402. For the reasons stated herein, Dr. Bakir requests that the Appellate Court's June 2, 2022 Order be affirmed.

MOUHAMAD BAKIR, M.D.,
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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 brief, excluding the pages containing the Rule 341(d) cover, the Rule 341(h)(1) 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 41 pages.

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CERTIFICATE OF FILING AND PROOF OF SERVICE

I certify that on **December 21, 2022**, I electronically filed and transmitted the foregoing with the Clerk of the Court for the Illinois Supreme Court using the Odyssey eFileIL system. I further certify that the other individuals in this case, named below have been served by sending a copy from my email address to the email addresses listed below on **December 21, 2022**.

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Under penalties as provided by law pursuant to section 1-109 of the Illinois Code of Civil Procedure [735 ILCS 5/1-109], I certify that the statements set forth in this Certificate of Filing and Proof of Service are true and correct, except as to matters therein stated to be on information and belief and as to such matters I certify as aforesaid that I verily believe the same to be true.

/s/ Ann C. Barron