No. 126748

IN THE SUPREME COURT OF ILLINOIS

JILL M. BAILEY, as Independent Representative of the Estate of Jill M. Milton Hampton, Deceased, and JILL M. BAILEY, Individually,
Plaintiff-Appellee,

v.

MERCY HOSPITAL AND MEDICAL CENTER,
Defendant,

SCOTT A. HEINRICH, M.D., BRETT M. JONES, M.D., AMIT ARWINDEKAR, M.D. HELENE CONNOLLY, M.D.,
Defendants-Appellants

TARA ANDERSON, R.N.,
Defendant,

and

EMERGENCY MEDICINE PHYSICIANS OF CHICAGO, LLC
Defendant-Appellant.

On Appeal from the Appellate Court of Illinois, First District
Case No. 1-18-2702
And Circuit Court of Cook County, Illinois
County Department, Law Division, Case No. 2013-L-8501,
The Honorable Thomas V. Lyons II, Trial Judge Presiding

BRIEF OF *AMICI CURIAE* ILLINOIS STATE MEDICAL SOCIETY AND AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLANTS

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INTEREST OF *AMICI CURIAE*

The attempt to rewrite jury instructions to circumvent the longstanding proximate cause requirements of the loss of chance doctrine and misapply the doctrine of informed consent is of utmost concern to the Illinois State Medical Society ("Medical Society") and the American Medical Association ("AMA").

The Medical Society is a non-profit, I.R.C. § 501(c)(6), professional organization that represents and unifies its physician members in their practice of medicine throughout the State of Illinois. Born out of a gathering of 12 physicians and surgeons in 1840, the Medical Society has grown into the leading advocate for Illinois physicians and patients, representing approximately 9,000 physicians in the State across all specialties and practice areas. The Medical Society represents the interests of its member physicians, fellows, residents, and medical students, as well as those of patients, and promotes the doctor-patient relationship, the ethical practice of medicine, the betterment of public health, and the delivery of quality, affordable care. The Medical Society has participated as *amicus curiae* in cases of importance to physicians and the medical community.

The AMA, headquartered in Chicago, Illinois, is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups, substantially all United States physicians, residents and medical students are represented in the AMA's policymaking process. The AMA, founded in 1847, promotes the science and art of medicine and the betterment of public health,

and these remain its core purposes. AMA members practice in every state, including Illinois, and in every medical specialty.

The Medical Society and AMA appear on their own behalf and as representatives of the AMA Litigation Center. The Litigation Center is a coalition among the AMA and the medical societies of every state. The Litigation Center is the voice of America's medical profession in legal proceedings across the country. The mission of the Litigation Center is to represent the interests of the medical profession in the courts. It brings lawsuits, files *amicus* briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians.

STATEMENT OF THE ISSUES ADDRESSED BY *AMICI CURIAE*

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

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

STATEMENT OF FACTS

Jill M. Milton-Hampton sought treatment in the emergency department at Mercy Hospital. As explained in the Court of Appeals ruling, Ms. Milton-Hampton complained of abdominal pain, nausea, vomiting, and diarrhea. Dr. Heinrich examined her, ordered several tests, and ordered intravenous fluids to help with dehydration. Dr. Heinrich did not have a definitive diagnosis, but, as noted in the ruling, believed Ms. Milton-Hampton had gastroenteritis or a

stomach flu caused by a virus. This initial diagnosis was based on Ms. Milton-Hampton's symptoms and that she started feeling better after receiving fluids. She did not have a fever or rash that would indicate toxic shock syndrome.

Dr. Heinrich transferred care of Ms. Milton-Hampton to Dr. Jones, who also evaluated Ms. Milton-Hampton and ordered additional tests. Dr. Jones also believed she had viral gastroenteritis. He recommended Ms. Milton-Hampton be admitted to the hospital for observation and testing to ensure she did not have another ailment. He testified he outlined the risks of her leaving the hospital that evening, including whether something else was causing her symptoms that may be "very, very serious." *Bailey v. Mercy Hosp. and Med. Ctr.*, 2020 IL App (1st) 182702 at ¶19. Nevertheless, Ms. Milton-Hampton chose to go home. The next day, Dr. Heinrich called her and was told she was returning to the emergency room. After additional treatment and tests, Ms. Milton-Hampton was transferred to the observation unit for ongoing care. The next morning, she went into cardiopulmonary arrest and ultimately died.

The plaintiff's theory of the case is that Ms. Milton-Hampton had a bacterial infection leading to sepsis. Plaintiff claims the jury should have been given a separate instruction on loss of chance, not just the pattern jury instruction on proximate cause, to determine whether the decision not to give Ms. Milton-Hampton antibiotics the first day she arrived at the emergency room amounted to medical negligence and was a cause of her death. Plaintiff also claims Dr. Jones did not properly inform Ms. Milton-Hampton of the risks

of the potential medical conditions she may have had before she decided to leave the hospital. They sought a separate jury instruction on informed consent. Defendants testified that she died from a viral infection, not sepsis, and argued the jury instructions were proper. The trial resulted in a defense verdict. The Court of Appeals overturned this verdict, agreeing with Plaintiff that such instructions must have been given.

ARGUMENT

Ms. Milton-Hampton was a 42-year old woman who contracted a deadly disease and died fairly suddenly. In an attempt to blame the emergency room physicians for not saving Ms. Milton-Hampton's life, Plaintiff brought this medical negligence claim. These cases are difficult and emotional. Plaintiff must prove a physician's negligence proximately caused Ms. Milton-Hampton's death, and here had the full opportunity to present her theories to the jury. She provided expert testimony that the physicians deprived Ms. Milton-Hampton of a chance of recovery from an alleged bacterial infection by failing to provide antibiotics during her first visit to the emergency room and that Dr. Jones did not provide her with sufficient information about the risks of leaving the hospital given the diseases she may have had. The trial court properly instructed the jury on the law to make sure the jury could decide the case while guarding against emotions and hindsight bias from giving rise to liability. The jury returned a defense verdict; there was no indication the jury did not understand its responsibilities or was not clear on the issues to decide.

In giving Plaintiff a second opportunity to sue, the Court of Appeals required two different jury instructions than the trial court gave—both of which would change Illinois law and effectively lower the legal standards for medical negligence claims. First, the Court of Appeals contradicted well-settled Illinois law by requiring a jury instruction on the loss of chance doctrine in addition to the traditional proximate cause jury instruction. This Court, though, has been clear that traditional proximate cause standards govern loss of chance in Illinois. *See Holton v. Mem'l Hosp.*, 176 Ill. 2d 95 (1997). As the Court stated in this seminal case: "juries routinely are asked to determine whether, and to what extent, a defendant's negligent treatment proximately caused the injury upon which the patient's lawsuit is based." *Id.* at 110. It then clearly affirmed the "Illinois Pattern Jury Instruction (IPI) on proximate cause," which was given in that case, is fully consistent with the "*Borowski* standard" for medical negligence. *Id.* at 110 (citing *Borowski v. Von Solbrig*, 60 Ill. 2d 418 (1975)). Thus, the Court of Appeals ruling requiring a separate instruction on loss of chance directly conflicts with settled law that the IPI on proximate cause properly instructs juries on loss of chance in Illinois.

Second, the Court of Appeals misapplied the doctrine of informed consent. It held that the informed consent jury instruction—that describes the process and content of information a physician must provide to a patient before the patient can consent to a medical procedure—also governs discussions about the risks of various potential existing medical conditions a patient may have.

Discussions about existing medical conditions and decisions a patient makes are governed by traditional medical negligence law, and the trial judge included such an instruction tailored to this question. Here, Dr. Jones recommended Ms. Milton-Hampton stay at the hospital for further tests because she may have a "very, very serious" disease. However, she chose to leave the hospital. The trial court instructed the jury that it was to consider whether Dr. Jones "failed to inform Jill Milton-Hampton of the risks associated with leaving the hospital." The IPI for informed consent includes additional factors that are inapplicable to that question and should remain restricted to the decision of whether to undergo a specific treatment.

Amici respectfully request the Court to reverse the ruling below. The goal of Illinois's civil justice system in medical negligence cases is to compensate wrongfully injured patients. The trial court followed Illinois law and issued proper jury instructions. In doing so, it provided Plaintiff with a full and fair opportunity to present her case to the jury. The Court of Appeals decision to overturn the jury's defense verdict and inject new jury instructions violates longstanding Illinois law, will result in lower legal standards for medical negligence claims, and will encourage speculative litigation when a patient succumbs to a disease. Patients and physicians must be able to rely on Illinois courts to follow precedent and sound legal principles, including in difficult cases such as this one.

I. THE COURT SHOULD CONTINUE APPLYING TRADITIONAL PROXIMATE CAUSE TO LOSS OF CHANCE CLAIMS

A. The Trial Court Properly Instructed the Jury on Plaintiff's Loss of Chance Claim Through the Proximate Cause Jury Instruction

In *Holton*, the Court decided the key substantive issues in the loss of chance theory at issue here: loss of chance is part of a traditional negligence claim governed by proximate cause as set forth in *Borowski*, and the IPI on proximate cause is consistent with the *Borowski* standard. *See Holton*, 176 Ill. 2d at 110-111. The Court in *Holton* sought to strike a delicate balance between recognizing the loss of chance doctrine and ensuring the new doctrine would not lower the standards for proximate cause. Several lower courts had expressed concern that recognizing the doctrine would lead to liability that is "too conjectural." *Id.* at 105. Accordingly, the Court emphasized, "the loss of chance concept, when properly analyzed, does not relax or lower plaintiffs' burden of proving causation." *Id*. at 120. As in *Borowski,* "when a plaintiff comes to a hospital already [with] . . . an existing undiagnosed medical condition . . . and while in the care off the hospital is negligently treated, the question of whether the defendant's negligent treatment" caused the patient's death is governed by the "traditional statement of proximate cause." *Id*. at 107.

Since *Holton*, as Defendants explain in their brief, the Courts of Appeals, with near uniformity, have used the IPI on proximate causation in loss of chance cases. As in *Holton* and the case at bar, this instruction provides plaintiffs with the ability "to present evidence to a jury that the defendant's

malpractice, to a reasonable degree of medical certainty, proximately caused the increased risk of harm or lost chance of recovery." *Id.* at 119. As in any other claim for medical negligence, the physician must have deviated from the applicable standards of care in causing the patient's injury. Diverting from this well-settled law decades after *Holton* by now requiring a separate instruction on loss of chance causation apart from proximate cause would give loss of chance the type of special treatment the Court concluded it does not deserve. Providing two instructions on the same causation determinations in medical negligence case where a plaintiff had a preexisting condition, would lead to jury confusion, inconsistent jury results, and the exact relaxed causation standard this Court explicitly rejected in *Holton*. *See id.* at 113 (stating the *Borowski* causation standard prevents loss of chance from "relaxing the traditional proximate cause standard in medical malpractice action").

The Court of Appeals ruling to require a loss of chance instruction is an open and obvious attempt to change the established common law of causation in loss of chance cases. The Court of Appeals did not hide from this characterization; it stated its belief, contrary to *Holton* and several decades of Court of Appeals rulings, that the IPI for proximate cause leaves the jury "without an instruction to guide them on the law" in loss of chance cases. 2020 IL App (1st) 182702 at ¶ 114. Make no mistake, providing a separate loss of chance jury instruction would create an alternative liability theory where loss of chance would become a fallback option if a plaintiff does not prove traditional

proximate cause. In practice, it would end up *reducing* the burden-of-proof requirements of a medical negligence case—a result that would inject the type of "collateral ramifications" this Court purposefully avoided when it struck its delicate balance in *Holton.* 176 Ill. 2d at 107 (citing *Borowski*, 60 Ill.2d at 424)). The Court of Appeals ruling, therefore, will fundamentally alter the meaning of causation, leading to uncertainty in medical liability cases in Illinois.

As practitioners have explained, when the loss of chance doctrine is provided as an alternative to proximate cause the result will be "a significant risk of jury confusion" and "a high risk of prejudice to defendants." Michael C. Mims & Richard S. Crisler, *Properly Limiting the Lost Chance in Medical Malpractice Cases: A Practitioners' Rejoinder,* 81 La. L. Rev. 863 (2021). Here is how the Court of Appeals ruling would work in practice: a plaintiff would be able to assert a traditional injury claim, such as wrongful death, but when she "realizes she has a causation problem," she asks for a loss of chance jury instruction as a fallback option. *Id*. at 870. The Court should guard against such gamesmanship where plaintiffs can "assert a lost chance theory for the first time at virtually any stage of the litigation, including just before the case is submitted to the jury.*" Id.*

In recent years, several courts have expressed concerns that changing the causation standard for loss of chance claims would undermine the veracity of medical liability litigation. In North Carolina, where the state supreme court has similarly ruled that traditional proximate cause principles applies to loss

of chance theories, the court clarified that "[i]f the evidence falls short of this causation standard, then there is no recovery." *Parkes v. Herman*, 852 S.E.2d 322, 325 (N.C. 2020). It is inappropriate to "create an anomaly" for causation in medical negligence litigation. *Id.*; *see also Dunnington v. Virginia Mason Med. Ctr.*, 389 P.3d 498, 504 (Wash. 2017) (reiterating "[t]raditional tort causation principles guide a loss of chance case"). The Court should join these other courts and reaffirm that proximate causation governs loss of chance claims in Illinois. A separate jury instruction is inappropriate and would undermine longstanding legal principles.

Here, the jury already assessed whether Defendants violated any standard of care in not providing her with antibiotics when she first presented at the emergency room with symptoms they diagnosed as indicative of a viral, not bacterial, disease. The Court should respect the jury's decision and not, as the Court of Appeals did, require the trial courts to ask different questions to drive a different answer.

B. Duplicative Instructions on Loss of Chance Causation Will Undermine the Ability of Illinois Courts to Make Principled Liability Rulings

Amici are filing this brief because of serious concerns the ruling below has raised in the medical community that health care providers are being singled out for a unique form of professional negligence liability that will degrade health care in Illinois. The practice of medicine is not an exact science. If the lower courts divert from the traditional proximate cause jury instruction and its reliance on medical standards of care, loss of chance liability in Illinois

would be increasingly speculative, based on small statistical probabilities for different courses of treatment where reasonable, experienced physicians might take different paths. In *Holton*, Chief Justice Heiple cautioned against any such developments that would "put an unprecedented burden on health care defendants to defend against *any possibility* of a more favorable outcome." 176 Ill. 2d at 139 (Heiple, C.J., concurring). He feared that separating loss of chance from traditional proximate cause would turn medical professionals into "the insurers of their patients, rendering health care providers liable without regard to whether their negligence caused injury to the plaintiff." *Id.*

Such speculative claims untethered to actual medical negligence would exacerbate a predicament courts have long identified with medical negligence claims, namely that one of the most difficult tasks is to "differentiate between adverse events and medical errors." David Sohn, *Negligence, Genuine Error, and Litigation*, 6 Int'l J. Gen. Med. 49, 50 (2013). According to a Harvard Public Health Study, only about 27 percent of adverse events are caused by negligence. *See* T. A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 13 Qual. Saf. Health Care 145, 146 (2004). As a result, more than two thirds of medical negligence claims (68.2%) end up being dropped, dismissed, or withdrawn without payment. *See* José R. Guardado, *Medical Professional Liability Insurance Indemnity Payments, Expenses, and Claim Disposition, 2006-2015*, at 3 (Am. Med. Ass'n, 2018).[1] In

[1]https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/

fact, the filing of a claim is a poor indicator of whether malpractice has actually occurred. *See* Barry F. Schwartz & Geraldine M. Donohue, *Practicing Medicine in Difficult Times: Protecting Physicians from Malpractice Litigation* 47, 49 (Jones & Bartlett Publishers, 2009) (poor communication is the largest factor). In cases such as the one at bar, the Court should ensure the claims have merit, not re-write the jury instructions to create a fallback option when medical negligence is not proved.

Without proper guidance, studies have shown that juries will often view an adverse outcome, such as Ms. Milton-Hampton's death here, as stemming from negligent care. *See* David P. Sklar, *Changing the Medical Malpractice System to Align with What We Know About Patient Safety and Quality Improvement*, 92 Acad. Med. 891, 891 (2017) (explaining juries may seek to "find someone to blame" to provide compensation to a sympathetic plaintiff). "Hindsight bias" refers to the "human tendency to look back upon past events and view them as being expected or obvious." Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 Tort & Ins. Prac. L.J. 895, 905 (2007). It leads those who know the outcome (good or bad) to view the level of medical care provided in the same manner. *See* Eric J. Thomas & Laura A. Petersen, *Measuring Errors and Adverse Events in Health Care*, 18 J. Gen. Intern Med. 61, 63 (2003).[2] It

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public/ government/advocacy/policy-research-perspective-liability-insurance-claim.pdf?preview=true&site_id=654

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494808/pdf/jgi_20147.pdf

can be "difficult for finders of fact to evaluate fairly (*e.g.*, without reference to whether the decision, in retrospect, turned out to be the right choice)." Haskel*, supra*, at 905. Adhering to the IPI for proximate cause, as the trial court did here, can reduce the gaps that juries can fill with hindsight bias.

Courts and scholars have also expressed concern that imposing liability for loss of chance without the proper safeguards that proximate cause provides can fuel defensive medicine. *See* Tory A. Weigand, *Lost Chances, Felt Necessities, and the Tale of Two Cities*, 43 Suffolk U. L. Rev. 327, 373 (2010). Physicians will be incentivized to choose aggressive treatments to minimize a loss of chance claim, rather than the least harmful path based on their medical judgment.[3] *See* Scott Spear, *Some Thoughts on Medical Tort Reform*, 112 Plastic & Reconstructive Surgery 1159 (Sept. 2003) ("[T]he fear of being sued . . . leads to an increase in the quantity of care rather than an increase in the efficiency or quality of care."). Some physicians may order costly tests to ward off potential liability. Others may turn away high-risk patients. *See* Brian Nahed et al., *Malpractice Liability and Defensive Medicine: A National Survey of Neurosurgeons*, PLoS ONE, vol. 7, no. 6, at 6 (June 2012) ("Reductions in

[3] *See* AMA, *Medical Liability Reform NOW!,* at 5-7 (discussing studies); Manish K. Sethi et al., *Incidence and Costs of Defensive Medicine Among Orthopedic Surgeons in the United States: A National Survey Study*, 41 Am. J. Orthop. 69 (2012) (96% of orthopedic surgeons reported having practiced defensive medicine to avoid liability); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts*, at 3-5 (Nov. 2008) (finding 83% of physicians reported practicing defensive medicine and that 28% of all CT scans, 27% of MRI studies, and 24% of ultrasound studies were ordered for defensive reasons).

offering 'high-risk' cranial procedures have decreased access to care for potentially life-saving neurological procedures."); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts*, at 3-5 (Nov. 2008) (finding 38% of physicians in the sample reduced the number of high-risk services or procedures; 28% reduced the number of high-risk patients).

Finally, affirming the Court of Appeals' loss of chance ruling would undermine this Court's insistence in *Holton* that the proximate cause standard that applies to medical claims, including for loss of chance, is the "same standard of proximate cause that is used in other types of negligence actions." 176 Ill. 2d at 110. Again, Chief Justice Heiple identified this issue, analogizing loss of chance to the legal profession: "if a disgruntled litigant loses a case that he probably would not have won, but is able to prove that his lawyer negligently reduced his chance of winning by some degree, no matter how small, the litigant would be able to pursue a cause of action for malpractice against his attorney under the lost chance doctrine." *Id.* at 139 (Heiple, C.J. concurring). If the Court approves a separate loss of chance instruction here, it would lead to separate loss of chance jury instructions in a wide variety of other cases. The collateral ramifications are significant.

For these reasons, many courts have found that departing from the traditional proximate cause law in loss of chance cases involves "significant and far-reaching policy concerns" more properly left to the Legislature, "where hearings may be held, data collected, and competing interests heard before a

wise decision is reached." *Smith v. Parrott*, 833 A.2d 843, 848 (Vt. 2003). *Amici* respectfully request that the Court adhere to longstanding Illinois law, maintain rational bounds on loss of chance theory, and refuse to create a separate jury instruction here as an alternative to proximate cause.

II. THE COURT SHOULD NOT IMPOSE THE INFORMED CONSENT JURY INSTRUCTION OUTSIDE OF ITS TRADITIONAL MOORINGS

The Court of Appeals ruling is also of significant concern to the health care community because it requires the use of the informed consent jury instruction, which was designed specifically to ensure a process for informing patients before they undergo a treatment option, to a situation where no such treatment is involved. As the Defendants' brief explains, the doctrine of informed consent applies only to treatments, such as surgery or other procedures a physician performs on a patient, not discussions about the risks associated with potential diseases a patient may have and their decisions of whether to seek follow up care or leave a hospital. *See Coryell v. Smith*, 274 Ill. App. 3d 543 (1st Dist. 1995) (stating informed consent applies when a patient has "consented to *treatment* she otherwise would not have consented to") (emphasis added). The standards of care for those discussions are governed solely by traditional medical negligence, not informed consent.

Here, the issue for the jury's consideration was whether Dr. Jones properly informed Ms. Milton-Hampton of the risks of leaving the hospital. He stated his medical recommendation that she stay in the hospital for further tests because she may have a "very, very serious" disease. The trial court

properly determined that the IPI for informed consent designed for medical procedures was not appropriate for this situation, so it adjusted the medical negligence instruction to specifically include whether Dr. Jones "failed to inform Jill Milton-Hampton of the risks associated with leaving the hospital." This instruction put the question to the jury into its proper context: was Dr. Jones negligent for not providing Ms. Milton-Hampton with more specific risk information when she chose to leave the hospital and whether that lack of information caused her to sustain more harm.

By contrast, the doctrine of informed consent for medical procedures stems from the notion that performing a procedure on a patient without informed consent amounted to a tortious battery for offensive touching. Before the doctrine arose early in the last century, the physician was "recognized and accepted as the guardian who use[d] his specialized knowledge and training to benefit patients, including deciding unilaterality what constitutes a benefit." J.J. Chin, *Doctor-patient Relationship: From Medical Paternalism to Enhanced Autonomy*, 43(3) Singapore Med. J. 152, 152 (2002). This idea went back to Hippocrates, who cautioned physicians to perform treatment "calmly and adroitly, concealing most things from the patient while you are attending to him." Hippocrates, Decorum, in 2 Hippocrates 279, 297 (W.H.S. Jones Trans., G.P. Putnam Sons 1923). As a result, patients did not exercise self-determination over their treatment options.

An early pronouncement of informed consent came from Justice Cardozo, who recognized that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129 (1914). Justice Cardozo found that a physician who does not secure consent from a patient to undergo a medical procedure could be subject to liability for committing a battery. Courts then began to differentiate between this concept of "basic consent" and "informed consent," which gave patients the right to decide which medically sound treatment to undergo, if at all.[4] The "obligation to obtain consent evolved over the course of the twentieth century into an obligation to obtain 'informed' consent, primarily to enable the patient to make an informed choice about a particular therapy or procedure so that healthcare providers did not substitute their own judgment for that of the patient's." *McQuitty v. Spangler*, 976 A.2d 1020, 1031 (Md. 2009).

Today, the doctrine of informed consent is the basis upon which patients can choose whether to undergo a particular treatment. As the AMA's Code of Medical Ethics explains, informed consent provides procedural and substantive requirements before a physician can execute a treatment option with respect to that patient. Patients are to "receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of

[4] *See, e.g.*, *Pratt v. Davis*, 224 Ill. 300 (1906); *Perry v. Hodgson*, 148 S.E. 659 (Ga. 1929); *Corn v. French*, 289 P.2d 173 (Nev. 1955).

appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment"; have the right to "ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered"; and have the right to "make decisions about the care the physician recommends and to have those decisions respected." Patient Rights, Code of Medical Ethics Opinion 1.1.3, Am. Med. Ass'n.[5] This history is the reason the IPI for informed consent relates to the "risks of" and/or "alternatives to" the procedure performed and whether a reasonable person "would not have submitted to" the "procedure performed." IPI (Civil) No. 105.07.02.

To be clear, the IPI for informed consent is inapposite to informing a patient of risks of medical conditions they may have. This information is governed by traditional negligence law and the jury was properly instructed on this element of Plaintiff's claim.

CONCLUSION

For these reasons, the Illinois State Medical Society and the American Medical Association respectfully request that this Court reverse the judgment of the First District.

[5] https://www.ama-assn.org/delivering-care/ethics/patient-rights.

Dated: June 9, 2021

Respectfully submitted,

ILLINOIS STATE MEDICAL ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION

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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 or words contained in the Rule 341(d) cover, the Rule 341(h)(1) table of contents and statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is 4547 words.

Dated: June 9, 2021 /s/ William F. Northrip

CERTIFICATE OF SERVICE

I, William F. Northrip, an attorney, hereby certify that on June 9, 2021, I caused a true and complete copy of the foregoing **BRIEF OF *AMICI CURIAE* ILLINOIS STATE MEDICAL SOCIETY AND AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLANTS** to be filed electronically with the Clerk's Office of the Illinois Supreme Court using e-filing provider **Odyssey eFileIL,** which sends notification to all counsel of record. I further certify that I caused an additional courtesy copy of this filing to be served by electronic mail upon the following:

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Under penalties by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certified that the statements set forth in this notice of filing and certificate of service are true and correct.

/s/ William F. Northrip