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., et al.
Defendants,

and

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

On Appeal from the Appellate Court of Illinois,
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 *AMICI CURIAE* ILLINOIS STATE MEDICAL SOCIETY AND AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENT IN DISCOVERY/APPELLEE

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INTEREST OF *AMICI CURIAE*

Upholding the Court of Appeals ruling that sets forth the proper standards and procedures for converting a respondent in discovery to a defendant 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. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine

and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including Illinois.

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 each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

STATEMENT OF THE ISSUES ADDRESSED BY *AMICI CURIAE*

I. Whether the Court of Appeals properly applied 735 ILCS 5/2-402 in affirming the denial of Plaintiff's motion to convert Dr. Bakir from a respondent in discovery to a defendant in this matter.

STATEMENT OF FACTS

Donald Cleeton sought treatment in the emergency department at Memorial Medical Center. As explained in the Court of Appeals ruling, Mr. Cleeton previously had a cervical cord injury that left him a quadriplegic. He had a programmable pump implanted in him to deliver baclofen, a medication that reduced involuntary muscle spasms. Days after a routine pump refill, he was brought to Memorial by ambulance with abdominal pain, a headache, and a urinary tract infection. An inspection of the pump showed no functional error, and he was diagnosed with sepsis and an acute urinary tract infection.

The next morning around 10 a.m., Mr. Cleeton was transferred to the intensive care unit, where Dr. Bakir was the attending pulmonary critical care specialist. As the lower courts observed, baclofen pumps and baclofen withdrawal symptoms were not part of Dr. Bakir's regular intensive care and pulmonary practice. Dr. Bakir

assembled a team of specialists in cardiology, neurology, neurosurgery, and baclofen pumps. He also reached out to the manufacturer of the pump and sought information, including on the risks of administering baclofen to a patient not in withdrawal. The other physicians who attended to Mr. Cleeton noted that the pump had been found to be working and concluded his symptoms were consistent with sepsis.

At 12:07 p.m., a code blue was called due to a lack of pulse, and Mr. Cleeton died. It was later revealed the catheter for the pump was perforated. At 10:44 a.m., the pump manufacturer had faxed emergency procedures for baclofen withdrawal to Memorial, but the fax was not delivered to Dr. Bakir. It was added to Mr. Cleeton's chart at 6:44 p.m.

When this case was filed, Dr. Bakir was not named as a defendant, but as "respondent in discovery" under 735 ILCS 5/2-402. This statute provides the criteria for when a respondent in discovery can be converted into a defendant. Plaintiff filed a motion to convert Dr. Bakir to a defendant, and Dr. Bakir objected. The trial court determined that Plaintiff failed to meet the statute's criteria and denied the motion. The Court of Appeals affirmed this denial.

ARGUMENT

This case arises from a tragic situation. Mr. Cleeton passed while receiving care and treatment at a hospital. That situation alone, though, does not create a medical negligence case against the physicians, including Dr. Bakir, who treated him. The Illinois Legislature has established two separate means for determining who a plaintiff can sue in a medical liability action to facilitate justice for both plaintiffs and potential defendants. To name a physician as a defendant in the initial filing, the

plaintiff must file a certificate of merit against that physician, certifying the plaintiff has consulted and reviewed the facts of the case with a qualified medical professional, who has set forth in a written report that "there is a reasonable and meritorious cause for filing [the] action." 735 ILCS 5/2-622(a)(1). For other physicians, the plaintiff may designate the physician as a "respondent in discovery," which extends the statute of limitations by six months for fact development. 735 ILCS 5/2-402. A physician can be converted to a defendant only "if the evidence discloses the existence of probable cause for such an action." *Id.*

The Court of Appeals and trial court found that such probable cause does not exist for converting Dr. Bakir. It is well-established in Illinois courts that establishing probable cause requires evidence that "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." Op. at *4 (citing multiple cases setting forth this standard). Thus, the plaintiff must put forth *evidence* of *proximate causation* and of the alleged *tortious conduct*. As the Court of Appeals explained, in a medical negligence claim, tortious conduct necessarily includes establishing the proper standard of care and how the physician deviated from that standard of care. *Id*. at *5. However, Plaintiff's motion to convert Dr. Bakir included only bald *assertions* that Dr. Bakir failed to timely recognize baclofen withdrawal syndrome and order treatment for baclofen withdrawal. *See* Pet. at *13. It was devoid of any *facts* as to the standard of care for a pulmonary critical care specialist in Dr. Bakir's situation and how Dr. Bakir violated that standard.

Bald assertions do not establish probable cause—in medical negligence claims or any other action. This case, therefore, does not raise the "difficult question" of how much evidence is needed for a "strong enough showing" to reach probable cause. *Ingle v. Hosp. Sisters Health Sys.,* 141 Ill. App. 3d 1057, 1064 (1986). There were no such facts for the court to weigh. Because this evidentiary floor was never reached, the courts made the proper determination to deny Plaintiff's motion to convert Dr. Bakir to a defendant. The Court should affirm this determination as a straight-forward application of Illinois's statute.

In addition, the Court should use this opportunity to clarify that the probable cause standard is different in terminology, purpose and effect from the certificate of merit standard. Here, the lower courts properly explained that producing a certificate of merit that a "reasonable and meritorious" cause exists for naming Dr. Bakir was not sufficient to convert Dr. Bakir to a defendant at this point in the litigation. Pet. at *13. If the standards were treated as equivalents, as Plaintiff argues, a plaintiff could engage in gamesmanship by leveraging the respondents in discovery statute to merely extend the statute of limitations. Such a result would violate the terms and purpose of both statutes and excuse a lack of due diligence.

For these reasons, *amici* respectfully request the Court to affirm the rulings below. The goal of Illinois's civil justice system in medical negligence cases is to ensure there is a sufficient basis for naming a physician as a defendant. The trial court followed Illinois law and found that Plaintiff did not provide evidence to convert Dr. Bakir to a defendant in this case. Patients and physicians should be able to rely

on Illinois courts, as here, to follow precedent and sound legal principles, including in difficult cases.

I. THE COURT SHOULD HOLD THAT IDENTIFYING THE STANDARD OF CARE IS A NECESSARY REQUIREMENT FOR CONVERTING A PHYSICIAN NAMED AS A RESPONDENT IN DISCOVERY TO A DEFENDANT

The Court of Appeals properly held that, in a motion to convert in a medical liability case, the "plaintiff must first establish the proper standard of care against which the defendant physician's conduct is to be measured." Op. at *5 (citing *Sullivan v. Edward Hosp.*, 209 Ill. 2d 100, 112 (2004)). Judging a physician against the standard of care is the centerpiece of any medical negligence claim. As Illinois courts have explained, evidence showing probable cause to convert a physician to a defendant is different from the evidence allowing a respondent in discovery to be converted in a simple battery case. *See Medjesky v. Cole*, 276 Ill. App. 3d 1061, 1065 (1995) (stating a medical negligence claim requires "a significantly greater amount of 'evidence'" than less complex claims). An unfortunate outcome, as occurred here, is not determinative of malpractice. For this reason, factual allegations cannot be untethered from the liability law Plaintiff is asserting.

One of the critical challenges in medical liability cases is to "differentiate between adverse events and medical errors," which is why grounding the allegations in the standard of care is so important. David Sohn, *Negligence, Genuine Error, and Litigation*, 6 Int'l J. Gen. Med. 49, 50 (2013). Experience has shown that the filing of a lawsuit alleging malpractice 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). According to a Harvard Public Health Study, only 27 percent of adverse medical events are caused by negligence. *See* Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 New Eng. J. Med. 370, 371 (1991).[1] Yet, lawsuits may be filed anyway.

As a result, nationally, more than two thirds of medical negligence claims (68.2%) are dropped, dismissed, or withdrawn without any payment. *See* José R. Guardado, *Medical Professional Liability Insurance Indemnity Payments, Expenses, and Claim Disposition, 2006-2015*, at 3 (Am. Med. Ass'n 2018).[2] The average expense of defending a physician against a medical liability claim that is dropped, dismissed, or withdrawn exceeds $30,000. *See id.* at 7. In the aggregate, these costs account for 38.4 percent of total legal expenditures in medical cases—a cost that jeopardizes affordable and available care. *See id.* The Illinois General Assembly sought to deter these costs and injustices in establishing substantive criteria for naming a physician in a case, either initially or after being designated as a discovery respondent.

The problem the legislature recognized is that when a case proceeds against a physician and goes to trial without these safeguards, jurors may lack proper medical understanding and improperly fill the voids by presuming that physician must have caused the patient's alleged harms. *See generally* Michael A. Haskel, *A Proposal for*

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[1] https://www.nejm.org/doi/pdf/10.1056/NEJM199102073240604

[2] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-liability-insurance-claim.pdf?preview=true&site_id=654

Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases, 42 Tort & Ins. L. J. 895 (2007). "[T]he existence of these biases suggest that it may be difficult for finders of fact to evaluate fairly." *Id.* at 905. Juries may try to "find someone to blame" for an unfortunate outcome and seek to compensate a sympathetic plaintiff whenever possible. 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). Thus, it is important that courts screen out cases where there has been no evidentiary showing that the patient's injury was the proximate result of the tortious conduct of the respondent in discovery.

Respondent in discovery and certificate of merit acts, both of which required basic standard-of-care thresholds, have been successful in helping physicians avoid these costs and injustices. *See* Michael C. Stinson, *Medical Professional Liability – Trends in Claims and Legislative Responses*, 26 Health Law. 1, 12 (Aug. 2014) ("[They] weed out those cases which otherwise are eventually dropped, withdrawn or dismissed, but without having to go through the initial, and expensive, stages of litigation."). Just as importantly, they do not impede genuinely meritorious lawsuits. Thus, adhering to the standard of care, as done below, achieves the purpose of the Illinois legislature "to eliminate frivolous actions . . . and ensure that plaintiffs file only meritorious medical malpractice actions." *Williams v. Medenica*, 275 Ill. App. 3d 269, 272 (1995). The respondent in discovery statute cannot achieve these goals if it can be circumvented, as sought here, by merely putting forth conclusory assertions that a complication or adverse outcome resulted from deficient medical care.

II. THE COURT SHOULD CLARIFY THAT THE COURT OF APPEALS PROPERLY RECOGNIZED THE PURPOSE, STANDARDS, AND PROCESSES FOR CONVERTING A RESPONDENT IN DISCOVERY TO A DEFENDANT

The Court should use the opportunity here to affirm that judges are to be "gatekeepers" for ensuring the respondent in discovery and certificate of merit statutes are properly followed. *See McGee v. Heimburger*, 287 Ill. App. 3d 242, 247-48 (1997) ("[T]he trial court's role is that of gatekeeper—to simply assess whether it is fair to let the plaintiff proceed further against the respondents in discovery and subject them to the fact-finding process."); *Froehlich v. Sheehan*, 240 Ill. App. 3d 93, 102 (1992). As the Court of Appeals properly stated in this case, these two statutes have different standards and processes because they serve different purposes.

As this Court explained in upholding the constitutionality of the certificate of merit statute, before filing a complaint, a plaintiff's attorney must "conduct a 'reasonable inquiry' into whether a claim is well-founded in fact" before filing the complaint. *McAlister v. Schick*, 147 Ill. 2d 84, 94 (1992). A health care professional of his or her choosing must "make a factual determination concerning the quality of care." *Id.* at 97. The claim can be filed only if the medical professional certifies an "opinion that there is a 'reasonable and meritorious cause' for filing the suit." *Id.* This requirement ensures the "factual validity of the plaintiff's allegations." *Id.* at 99. Thus, the Court stated, "the provision is essentially no different from the parallel requirement generally applicable in malpractice cases that the plaintiff in such an action present expert testimony to demonstrate the applicable standard of care and its breach." *DeLuna v. St. Elizabeth's Hosp.*, 147 Ill. 2d 57, 73 (1992).

The respondent in discovery statute serves a complementary purpose. The Illinois General Assembly has imposed a two-year statute of limitations for bringing a medical negligence claim, but "there may be times when a plaintiff does not have access to information that will help determine who is responsible for her damage." *Long v. Mathew*, 336 Ill. App. 3d 595, 601 (2003). The statute provides the plaintiff with a six-month extension to the statute of limitations by naming the individual as a respondent in discovery. *See id.* The purpose of this extension is to allow the plaintiff additional time "to discover if the evidence demonstrates the individual should be converted." *Id.* at 603. The requirement that there now be "probable cause for such action," rather than just a certificate of merit, makes sense because conversion is supposed to be informed by discovery. *See Torley v. Foster G. McGaw Hosp.*, 116 Ill. App. 3d 19, 22-23 (1983) (referring to probable cause as a "further requirement").

Once evidence has been put forth meeting this standard—which, again, has not occurred here—Illinois courts are to hold an evidentiary hearing, look at "all sources" of evidence, and make a legal determination as to whether a respondent in discovery can be converted to a defendant. *Browning v. Jackson Park Hosp*. 163 Ill. App. 3d 543, 549 (1987). Again, this process is different from the way courts treat certificates of merit at the pleading stage. That is why producing a certificate of merit here, even if it makes fact-based allegations, may not suffice at this point in the litigation. The court must consider "the totality of the matter" when determining whether probable causes exists. *Ingle v. Hospital Sisters Health System*, 141 Ill. App. 3d 1057, 1064 (1986); *Medenica*, 275 Ill. App. 3d at 272 (stating courts are to assess

the "quantum of evidence necessary to establish probable cause to convert a respondent in discovery to a defendant"). "Scrupulous adherence to the requirements of section 2-402 is a condition precedent to the plaintiff's right to seek a remedy." *Knapp v. Bulun*, 392 Ill. App. 3d 1018, 1024 (1983).

Here, the Court should uphold this statutory regime and clarify that allowing litigants to use the respondent in discovery statute to merely extend the statute of limitations period is not the proper use of the law. Statutes of limitations, which promote the prompt and fair adjudication of claims, are essential to a fair and well-ordered civil justice system. They help make sure the requirement to show that a physician failed to meet the appropriate standards of care and whether any such failure caused the alleged injury are made before evidence and expert testimony becomes stale and unreliable. *Cf.* 2 Am. Law Med. Malp. § 7:8 (2005) (discussing statutes of limitations for medical claims).

III. THE COURT SHOULD ENSURE THAT THE MEDICAL LIABILTY REGIME IN THIS STATE IS CONSISTENT WITH THE WAY HEALTH CARE IS PROVIDED

Finally, the Court should affirm the ruling below because of the negative impact that overturning it would have on patient care. As here, physicians have different specialties and often work in teams in delivering health care. The American Board of Medical Specialties now issues certificates in thirty-eight specialties and 130 subspecialties.[3] These certifications, in addition to impacting a physician's

[3] *See* ABMS Guide to Medical Specialties 2017, Am. Bd. of Med. Specialties (providing descriptions of each specialty and subspecialty). Approximately 80 to 85 percent of all

"hospital privileges [and] peer and patient recognition," instruct physicians on "the standard of care" that physicians in a particular specialty or subspecialty owe to their patients. John J. Smith, *Legal Implications of Specialty Board Certification*, 17 J. Legal Med. 73, 74-75 (1996); *see also* Restatement (Second) of Torts § 299A, cmt. d (1965) ("A physician who holds himself out as a specialist in certain types of practice is required to have the skill and knowledge" common to similar specialists.). These standards of care regularly change based on developments in medical science. They are highly technical, taking into account numerous factors, and are not established by a manufacturer's emergency procedure documents, as alleged in this case.

Here, Dr. Bakir, a pulmonary critical care specialist, brought together a team of physicians with experience in the areas of treatment for Mr. Cleeton, including baclofen pumps. *See* Op. at *5 (noting Dr. Bakir "consulted multiple specialists regarding [Mr. Cleeton's] care"). Facilitating such team-based approaches to patient care has been a priority in the medical community. *See* Team-Based Health Care Delivery: Lessons from the Field, Am. Hosp. Ass'n Physician Leadership Forum (2012), at 8[4] (noting there have been significant efforts "to improve collaboration and team-based care," particularly in hospital settings); Physician-led Team-based Care, Am. Med. Ass'n.[5] Physicians are encouraged to refer patients to other physicians

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U.S. licensed physicians are Board Certified by an ABMS Member Board. *See* Better Patient Care is Built on Higher Standards, Am. Bd. of Med. Specialties (2012), at 1.

[4] http://www.ahaphysicianforum.org/resources/leadership-development/team-based-care/team-delivery-report.pdf

[5] https://www.ama-assn.org/delivering-care/physician-led-team-based-care

when needed to inform and advance patient care, and to "not refuse a request from a colleague to assist in the care of a patient who is having an emergency, whether or not that physician has a preexisting duty to do so." Stewart R. Reuter, *Physicians As Good Samaritans,* 20 J. Legal Med. 157 (1999).

Judging physicians in medical negligence claims without adherence to the appropriate standard of care, or based on the standard of care that may apply to others on the team, would chill this collaboration. The ripple effects of overturning the ruling below could be felt wherever teamwork provides a patient with effective care, setting back these efforts and diminishing care.

CONCLUSION

For these reasons, the Illinois State Medical Society and the American Medical Association respectfully request that this Court affirm the judgment below.

Dated: December 21, 2022

Respectfully submitted,

ILLINOIS STATE MEDICAL SOCIETY 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 3414 words.

Dated: December 21, 2022 /s/ William F. Northrip