2026 IL App (1st) 250311
No. 1-25-0311
Opinion filed November 24, 2026

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT, SECOND DIVISION

BRIDGET LONG, Plaintiff-Appellant,

v.

NOEL CAMBA, M.D., and ASSOCIATED CARDIOVASCULAR PHYSICIANS, S.C., Defendants-Appellees.

Appeal from the Circuit Court of Cook County.
Honorable Patricia O'Brien Sheahan, Judge, Presiding.
No. 20 L 9631

JUSTICE VAN TINE delivered the judgment of the court, with opinion.
Presiding Justice D.B. Walker and Justice McBride concurred in the judgment and opinion.

OPINION

¶ 1 In this medical malpractice lawsuit, a jury found for defendants Dr. Noel Camba and his employer, Associated Cardiovascular Physicians. Plaintiff Bridget Long appeals, arguing that (1) the trial court erred in barring two of her independent treating expert's opinions as undisclosed under Illinois Supreme Court Rule 213 (eff. Jan. 1, 2018); (2) the jury's verdict was against the manifest weight of the evidence; (3) the trial court should have granted her motions for a directed verdict, judgment notwithstanding the verdict (judgment *n.o.v.*), or a new trial; and (4) cumulative trial error warrants reversal. We affirm.

¶ 2 I. BACKGROUND

¶ 3 A. Pleadings

¶ 4 Plaintiff sued defendants in 2020. Her complaint did not define the following medical terms, but we define them here for context. We base these definitions on the medical expert testimony at trial.

¶ 5 Plaintiff alleged that on January 2, 2017, Dr. Camba performed surgery to place an implantable cardioverter defibrillator (ICD) in her chest. An ICD corrects irregular heartbeats by delivering small electric shocks to the heart. During surgery, plaintiff experienced a vagal reaction, which is a neurological response that causes a decrease in heart rate and blood pressure. Outside of surgery, vagal reactions often manifest as fainting.

¶ 6 Plaintiff alleged that Dr. Camba did not diagnose the vagal reaction. Rather, he mistakenly believed that he had perforated plaintiff's heart's right ventricle, causing blood to flow into the pericardial sac, which is a "bag" that surrounds the heart. Blood flowing into the pericardial sac is called a pericardial effusion. A pericardial effusion can cause a buildup of blood in the pericardial sac and prevent the heart from pumping. This life-threatening medical emergency is known as cardiac tamponade. Based on this misdiagnosis, Dr. Camba inserted a catheter to drain the nonexistent blood (a procedure called pericardiocentesis), which actually *did* perforate plaintiff's left ventricle, causing it to bleed into the pericardial sac. Dr. Camba inserted a second catheter, which drained that blood. Dr. George Hodakowski then conducted open-heart surgery to repair the left ventricle perforation that Dr. Camba caused.

¶ 7 Plaintiff alleged that Dr. Camba committed medical malpractice by (1) improperly assessing her decrease in blood pressure, (2) failing to diagnose the vagal reaction, (3) failing to

properly treat the vagal reaction, (4) incorrectly diagnosing cardiac tamponade, and (5) performing an unnecessary pericardiocentesis.

¶ 8 Defendants' answer admitted that "[d]uring the implantation of the ICD Plaintiff Long suffered a vagal reaction." It denied that "[Dr.] Camba came to the premature and incorrect diagnosis of right ventricular perforation and pericardial tamponade."

¶ 9 B. Trial

¶ 10 The case proceeded to a jury trial. For brevity, we set out only the relevant testimony regarding whether Dr. Camba breached the standard of care. The trial exhibits are not in the record on appeal.

¶ 11 1. Dr. Noel Camba

¶ 12 Dr. Camba testified that he is a board-certified cardiologist. On January 2, 2017, he performed surgery at Palos Hospital to place an ICD in plaintiff's chest. Prior to surgery, Dr. Camba advised plaintiff that a risk of this procedure was perforating the heart, which occurs in 0.3% to 1.3% of ICD placement surgeries.

¶ 13 During surgery, plaintiff was under conscious sedation, which used a general sedative to keep her relaxed and a local anesthetic to numb the area of surgery. Dr. Camba first made an incision in plaintiff's chest to place the ICD itself. He then attempted to place a lead, which is a wire that connects the ICD to the heart's right ventricle. Dr. Camba unsuccessfully tried to place the lead three times.

¶ 14 Plaintiff's blood pressure and heart rate dropped, and she became sweaty. Based on those symptoms, Dr. Camba suspected that he had perforated the right ventricle while attempting to place the lead, causing a pericardial effusion. Dr. Camba administered Neo-Synephrine, a medication

that constricts the blood vessels and raises blood pressure. Within two minutes, plaintiff's blood pressure increased to a normal level.

¶ 15 Dr. Camba ordered an echocardiogram (an ultrasound that generates images of the heart) to determine whether the right ventricle was bleeding. At trial, Dr. Camba testified that the echocardiogram confirmed that fluid was surrounding the heart. He acknowledged that, at his deposition, he testified that he decided to perform a pericardiocentesis based more on plaintiff's vital signs than on "seeing blood."

¶ 16 Using the echocardiogram for guidance, Dr. Camba performed a pericardiocentesis to drain the blood using a catheter. The catheter drained bright red blood, which indicated it was draining directly from the left ventricle and not the pericardial sac. Dr. Camba injected saline into the pericardial sac and did not see microbubbles on the echocardiogram, which indicated that "the catheter was not in the right spot."

¶ 17 Dr. Camba inserted a second catheter. He knew that this second catheter was successful because it drained dark red blood and, on the echocardiogram, the fluid surrounding the heart disappeared. Plaintiff's blood pressure rose to 140/90, which indicated a successful pericardiocentesis. Dr. Camba discontinued Neo-Synephrine. Dr. Camba acknowledged that the medical records reflected he administered Neo-Synephrine after placing the catheters, not before.

¶ 18 Dr. Camba alerted the cardiothoracic surgery team. To prepare plaintiff for open-heart surgery, Dr. Camba sutured both catheters in place. Even though the first catheter was misplaced, Dr. Camba left it in place because, if he removed it, plaintiff's heart could begin bleeding again. He then removed the ICD leads, cleaned the chest incision with an antibiotic, sutured it, and dressed the wound. Plaintiff was in stable condition when she was transported to open-heart surgery, which Dr. Hodakowski performed.

¶ 19 Dr. Camba testified that he appropriately diagnosed a pericardial effusion and cardiac tamponade, confirmed that diagnosis using the echocardiogram before beginning pericardiocentesis, "timely and appropriately treat[ed] this potentially life-threatening condition by performing the pericardiocentesis drainage procedure," and complied with the standard of care.

¶ 20 On cross-examination, Dr. Camba acknowledged that tachycardia (a heart rate above 100 beats per minute) indicates cardiac tamponade but that plaintiff was not tachycardic between the time Dr. Camba tried to place the first lead and the time he placed the first catheter. Rather, she was bradycardic (a heart rate below the normal range) during that time.

¶ 21 Also during cross-examination, the following exchange occurred:

"Q. Doctor, a reasonably careful physician would timely and accurately diagnose a patient's condition during an attempted placement of an ICD, correct?

A. Yes.

Q. And a reasonably careful physician would timely and appropriately treat a patient's condition during an attempted ICD placement, correct?

A. Yes.

Q. Doctor, you never diagnosed Bridget Long with a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?

A. True [remainder of answer stricken pursuant to objection].

***

[Q.] Doctor, you never treated Bridget Long for a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?

A. True."

¶ 22 Immediately after this exchange, plaintiff moved for a directed verdict on negligence, which the court found was improper during Dr. Camba's examination.[1] The court reserved ruling on the motion.

¶ 23 2. Dr. George Hodakowski

¶ 24 Dr. George Hodakowski testified via a video-recorded evidence deposition. He is a cardiologist and is board certified in general surgery and thoracic surgery.

¶ 25 Dr. Hodakowski performed open-heart surgery on plaintiff approximately two hours after Dr. Camba. Dr. Hodakowski sawed plaintiff's sternum in half to access her heart. He opened the pericardial sac and found one catheter in plaintiff's left ventricle and another catheter in the pericardial sac. The catheter in the left ventricle would not drain blood from the pericardial sac, but the second catheter was "in an appropriate place." Dr. Hodakowski removed the catheter from the left ventricle and repaired the perforation it caused. He then examined plaintiff's heart and found no other perforations that were bleeding.

¶ 26 Dr. Hodakowski testified that "perforation is a recognized complication of a defibrillator placement procedure." If a patient's right ventricle is perforated during ICD placement surgery, it may or may not bleed depending on "how big the hole is." But generally, if the surgeon perforates the right ventricle, it will bleed, and if "there's any blood of significance *** it will accumulate in the pericardium." Dr. Hodakowski testified that just because he "did not find a perforation of the right ventricle during [his] procedure does not mean that one never existed." There "could have been a microperforation that was too small to detect during [his] procedure," and "[p]erforations

[1]Plaintiff sometimes calls this a motion for a "directed finding" rather than a motion for a directed verdict. "Normally, a party moves for a directed verdict in a jury trial (735 ILCS 5/2-1202 (West 2006)) and a directed finding in a bench trial (735 ILCS 5/2-1110 (West 2006))." *527 S. Clinton, LLC v. Westloop Equities, LLC*, 403 Ill. App. 3d 42, 48 n.1 (2010). Because this was a jury trial, we use the term "directed verdict."

can also seal off spontaneously." So, "[t]here could have been a perforation that sealed up before the time when [he] operated on" plaintiff. However, in this case, he did not "see any evidence of a perforation in the right ventricle that sealed on its own."

¶ 27 A pericardial effusion can lead to cardiac tamponade, which is a life-threatening condition. A decrease in blood pressure during surgery can indicate a cardiac tamponade, and the surgeon "needs to act immediately to address cardiac tamponade if it's suspected." If a surgeon suspects cardiac tamponade, it is appropriate to administer Neo-Synephrine for blood pressure, order an echocardiogram, and notify the cardiothoracic surgery team.

¶ 28 Outside the jury's presence, plaintiff made an offer of proof regarding certain opinions that the trial court had barred during earlier discussions about objections to Dr. Hodakowski's evidence deposition. Plaintiff proffered that Dr. Hodakowski would have testified (1) that Dr. Camba probably did not perforate the right ventricle and (2) whether a microperforation of the right ventricle would have caused a "moderate to large" pericardial effusion. The trial court correctly noted that plaintiff had previously withdrawn "at least one of those two" opinions by the parties' agreement.

¶ 29 3. Dr. Brian Swirsky

¶ 30 Dr. Brian Swirsky was plaintiff's retained expert. He is board certified in cardiovascular disease and internal medicine.

¶ 31 Dr. Swirsky testified that a decrease in blood pressure during ICD placement surgery indicates either a vagal reaction or a pericardial effusion and cardiac tamponade. The surgeon must differentiate between the two conditions based on the patient's heart rate. If the patient's heart rate decreases, that indicates a vagal reaction. Being under conscious sedation, as plaintiff was during ICD placement surgery, can cause a vagal reaction because a patient in "twilight sleep" is still

somewhat aware of her surroundings and can become anxious. But a pericardial effusion cannot cause a vagal reaction because the patient cannot feel it and does not know it is happening. Treating a vagal reaction takes 30 to 60 seconds.

¶ 32 By contrast, if the patient's heart rate increases, that indicates a pericardial effusion and cardiac tamponade, which is life-threatening and requires immediate treatment. A heart rate over 100 beats per minute (tachycardia) indicates cardiac tamponade because the heart beats faster to compensate for the loss of blood from its chambers.

¶ 33 Dr. Swirsky concluded that plaintiff's heart rate decreased during ICD placement because surgical records showed that, in the span of 12 minutes, her heart rate dropped from 101 beats per minute to 50 beats per minute. "A drop in heart rate associated with a fall in blood pressure is a classic vagal reaction."

¶ 34 Dr. Swirsky opined that Dr. Camba should have diagnosed plaintiff's decrease in heart rate and blood pressure as a vagal reaction but that he misdiagnosed it as a pericardial effusion and cardiac tamponade. The standard of care required Dr. Camba to diagnose the vagal reaction and treat it with atropine and intravenous fluids, not a pericardiocentesis. If Dr. Camba had properly diagnosed and treated the vagal reaction, he would have completed ICD placement, and plaintiff would not have required open-heart surgery.

¶ 35 Based on Dr. Camba's deposition testimony, Dr. Swirsky opined that, when Dr. Camba used the echocardiogram's ultrasound probe, he did not see fluid surrounding the heart. But the echocardiogram did not store that image because the echocardiogram tech had not finished setting the machine up. Even though he saw no fluid in the pericardial sac, Dr. Camba placed the first catheter based solely on plaintiff's vital signs. Placing a catheter into the pericardial sac when there is no fluid is "nearly impossible and should not be attempted."

¶ 36 Because there was no blood in the pericardial sac when Dr. Camba placed the first catheter, the pericardial sac and the heart were close together, so the first catheter "traverse[d] right through the sac" and entered the left ventricle. That caused blood to exit the left ventricle and flow into the pericardial sac. At that point, the echocardiogram recorded an image showing a "[m]oderate to large pericardial effusion." The second catheter drained that blood from the pericardial sac. The echocardiogram then showed that "the effusion ha[d] resolved." Medical records showed that Dr. Camba administered Neo-Synephrine after he placed both drains.

¶ 37 Dr. Swirsky concluded, based on Dr. Hodakowski's records, that there was no perforation to the right ventricle. An ICD lead is 2.7 millimeters in diameter, so if a lead had perforated the right ventricle, that hole would not have sealed on its own.

¶ 38 Dr. Swirsky opined that Dr. Camba breached the standard of care because he (1) failed to diagnose a vagal reaction based on plaintiff's decrease in heart rate and blood pressure, (2) failed to treat that vagal reaction, and (3) performed an unnecessary pericardiocentesis when he placed the first catheter. Due to Dr. Camba's negligence, plaintiff had to undergo open-heart surgery and stay in the hospital for four nights instead of one, required six weeks of recovery, and had a pacemaker defibrillator implanted approximately five months later.

¶ 39 Dr. Swirsky acknowledged that right ventricle perforations are known risks of ICD placement surgery and can occur even if the surgeon is operating within the standard of care. Dr. Swirsky also acknowledged that, if Dr. Camba did perforate plaintiff's right ventricle, he responded appropriately by ordering an echocardiogram, performing a pericardiocentesis, and alerting the cardiothoracic surgery team.

¶ 40 4. Dr. Kousik Krishnan

¶ 41 Dr. Kousik Krishnan was defendants' retained expert. He is board certified in cardiology and cardiac electrophysiology.

¶ 42 Dr. Krishnan testified that the symptoms of a vagal reaction are a decrease in heart rate, a decrease in blood pressure, or both, and often sweating. Plaintiff displayed all those symptoms during ICD placement surgery. However, a vagal reaction is not life threatening and does not require immediate treatment. If a surgeon suspects a vagal reaction, he or she should first "make sure there's not a more serious reason for that happening before defaulting to a benign, non-life-threatening answer."

¶ 43 Cardiac tamponade presents as an abrupt drop in blood pressure and "could be variable on the heart rate." An elevated heart rate (tachycardia) is "one potential sign" of cardiac tamponade because the heart beats faster to compensate for blood flowing out of its chambers.

¶ 44 Before Dr. Camba placed the right ventricular lead, plaintiff's heart rate was 111 beats per minute, which was tachycardic. Four minutes after Dr. Camba attempted to place the lead, plaintiff's heart rate decreased to 101 beats per minute but was still tachycardic. Thereafter, plaintiff's heart rate decreased because her heart function could no longer "keep up." The standard of care required Dr. Camba to differentiate between the potential causes of her decrease in heart rate and blood pressure and prioritize "the one that's both most likely and most serious."

¶ 45 Dr. Krishnan opined that "during the placement of the right ventricular lead there was a right ventricular perforation or a small hole was made in the right ventricle. Blood collected around the heart resulting in a drop in blood pressure and resulting in the pericardial effusion and, subsequently, the pericardial tamponade." The right ventricle perforation sealed on its own because the blood collecting around the heart put pressure on the perforation, which is "very common with

perforations of the right ventricle." Blood surrounding the heart could seal a 2.7-millimeter perforation caused by an ICD lead. The right ventricle perforation sealed itself, which "explain[ed] why Dr. Hodakowski did not visualize any hole in the right ventricle when he inspected the heart." Right ventricular perforations occur in 0.3% to 1.3% of ICD placement surgeries.

¶ 46 Dr. Krishnan opined that Dr. Camba appropriately diagnosed pericardial effusion and impending cardiac tamponade based on plaintiff's drop in blood pressure after he attempted to place the right ventricular lead, which "is a very classic symptom and sign of possibly cardiac perforation."

¶ 47 When Dr. Camba diagnosed the pericardial effusion and cardiac tamponade, he appropriately ordered an echocardiogram, performed a pericardiocentesis, and alerted the cardiothoracic surgery team. Dr. Krishnan opined that the echocardiogram must have occurred before the pericardiocentesis because surgical records stated that Dr. Camba performed the pericardiocentesis "under echo guidance." The echocardiogram showed a "moderate to large pericardial effusion that was seen to recede on future images." That is, the echocardiogram confirmed that there was blood around the heart before Dr. Camba began the pericardiocentesis. By treating the pericardial effusion and impeding cardiac tamponade, Dr. Camba saved plaintiff's life. Dr. Krishnan opined that Dr. Camba complied with the standard of care.

¶ 48 Dr. Krishnan opined that the standard of care did not require Dr. Camba to diagnose and treat the vagal reaction because it is "the least serious cause of a drop in blood pressure and in an invasive cardiac procedure." Dr. Krishnan opined that the pericardial effusion could have caused a vagal reaction and that treating the pericardial effusion would have effectively treated the vagal reaction. Plaintiff objected to this testimony as undisclosed under Rule 213, and the court held a

sidebar about that objection, but it is not clear whether the court sustained or overruled it. The court did not tell the jury to disregard that testimony, however.

¶ 49 Dr. Krishnan opined that, if plaintiff experienced only a vagal reaction and not a cardiac tamponade, the appropriate treatment would have been administering atropine or Neo-Synephrine to raise her blood pressure. In that scenario, Dr. Camba should not have performed a pericardiocentesis.

¶ 50 5. Verdict

¶ 51 At the close of her case-in-chief, plaintiff renewed her motion for a directed verdict as to negligence. She argued that defendants' answer admitted that "[d]uring implantation of the ICD Plaintiff Long suffered a vagal reaction," which was a binding judicial admission that defendants could not contradict at trial. The motion also claimed that Dr. Camba "admitted on adverse examination that the standard of care requires diagnosis and treatment of [a] vagal reaction if it occurs [and] that he did not diagnose [a] vagal reaction during the attempted ICD placement, and did not treat [that] vagal reaction." The court denied the motion, and the jury returned a verdict for defendants.

¶ 52 C. Posttrial Motion

¶ 53 Plaintiff moved for a new trial based on the trial court's exclusion of Dr. Hodakowski's opinions (1) that Dr. Camba most likely did not perforate plaintiff's right ventricle and (2) about whether a microperforation of the right ventricle would have caused a "moderate to large" pericardial effusion. Plaintiff contended that Dr. Hodakowski disclosed these opinions at his discovery deposition, either directly or as "logical corollaries" of his testimony. Plaintiff also moved for judgment *n.o.v.* on the same basis as her motion for a directed verdict; *i.e.*, that defendants' answer and Dr. Camba's cross-examination testimony had admitted negligence.

¶ 54 In response, defendants contended that the trial court properly barred Dr. Hodakowski's opinion about whether Dr. Camba perforated the right ventricle during ICD placement surgery because it was different from his discovery deposition testimony about what he personally observed during open-heart surgery. Defendants also argued that the parties agreed to withdraw Dr. Hodakowski's testimony about whether a microperforation of the right ventricle would have caused a moderate to large pericardial effusion. In addition, defendants contended that the exclusion of these opinions did not prejudice plaintiff.

¶ 55 Defendants also argued that plaintiff was not entitled to judgment *n.o.v.* because Dr. Camba did not admit the standard of care required him to diagnose and treat a vagal reaction specifically and Dr. Krishnan explained that the standard of care did not require Dr. Camba to diagnose or treat a vagal reaction.

¶ 56 The trial court denied plaintiff's posttrial motion. The court found that plaintiff could have disclosed Dr. Hodakowski's barred opinions during his discovery deposition but did not, and that the exclusion of those opinions did not prejudice plaintiff anyway. In addition, the court found that plaintiff had not established she was entitled to judgment *n.o.v.* because there were substantial factual disputes, issues of credibility, and conflicting evidence the jury properly resolved.

¶ 57 Plaintiff timely appealed.

¶ 58 II. ANALYSIS

¶ 59 Plaintiff argues that the trial court erred in barring Dr. Hodakowski's two opinions he offered on redirect examination at his evidence deposition, which became his trial testimony. She also contends that the jury's verdict was against the manifest weight of the evidence. In addition, plaintiff argues that defendants admitted Dr. Camba's negligence, so the trial court should have granted a new trial or entered a directed verdict or judgment *n.o.v.* in her favor.

¶ 60 A. Dr. Hodakowski's Barred Opinions

¶ 61 On redirect examination at his evidence deposition, Dr. Hodakowski testified (1) that Dr. Camba probably did not perforate plaintiff's right ventricle during ICD placement surgery and (2) about whether a right ventricle microperforation would have caused a "moderate to large" pericardial effusion. The trial court barred both opinions as undisclosed under Rule 213.

¶ 62 Illinois Supreme Court Rule 213(f)(2) (eff. Jan. 1, 2018) governs independent expert witnesses such as Dr. Hodakowski. "For each independent expert witness, the party must identify the subjects on which the witness will testify and the opinions the party expects to elicit." *Id.* A disclosure "is sufficient if it gives reasonable notice of the testimony, taking into account the limitations on the party's knowledge of the facts known by and opinions held by the witness." *Id.* "[T]he burden is on the proponent of the witness to prove the information was provided in a Rule 213(f) answer or in the discovery deposition." Ill. S. Ct. R. 213(g) (eff. Jan. 1, 2018). "Except upon a showing of good cause, information in an evidence deposition not previously disclosed in a Rule 213(f) interrogatory answer or in a discovery deposition shall not be admissible upon objection at trial." *Id.* "The Rule 213 disclosure requirements are mandatory and subject to strict compliance by the parties." *Tirado v. Slavin*, 2019 IL App (1st) 181705, ¶ 48.

¶ 63 We review a trial court's decision to bar an opinion as undisclosed under Rule 213 for an abuse of discretion. *Id.* ¶ 49. A trial court abuses its discretion when "no reasonable person would take the view of the trial court." *Steele v. Provena Hospitals*, 2013 IL App (3d) 110374, ¶ 93.

¶ 64 1. Right Ventricle Perforation Opinion

¶ 65 The first opinion the trial court barred was as follows:

"Q. Doctor, now having kind of reviewed some additional documents, do you have an opinion as to whether or not it is more probably true than not true that Dr. Camba perforated the right ventricle during his ICD placement?

***

A. Based on the operative findings, no.

Q. He didn't perforate the right ventricle in your opinion; is that accurate?

***

A. Not that I identified."

¶ 66 Plaintiff's answer to Rule 213 interrogatories did not disclose this opinion. That answer stated:

"Dr. George T. Hodakowski is expected to testify based upon his training, experience and education. The doctor is expected to testify to the care that had been provided to Plaintiff prior and after to [*sic*] her medical treatment, and the physical condition Plaintiff was in upon arrival at the hospital. He is expected to also testify Plaintiff was admitted to Palos [Hospital] and discharged at an unexpected date due to the surgical error. The witness is expected to testify about the Plaintiff's physical conditions, injuries and treatment. He is expected to testify to the condition Plaintiff was in at discharge post-surgery and his follow-up recommendations. Dr. Hodakowski is expected to also testify consistent with any and all statements made in his discovery deposition."

¶ 67 This answer did not disclose that Dr. Hodakowski would opine as to whether Dr. Camba caused a specific injury (a right ventricle perforation) during a procedure in which Dr. Hodakowski was not involved. A party's Rule 213 disclosures must "drop down to specifics," and this disclosure did not meet that standard. (Internal quotation marks omitted.) See *Sullivan v. Edward Hospital*,

209 Ill. 2d 100, 109 (2004). Instead, it used generic terms like "physical condition" and "surgical error."

¶ 68 Nor did plaintiff disclose this opinion at Dr. Hodakowski's discovery deposition. The only discovery deposition testimony plaintiff cites as "disclosing" this opinion is

> "Q. Did *[you] see* any evidence of a right ventricular lead accidentally perforating the right ventricular apex during *your surgery*?
>
> A. No, sir." (Emphases added.)

This testimony addressed what Dr. Hodakowski personally observed during the surgery he performed. It said nothing about whether *Dr. Camba* perforated plaintiff's right ventricle during ICD placement surgery. That difference justified barring this opinion as undisclosed, especially because the main issue at trial was whether Dr. Camba perforated the right ventricle. See *Tirado*, 2019 IL App (1st) 181705, ¶ 49 (" '[I]f an opinion is important to the theory of one's case, it is essential that it and the bases [for it] be disclosed. This is a bright line rule and must be followed.' " (quoting *Seef v. Ingalls Memorial Hospital*, 311 Ill. App. 3d 7, 24 (1999))).

¶ 69 The committee comments to Rule 213 explain that an independent expert witness like Dr. Hodakowski may be "a doctor who gives expert testimony based on the doctor's treatment of the plaintiff's injuries." See Ill. S. Ct. R. 213, Committee Comments (rev. Mar. 28, 2002). But if a party intends for "a treating doctor [to] testify about *another* doctor's compliance with the standard of care," that opinion "go[es] beyond those that would be reasonably expected based on the witness'[s] apparent involvement in the case. To prevent unfair surprise in circumstances like these, an answer must set forth a more detailed statement of the opinions the party expects to elicit." (Emphasis added.) *Id.* That is what happened here. Plaintiff disclosed Dr. Hodakowski as an independent treating expert, so defendants could expect that he would testify about what *he*

observed and did during open-heart surgery. But if plaintiff wanted Dr. Hodakowski to testify about what *Dr. Camba* did during a procedure Dr. Hodakowski was not present for and had opinions about, she had to disclose those opinions in more detail. Plaintiff did not, so the trial court did not abuse its discretion in barring this opinion.

¶ 70 Plaintiff argues that Dr. Hodakowski's barred opinion was a "logical corollary" to his discovery deposition testimony. At trial, a treating physician can elaborate on what he personally did or observed and can give "logical corollaries to Rule 213 disclosures." *Skubak v. Lutheran General Health Care Systems*, 339 Ill. App. 3d 30, 39 (2003) (citing *Scassifero v. Glaser*, 333 Ill. App. 3d 846, 860 (2002)). However, the disclosed opinion must encompass the elaboration or logical corollary. *Steele*, 2013 IL App (3d) 110374, ¶ 98. Dr. Hodakowski's barred testimony was not an elaboration on or a logical corollary to his discovery deposition testimony. Rather, it was a new opinion about what another doctor did during a procedure that Dr. Hodakowski did not participate in.

¶ 71 Finally, the exclusion of Dr. Hodakowski's testimony on this point did not prejudice plaintiff. We will not reverse a trial court's evidentiary rulings unless the error substantially prejudiced the complaining party and affected the outcome of the case. *Kovera v. Envirite of Illinois, Inc.*, 2015 IL App (1st) 133049, ¶ 55. The party seeking reversal bears the burden of establishing prejudice. *Id.* Here, the jury heard Dr. Hodakowski testify that he saw no evidence of a right ventricle perforation and made no repairs to the right ventricle. They also heard Dr. Swirsky testify that, if a 2.7-millimeter ICD lead had perforated the right ventricle, that hole would not have sealed on its own. From that evidence, the jury could have concluded that Dr. Camba did not perforate the right ventricle. Plaintiff made that argument in closing. We find that the trial court did not abuse its discretion in barring this opinion as undisclosed.

¶ 72 2. Microperforation Opinion

¶ 73 The second opinion the trial court barred as undisclosed was

> "Q. If there was a microperforation of the right ventricle, would that lead to a moderate to large pericardial effusion?
>
> ***
>
> A. Yes. Yeah, more likely than not, as you say.
>
> Q. It would not have caused a moderate to large perforation if there was a microperforation [*sic*]? Do you agree?
>
> ***
>
> A. Yes."

¶ 74 It is not clear what this testimony means. The first question and answer indicate that a right ventricle microperforation *would* cause a moderate to large pericardial effusion. The second question appears to be a garbled attempt to negate that opinion. We cannot tell what "Yes" in response to the second question means. Tellingly, plaintiff's brief never quotes this testimony. Rather, plaintiff "summarizes" this testimony by claiming that Dr. Hodakowski meant a right ventricle microperforation would *not* cause a moderate to large pericardial effusion. The first answer supports the opposite conclusion, while the second leaves his intended opinion unclear.

¶ 75 Further muddling this issue is the fact that the parties withdrew this testimony by agreement. During a conference on objections to Dr. Hodakowski's deposition testimony, the parties agreed to "take out Line 12 on Page 62 all the way through [page] 63, [line] 6," which is the exchange above.

¶ 76 In any event, plaintiff did not disclose that Dr. Hodakowski would opine on how much bleeding a right ventricle microperforation would cause. Her answer to Rule 213 interrogatories did not mention microperforations at all.

¶ 77 More importantly, plaintiff learned that self-sealing microperforations were part of the defense's theory during Dr. Hodakowski's March 2022 *discovery* deposition. On cross-examination at that deposition, Dr. Hodakowski testified:

> "Q. Just because you didn't find a perforation of the right ventricle, that does not mean one never existed, true?
>
> A. Yes.
>
> Q. It could have been a microperforation that was too small to detect during your procedure?
>
> A. Sure.
>
> Q. It could have sealed itself up by the time you were called in?
>
> A. Yes."

¶ 78 Plaintiff could have further explored Dr. Hodakowski's opinions about self-sealing microperforations at his discovery deposition, but she did not. Rather, she elicited only the following testimony:

> "Q. If you perforate the right ventricle, will it bleed?
>
> A. Yes.
>
> Q. And will that blood collect in the pericardium?
>
> A. Yes."

This testimony did not disclose anything about the amount of bleeding a microperforation would cause.

¶ 79 After the discovery deposition, plaintiff could have supplemented her Rule 213 disclosures to indicate that Dr. Hodakowski would opine about how much bleeding right ventricle microperforations cause. See Ill. S. Ct. R. 213(i) (eff. Jan. 1, 2018) ("A party has a duty to seasonably supplement or amend any prior answer or response whenever new or additional information subsequently becomes known to that party."). Plaintiff did not do that either. Rather, she waited until redirect examination at the June 2024 *evidence* deposition (which became Dr. Hodakowski's trial testimony) to elicit an opinion about how much bleeding a right ventricle microperforation would cause.

¶ 80 By that point it was too late. Dr. Hodakowski could not offer new, undisclosed opinions on redirect examination of his trial testimony. See *Regala v. Rush North Shore Medical Center*, 323 Ill. App. 3d 579, 585 (2001). Dr. Hodakowski was plaintiff's witness, so she "bore the obligation to ensure that [he did] not exceed previously disclosed opinions" on redirect examination at trial. See *id.* "The penalty for the introduction of such inadmissible testimony is extracted from the proponent of the witness, regardless of whether the testimony comes out on direct, cross, or redirect examination." *Id.* The trial court's finding that plaintiff did not disclose this opinion was not an abuse of discretion.

¶ 81 To the extent plaintiff argues that defendants "opened the door" to this opinion by asking Dr. Hodakowski about microperforations at his evidence deposition, that is not a basis for reversal. Rule 213(g) provides that, "[w]ithout making disclosure under this rule, *** a cross-examining party can elicit information, including opinions, from the witness." Ill. S. Ct. R. 213(g) (eff. Jan. 1, 2018). The Committee Comments explain that "[p]arties are to be allowed a full and complete cross-examination of any witness and may elicit additional undisclosed opinions in the course of cross-examination." Ill. S. Ct. R. 213, Committee Comments (rev. Mar. 28, 2002). "[T]he

exception to disclosure described in this paragraph is limited to the cross-examining party. It does not excuse the party calling the witness from the duty to supplement" her disclosures. *Id.*

¶ 82 Finally, if Dr. Hodakowski meant that a microperforation *would* cause a moderate to large pericardial effusion, that opinion would not have helped plaintiff anyway. That testimony meant that, even if Dr. Camba caused only a *micro*perforation of the right ventricle, it still would have caused a significant pericardial effusion, which was exactly what Dr. Camba diagnosed. The trial court barring this opinion did not prejudice plaintiff. See *Kovera*, 2015 IL App (1st) 133049, ¶ 55. We affirm the trial court's Rule 213 evidentiary rulings.

¶ 83 B. Manifest Weight of the Evidence

¶ 84 Plaintiff contends that the jury's verdict for defendants was against the manifest weight of the evidence.

¶ 85 A jury's verdict is against the manifest weight of the evidence when it is unreasonable, arbitrary, and not based on any evidence. *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38. The jury is responsible for weighing the evidence, making credibility determinations, and resolving conflicts in the evidence, including expert testimony. *Gulino v. Zurawski*, 2015 IL App (1st) 131587, ¶ 74. We do not substitute our judgment for the jury's. *Id.*

¶ 86 In this case, there are several ways the jury could have reasonably reached a verdict for defendants. First, there was no dispute that right ventricle perforations are a known risk of ICD placement surgery that can occur even in the absence of negligence. The jury may have concluded that Dr. Camba operated within the standard of care and that this procedure was simply one of the 0.3% to 1.3% of ICD placement surgeries that result in a nonnegligent right ventricle perforation. Plaintiff's retained expert Dr. Swirsky agreed that was possible even if Dr. Camba was operating within the standard of care.

¶ 87 The jury may have concluded that Dr. Camba nonnegligently perforated the right ventricle during ICD placement surgery. Dr. Camba testified that, after he attempted to place the right ventricular lead but before he began pericardiocentesis, the echocardiogram confirmed an effusion of blood around the heart. If the jury accepted that timeline, the effusion of blood could only have come from a perforation that the right ventricular lead caused. And if that occurred, there was no dispute that Dr. Camba responded appropriately by conducting a pericardiocentesis to drain the blood and alerting the cardiothoracic surgery team to repair the perforation. Although Dr. Hodakowski did not see evidence of a right ventricle perforation, the jury may have accepted Dr. Krishnan's theory that blood surrounding the heart sealed the perforation and it was no longer visible when Dr. Hodakowski operated on plaintiff.

¶ 88 Alternatively, the jury may have found that Dr. Camba did *not* perforate the right ventricle but responded appropriately to what he reasonably *believed* was a life-threatening pericardial effusion and cardiac tamponade. In that scenario, Dr. Camba may have misdiagnosed plaintiff's vital signs, but he erred on the side of caution by immediately treating what could have been a fatal condition. There was no dispute that a pericardial effusion and cardiac tamponade are life-threatening. So, the jury may have reasoned that, if there was even a slight chance plaintiff was suffering a pericardial effusion and cardiac tamponade, Dr. Camba acted reasonably in addressing that life-threatening possibility rather than excusing her vital signs as a harmless vagal reaction. Dr. Krishnan's testimony supported that conclusion. He explained that, even if plaintiff's decrease in blood pressure was just a vagal reaction, Dr. Camba had to first "make sure there's not a more serious reason for that happening before defaulting to a benign, non-life-threatening" diagnosis. In other words, "the standard of care require[d Dr. Camba] to prioritize the different causes and cho[o]se the one that's both most likely and most serious."

¶ 89 Yet another possibility is that the jury was unsure exactly what happened during ICD placement surgery and therefore found that plaintiff did not carry her burden of proving Dr. Camba's negligence by a preponderance of the evidence.

¶ 90 This case was a classic "battle of the experts" that required the jury to evaluate conflicting expert testimony. Such a case generally does not warrant finding that the jury's verdict was against the manifest weight of the evidence. See, *e.g.*, *Snelson v. Kamm*, 204 Ill. 2d 1, 35-36 (2003) (verdict was not against the manifest weight of the evidence where the case involved a "classic battle of the experts" (internal quotation marks omitted)); *Sottile v. Carney*, 230 Ill. App. 3d 1023, 1031 (1992) (verdict was not against the manifest weight of the evidence where the "medical expert testimony [was] merely conflicting").

¶ 91 The medical expert opinions were not the only conflicting evidence in this case. The jury had to resolve conflicting medical records and testimony regarding (1) whether plaintiff was bradycardic or tachycardic when Dr. Camba diagnosed a pericardial effusion and impending cardiac tamponade; (2) whether Dr. Camba confirmed the pericardial effusion using the echocardiogram before he began the pericardiocentesis, as defendants argued, or whether he began that procedure based solely on plaintiff's vital signs, as plaintiff contended; and (3) when Dr. Camba began using the echocardiogram and why it did or did not store certain images. The jury was responsible for resolving this conflicting evidence, and we will not usurp its role on appeal. See *Gulino*, 2015 IL App (1st) 131587, ¶ 74.

¶ 92 Plaintiff argues that "[i]t is undisputed that [she] had bradycardia, not tachycardia, during the ICD placement," presumably to suggest that Dr. Camba should have diagnosed her with a vagal reaction as opposed to cardiac tamponade. But the evidence on this point was not "undisputed." Drs. Camba and Krishnan testified that plaintiff was tachycardic with a heart rate of 101 beats per

minute *after* Dr. Camba attempted to place the right ventricular lead. Only then did her heart rate decrease and reach a bradycardic level. Both doctors explained that occurred because her heart could no longer "keep up" given the loss of blood due to the pericardial effusion. The jury's verdict for defendants was not against the manifest weight of the evidence, and we affirm it.

¶ 93 C. Motions for Directed Verdict, Judgment *n.o.v.*, and New Trial

¶ 94 Plaintiff argues that the trial court should have granted her motion for a directed verdict, judgment *n.o.v.*, or a new trial because defendants admitted Dr. Camba's negligence. Specifically, she contends that defendants' answer admitted she experienced a vagal reaction during ICD placement surgery and, on cross-examination at trial, Dr. Camba admitted he did not diagnose or treat that vagal reaction even though the standard of care required him to do so.

¶ 95 "Although motions for directed verdicts and motions for judgments *n.o.v.* are made at different times, they raise the same questions and are governed by the same rules of law." *Lawlor*, 2012 IL 112530, ¶ 37. A trial court should grant a motion for a directed verdict or judgment *n.o.v.* only when all the evidence, viewed in the light most favorable to the nonmovant, so overwhelmingly favors the movant that no contrary verdict could ever stand. *Id.* The standard for a directed verdict or judgment *n.o.v.* is high, and a court should not grant such motions if reasonable people could draw different inferences or conclusions from the evidence. *Id.* We review the trial court's rulings on these motions *de novo*. *Id.*

¶ 96 By contrast, "on a motion for a new trial, the trial court will weigh the evidence and order a new trial if the verdict is contrary to the manifest weight of the evidence." *Id.* ¶ 38. "A verdict is against the manifest weight of the evidence only where the opposite result is clearly evident or where the jury's findings are unreasonable, arbitrary and not based upon any of the evidence." *Id.*

We will reverse the trial court's ruling on a motion for a new trial only if the trial court abused its discretion. *Id.*

¶ 97 Defendants' answer admitted that plaintiff experienced a vagal reaction during ICD placement surgery, which was a judicial admission defendants could not contradict at trial. See *Bank of New York Mellon v. Wojcik*, 2019 IL App (1st) 180845, ¶ 23. But the second basis for plaintiff's argument on this point, Dr. Camba's trial testimony, was not so straightforward:

> "Q. Doctor, a reasonably careful physician would timely and accurately diagnose a patient's condition during an attempted placement of an ICD, correct?
>
> A. Yes.
>
> Q. And a reasonably careful physician would timely and properly treat a patient's condition during an attempted ICD placement, correct?
>
> A. Yes.
>
> Q. Doctor, you never diagnosed Bridget Long with a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?
>
> A. True [rest of answer stricken pursuant to objection].
>
> ***
>
> [Q.] Doctor, you never treated Bridget Long for a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?
>
> A. True."

¶ 98 This testimony established that the standard of care required Dr. Camba to treat "a patient's condition," but it did not necessarily establish that *plaintiff's* vagal reaction was a "condition" that required treatment. Plaintiff's "condition" that required treatment could have been the pericardial effusion and cardiac tamponade. Interpreting this testimony to mean that the vagal reaction was

the "condition" Dr. Camba was required to treat views the evidence in the light most favorable to plaintiff, which is not the standard for a directed verdict or judgment *n.o.v.* See *Lawlor*, 2012 IL 112530, ¶ 37.

¶ 99 Furthermore, motions for directed verdict, judgment *n.o.v.*, and a new trial must consider *all* the evidence (*id.* ¶¶ 37-38), and Dr. Camba's testimony was not the only evidence on this point. Dr. Krishnan explained that a vagal reaction is not life threatening and does not require immediate treatment. He also testified that, even if plaintiff had a vagal reaction, Dr. Camba was correct in addressing the life-threatening pericardial effusion and cardiac tamponade first and that treating those conditions would have effectively treated the vagal reaction. The evidence was not so overwhelming that no contrary verdict could ever stand, nor was a finding of negligence clearly evident. See *id.* The trial court correctly denied plaintiff's motions for a directed verdict, judgment *n.o.v.*, and a new trial.

¶ 100 Plaintiff claims that the trial court "improperly allow[ed] Dr. Camba to contradict his binding judicial admission[ ]." In fact, the court did the opposite. It struck Dr. Camba's attempt to claim that plaintiff did not experience a vagal reaction:

> "Q. Doctor, you never diagnosed Bridget Long with a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?
>
> A. True, because she didn't have one.
>
> [PLAINTIFF'S COUNSEL]: Your Honor, I'd move to strike the portion of the answer that's non-responsive.
>
> THE COURT: Counsel will have an opportunity to follow up, so that last portion is stricken.
>
> [PLAINTIFF'S COUNSEL]: Thank you.

Doctor, you never treated Bridget Long for a vagal reaction during your attempted ICD placement on January 2nd, 2017, true?

A. True."

¶ 101 Similarly, plaintiff claims that the trial court allowed defendants "to contradict Dr. Camba's binding judicial admissions with expert testimony." Her brief does not explain this claim; rather it cites approximately a dozen places in the reports of proceedings where this supposedly happened. We have reviewed those citations, and they do not reflect defense experts testifying that plaintiff did not experience a vagal reaction. On the contrary, Dr. Krishnan testified as follows:

"Q. First, do you agree or disagree that Ms. Long had only a vagal reaction.

***

[A.] I disagree with that statement.

***

Q. Can you explain why?

A. Because the patient had another medical condition, the cardiac tamponade and the pericardial effusion, and those can lead to exactly the same symptoms that were seen and the vital sign findings that were found. And the more serious condition, it's imperative to evaluate that first.

Q. Is that what Dr. Camba did?

A. Yes."

Dr. Krishnan testified that plaintiff had a vagal reaction and other conditions: a pericardial effusion and cardiac tamponade. That testimony did not contradict defendants' judicial admission that plaintiff experienced a vagal reaction.

¶ 102 Plaintiff cites *Dunning v. Dynegy Midwest Generation, Inc.*, 2015 IL App (5th) 140168, ¶¶ 53-56, for the proposition that a trial court can direct a verdict on negligence based on the defendants' judicial admissions and trial testimony. That is true in general. But in this case, we find no error in the trial court's decision not to direct a verdict on negligence. *Dunning* is distinguishable in any event. It was a workplace injury case, not a complex medical negligence case, and it did not involve conflicting expert opinions. We affirm the trial court's denial of plaintiff's motions for a directed verdict, judgment *n.o.v.*, and a new trial.

¶ 103 D. Cumulative Error

¶ 104 Finally, plaintiff raises a claim of cumulative trial error. She argues that the trial court allowed defendants to present a "speculative" theory that Dr. Camba caused a microperforation of plaintiff's right ventricle, which sealed itself by the time Dr. Hodakowski operated on her, but did not allow plaintiff to rebut that theory. We reject this claim of cumulative error for several reasons.

¶ 105 First, defendants' microperforation theory was not "speculative." Dr. Hodakowski confirmed that self-sealing ventricle perforations are "documented in medical literature."

¶ 106 Second, plaintiff presented evidence to rebut defendants' microperforation theory. Her retained expert, Dr. Swirsky, opined that a 2.7-millimeter ICD lead could not have caused a hole small enough to seal on its own; *i.e.*, there could not have been a self-sealing microperforation in this case.

¶ 107 Third, the jury did not have to accept the microperforation theory to find for defendants. As explained above, the jury may have found that Dr. Camba did not perforate the right ventricle but reasonably believed he did and acted appropriately in what appeared to be a life-threatening situation. Or the jury may have simply concluded that plaintiff did not carry her burden of proof.

¶ 108 Finally, the jury heard the testimony of five doctors and two fact witnesses over four days of evidence. The jury's only note asked to see certain exhibits, which the parties agreed not to send back to them. The jurors expressed no doubt, hesitation, or division in their numbers. There is no indication that the trial as a whole was unfair. See *Kos v. Muzykansky*, 2026 IL App (1st) 242359, ¶ 77. And because we have not identified any reversible individual errors in this well-run trial, we cannot find cumulative error. See *id.* ¶ 78. We affirm the jury's verdict for defendants.

¶ 109 III. CONCLUSION

¶ 110 We affirm the judgment of the circuit court of Cook County.

¶ 111 Affirmed.

Decision Under Review:	Appeal from the Circuit Court of Cook County, No. 20-L-9631; the Hon. Patricia O'Brien Sheahan, Judge, presiding.
Attorneys for Appellant:	Robert J. Napleton and David Gallagher, of Napleton & Partners, of Chicago, and Lynn D. Dowd and Patrick C. Anderson, both of Naperville, for appellant.
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