No. 126748

In the

Supreme Court of Illinois

JILL M. BAILEY, as Independent Representative of the Estate of JILL M. MILTON-HAMPTON, Deceased,

Plaintiff-Appellee,

v.

MERCY HOSPITAL AND MEDICAL CENTER, et al.,

Defendants-Appellants.

On Leave to Appeal from the Appellate Court of Illinois,
First Judicial District, No. 1-18-0072.
There Heard on Appeal from the Circuit Court of Cook County, Illinois,
County Department, Law Division, No. 13 L 008501.
The Honorable **Thomas V. Lyons II**, Judge Presiding.

AMICUS CURIAE BRIEF OF ILLINOIS TRIAL LAWYERS ASSOCIATION IN SUPPORT OF PLAINTIFF-APPELLEE

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"The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."
-Hubert Humphrey, November 1977

The loss of chance doctrine protects the critically ill and the most vulnerable amongst us. Predictably, they are the members of our community most in need of frequent medical care and the most at risk for experiencing healthcare inequalities.[1] It follows that they are at the highest risk of falling victim to medical negligence.[2] In 1997, this Court recognized that the loss of chance doctrine was integral to maintaining equity in healthcare and protecting the sickest amongst us. *Holton v. Mem'l Hosp.,* 176 Ill. 2d 95, 119–20, 679 N.E.2d 1202, 1213 (1997). Rejecting the reasoning of cases which held that plaintiffs may not recover for medical malpractice injuries if they are unable to prove that they would have enjoyed a greater than 50% chance of survival or recovery absent the alleged malpractice of the defendant, this

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[1] See *Persons With Disabilities as an Unrecognized Health Disparity Population* Gloria L. Krahn, PhD, MPH, Deborah Klein Walker, EdD, and Rosaly Correa-De-Araujo, MD, Ph Am J Public Health. 2015 April; 105(Suppl 2): S198–S206. "The disparities in unmet health care needs of people with disabilities stand as a stark reminder of the work that must be done to improve access to care." Although they have higher rates of chronic diseases than the general population, adults with disabilities are significantly less likely to receive quality preventive care. As a result As a group, people with disabilities experience more chronic diseases and conditions, and experience them at earlier ages. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/

[2] According to a study by Johns Hopkins, more than 250,000 people in the United States die every year because of medical mistakes, making it the third leading cause of death after heart disease and cancer. Available at: https://s3.documentcloud.org/documents/2822345/Hopkins-CDC-letter.pdf An evidence based estimate published by the Journal of Patient Safety reported the true number of premature deaths associated with preventable harm to patients was estimated at more than 400,000 per year, with serious harm being 10- to 20-fold more common than lethal harm. Available at https://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx

Court declared that, "[t]o hold otherwise would free health care providers from legal responsibility for even the grossest acts of negligence, as long as the patient upon whom the malpractice was performed already suffered an illness or injury that could be quantified by experts as affording that patient less than a 50% chance of recovering his or her health." *Id.* at 119. Thus, it has now long been established that the loss of chance doctrine comports with Illinois law and public policy promoting equity in healthcare and equal access to justice for the critically ill and injured among us.

Similarly, Illinois courts have long recognized a litigant's fundamental right to have the jury instructed on her theory of the case. "A party has a *right* to have the jury instructed on his or her theory of recovery or defense if the facts in evidence or a reasonable inference from those facts support that theory." *Alden Press, Inc. v. Block & Co.*, 173 Ill. App. 3d 251, 260, 527 N.E.2d 489, 494 (1st Dist. 1988); *Aimonette v. Hartmann,* 214 Ill. App. 3d 314, 321, 574 N.E.2d 776, 780 (2d Dist. 1991); *Smith v. Ford,* 43 Ill. App. 3d 407, 411, 356 N.E.2d 1306, 1309 (3d Dist. 1976); *Schuchman v. Stackable, 1*98 Ill. App. 3d 209, 225, 555 N.E.2d 1012, 1023 (5th Dist. 1990). This fundamental right was first recognized by this Court in the early 1900s when Justice Cartwright declared that "[a] party is entitled to instructions which apply *directly and specifically* to his theory of the facts which there is evidence tending to prove." *Chicago Union Traction Co. v. Leach,* 215 Ill. 184, 187, 74 N.E. 119, 120 (1905)(emphasis added). For the last one hundred and sixteen (116) years this Court has reiterated and reinforced a party's right to instruct the jury on his or her specific theory of recovery. *See Thomas v. Chicago Embossing Co.,* 307 Ill. 134, 141, 138 N.E. 285, 288 (1923)("There can be no question that a party to a cause of action is entitled to instructions which apply directly and specifically to his theory of the facts when there is evidence tending to prove these facts."); *Blanchard v. Lewis*, 414 Ill. 515, 523, 112 N.E.2d 167, 172 (1953); *Ervin v. Sears, Roebuck & Co.,* 65 Ill. 2d 140,

145, 357 N.E.2d 500, 503 (1976)("Plaintiff also had the right to have the jury clearly and fairly instructed upon each theory which was supported by evidence.").

In the context of proximate cause in medical negligence cases, this Court has repeatedly held that litigants have a right to instruct the jury on specific and distinct theories of causation. In 1995, when considering a defendant's right to instruct the jury on the theory of sole proximate cause, this Court declared that "a litigant has the right to have the jury clearly and fairly instructed upon each theory which [is] supported by the evidence." *Leonardi v. Loyola University,* 168 Ill.2d 83, 100, 658 N.E.2d 450 (1995). In 2007, when considering a plaintiff's right to instruct the jury on her theory of *res ipsa loquitur*, this Court reiterated the right to instruct the jury on each theory of causation and liability presented at trial:

> The threshold for giving an instruction in a civil case is, after all, not a high one. Generally speaking, litigants have the right to have the jury instructed on each theory supported by the evidence. Whether the jury would have been persuaded is not the question. All that is required to justify the giving of an instruction is that there be some evidence in the record to justify the theory of the instruction. The evidence may be insubstantial. *Heastie v. Roberts,* 226 Ill. 2d 515, 543, 877 N.E.2d 1064, 1082 (2007).

In 2008, this Court clarified that the expression "theory of the case" was not confined to theories of liability, rather, "[i]t refers, instead, to each party's framing of the issues and arguments in support of its position." *Mikolajczyk v. Ford Motor Co.*, 231 Ill. 2d 516, 549, 901 N.E.2d 329, 348–49 (2008).

Given this Court's long history of recognizing a litigant's right to have the jury instructed on his or her theory of the case, the question now before this Court is again, at its core, an issue of equity: Does a critically ill, injured or disabled litigant enjoy the same rights as other litigants to have the jury instructed on his or her theory of the case if the facts in evidence or reasonable inferences from those facts supports the theory? This *amicus curiae*, the Illinois Trial Lawyers Association, respectfully suggests that the only answer to that

question is yes. To hold otherwise would deny recovery to those with demonstrated injuries that have suffered and give defense lawyers license to argue that a disabled patient that presents for treatment with a less than a 50% chance of recovering his or her health or survival has no right to recovery in an Illinois court of law.

Without proper instruction to the jury on loss of chance it is not fully, comprehensively and accurately informed of the relevant and well-established law that affords this group of individuals a right to a fair trial. Those that have previously suffered injury or illness have the same right as any party to pursue full compensation for all their demonstrated injuries and to have a jury instructed on their theory of the case. *Bailey v. Mercy Hosp. & Med. Ctr.,* 2020 IL App (1st) 182702, ¶ 108, 166 N.E.3d 301, 324, reh'g denied (Nov. 9, 2020), appeal allowed, 167 N.E.3d 647 (Ill. 2021) *quoting Tsoukas v. Lapid*, 315 Ill. App. 3d 372, 377, 248 Ill.Dec. 148, 733 N.E.2d 823; *Dillon v. Evanston Hosp.,* 199 Ill. 2d 483, 504, 771 N.E.2d 357, 370 (2002).

Considering this Court's longstanding recognition of a party's right to jury instructions on specific theories of recovery, defendant-appellants' efforts to characterize the appellate court's well-reasoned opinion in *Bailey* as a "sudden departure" from precedent is far-fetched and dramatic. This Court has always recognized the power and propriety of a properly instructed jury and the rights of litigants in that regard. "The test in determining the propriety of tendered instructions is whether the jury was fairly, fully, and comprehensively informed as to the relevant principles, considering the instructions in their entirety." *Leonardi,* 168 Ill. 2d at 100. The Illinois Pattern Jury Instructions do not currently provide any instruction on the loss of chance doctrine. Accordingly, the appellate court simply recognized, as has happened many times, that this is a situation in which our pattern instructions are inadequate and additional instruction is appropriate.

This is clearly not a novel or sudden departure from precedent. In fact, as far back as 1903, this Court has held that when a theory addresses a vital and controlling feature of the case, general principles of law will *not* suffice:

> The general principle announced in some other of the instructions, that the law required the exercise of ordinary care on the part of the plaintiff, cannot, under the circumstances of the case, be regarded as the equivalent of the instruction which was refused. The refused instruction sought to apply a principle of law to the facts as found by the jury, and it can hardly be deemed to be merely a repetition of an instruction which announces the principle in the abstract. Ency. of Pl. & Pr. 298. We think the instruction should have been given. It touched upon a vital and controlling feature of the case, and the refusal to give it must be regarded as error of reversible character. *Mallen v. Waldowski*, 203 Ill. 87, 91, 67 N.E. 409, 410 (1903).

While Illinois Pattern Jury Instruction 15.01 instructs as to the general principle of proximate cause, it does not touch upon the vital and controlling feature of a critically ill patient's case – their lessened chance to recover and/or survive. As such, IPI 15.01 does not distinctly inform the jury that they may consider that a defendant's negligence which lessened the effectiveness of the treatment or increased the risk of an unfavorable outcome was a proximate cause of a patient's injury. *Bailey,* 2020 Il App (1st) 182702, ¶115.

Importantly, as discussed *infra,* Illinois is not alone in finding that it is necessary to instruct the jury on this theory of recovery to fully protect the rights of litigants who suffered a reduction in their chance of healing or survival. Among the twenty-four (24) states that have formally adopted the loss of chance doctrine, a majority have a pattern loss of chance instruction to ensure their jurors are distinctly and correctly informed on this theory of causation.

A. With Holton, Illinois Joined the Majority of States Recognizing the Loss of Chance Doctrine

In 1997, Illinois joined the majority of states in recognizing the loss of chance doctrine as a theory of recovery. In *Holton*, this Court established that, "[t]o the extent a plaintiff's

chance of recovery or survival is lessened by the malpractice, he or she should be able 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." *Holton v. Memorial Hospital,* 176 Ill. 2d 95, 119, 679 N.E.2d 1202 (1997). Thus, there is no question that following *Holton*, a plaintiff may submit evidence and recover on a loss of chance theory. *Bailey v. Mercy Hosp. & Med. Ctr.*, 2020 IL App (1st) 182702, ¶ 114.

Despite the fact that Illinois has recognized the loss of chance theory as a viable theory of recovery for over 24 years, the defendants-appellants and their *amici* waste this Court's valuable time rehashing the merits of the loss of chance doctrine. On this point, defendants-appellants and their *amici* deploy their same tried and true tactics: fear, misinformation and tort reform rhetoric. Defendants-appellants' *amici* spend countless pages attempting to convince this Court that the doctrine itself is bad and will "degrade health care in Illinois." However, nothing could be further from the truth. When this Court recognized the loss of chance doctrine it did so to protect the rights of critically ill patients and to ensure quality healthcare for *all* Illinois citizens:

> Disallowing tort recovery in medical malpractice actions on the theory that a patient was already too ill to survive or recover may operate as a disincentive on the part of health care providers to administer quality medical care to critically ill or injured patients. Moreover, it has been noted that "[i]t is impossible to divine who would fall into one category [survivor] or the other [nonsurvivor]. Not allowing such a case to be decided by a jury means that statistical proof of a less than 50% chance would be dispositive, even though no expert in the world could prospectively state who would survive and who would die. That is why doctors treat all patients, not just those with better than even odds." *Holton v. Mem'l Hosp.*, 176 Ill. 2d 95, 119–20, 679 N.E.2d 1202, 1213 (1997) *quoting* 84 Ill. B.J. at 462.2

Since *Holton,* this Court has twice held that an injured party does not need to prove that he or she would have been better off had the health care professional not intervened. In addition to ensuring that critically ill persons are allowed access to justice, the loss of chance

doctrine ensures that doctors treating the critically ill will be held to the same professional standard and be held accountable if they do not.

B. Pre-*Holton* Case Law Has No Bearing on the Issue Before this Court Which is Whether to Properly Instruct the Jury on the Loss of Chance Doctrine.

Inexplicably, much of the defendant-appellants' brief is also a recitation of pre-*Holton* caselaw, which has no bearing on this case and should not be considered. Pre-*Holton*, this Court had not resolved the application of the loss of chance doctrine in medical malpractice actions. In *Holton*, following a thorough analysis of the existing case law, this Court declared that "the loss of chance concept, when properly analyzed, does not relax or lower plaintiffs' burden of proving causation." *Holton*, 176 Ill. 2d at 120. In so holding, this Court overruled the appellate court's decisions in *Hare v. Foster G. McGaw Hosp.*, 192 Ill.App.3d 1031 (1st Dist. 1989) and *Netto v. Goldenberg*, 266 Ill.App.3d 174 (2d Dist. 1994). As such, the defendant-appellants' citation to and discussion of pre-Holton caselaw such as *Curry v. Summer,* 136 Ill.App.3d 468 (4th Dist. 1985), *Netto v. Goldenberg*, 266 Ill.App.3d 174 (2d Dist. 1994), *Hajijan v. Holy Family Hosp.*, 273 Ill.App.3d 932 (1st Dist. 1995), *Northern Trust Co v. Louis A. Weiss Mem'l Hosp.*, 143 Ill.App.3d 479 (1st Dist. 1986), are irrelevant to this Court's decision on the necessity of instructing the jury on this recognized theory of recovery.

C. *Holton* Did Not Resolve Whether Juries Require Instruction on This Issue but the Appellate Court in *Bailey* Rightly Resolved This Issue.

The defendants-appellants' brief falsely states at page 38 that "the Court in *Holton* concluded that "lost chance" is *not* a separate theory of recovery that requires instruction." To the contrary, after recognizing loss of chance as a viable theory of recovery, the Court in *Holton* declined to address (a) whether loss of chance was a "separate injury" or (b) whether the plaintiff had a right to have additional jury instruction on the issue because it was not asked to do so by the parties.

The appellate court's opinion in *Holton* demonstrates that the plaintiff did not tender a nonpattern jury instruction on the loss of chance doctrine at the time of trial and therefore the issue was not considered on appeal. *Holton v. Mem'l Hosp.,* 274 Ill. App. 3d 868, 655 N.E.2d 29 (1995), rev'd, 176 Ill. 2d 95, 679 N.E.2d 1202 (1997). This make sense because *Holton* was an appeal by the defendants from a verdict in favor of the plaintiff for the paraplegia she suffered due to a spinal injury caused by a bone infection which went undiagnosed and untreated by the defendants. On appeal the defendants argued that the plaintiff had failed to meet her burden on the issue of causation and therefore the trial court had erred in denying defendant's motion for judgment notwithstanding the verdict. *Id.* at 111.

In footnote 1 of the opinion, the *Holton* Court specifically noted that it had not been asked to resolve the issues of whether loss of chance was a "separate injury" or whether it required instruction beyond the traditional Borowski statement of proximate cause articulated in IPI 15.01:

> In contrast to the relaxed causation approach to lost chance theory, which has been criticized as diluting the standard burden of proof, the "separate injury" approach, also known as "pure chance," redefines the relevant injury to the plaintiff by recognizing a separate cause of action for a loss of a chance to survive or recover. See 84 Ill. B.J. at 460, citing J. King, Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 Yale L.J. 1353, 1365 (1981). Adoption of the separate injury approach permits plaintiffs to recover damages proportionate to their lost chance of avoiding the ultimate harm. For example, if a plaintiff had only a 30% chance of recovering from cancer but proved that his doctor negligently failed to diagnose the cancer until it became inoperable, the plaintiff may recover 30% of the value of his life under the theory that the defendant's malpractice deprived him of a 30% chance of a cure. We note that the Illinois cases which approve the loss of chance theory generally adhere to the Borowski standard of proximate cause, without expressly analyzing loss of chance in terms of a separate injury to plaintiff for which damages may be proportionately awarded. **The parties in the instant case do not request this court to depart from Borowski or to recognize a "separate injury" cause of action.**
>
> *Id.* at 114 (emphasis added).

In contrast, here, the issue was before the *Bailey* court and ripe for it to decide, which it did with impeccable and straightforward reasoning. There was no sudden departure from precedent or deviation from common law. The appellate court simply followed well-settled precedent and recognized that when a party has put forth sufficient facts to support a theory of loss of chance, that party has a right to have the jury instructed on the theory. Refusing to do so denies the litigant this basic litigation right and therefore a fair trial. *Bailey*, 2020 IL App (1st) 182702, ¶ 108. The court correctly concluded that while the general proximate cause standard articulated by Illinois Pattern Jury Instruction 15.01 may "encompass" a theory of loss of chance under its large umbrella, it does not "*distinctly"* inform the jury about loss of chance:

> ¶ 115 We recognize that this court has previously held that the loss of chance theory is encompassed in the long-form proximate cause instruction in IPI Civil No. 15.01, which was given here. However, "jury instructions must state the law fairly and *distinctly* and must not mislead the jury or prejudice a party." (Emphasis in original.) *Dillon*, 199 Ill. 2d at 507, 264 Ill.Dec. 653, 771 N.E.2d 357. The proximate cause instruction in IPI Civil No. 15.01 provides that the cause "need not be the only cause, nor the last or nearest cause" but does not distinctly inform the jury about loss of chance, *i.e.*, that the jury may consider, as a proximate cause of a patient's injury, that a defendant's negligence lessened the effectiveness of the treatment or increased the risk of an unfavorable outcome to a plaintiff. See *Hemminger*, 2014 IL App (3d) 120392, ¶ 16, 381 Ill.Dec. 889, 11 N.E.3d 825 (loss of chance in medical malpractice is where the malpractice lessened the effectiveness of treatment or increased the risk of an unfavorable outcome). *Bailey*, 2020 IL App (1st) 182702, ¶ 115.

Arguably, the umbrella of many Illinois Pattern Jury Instructions which articulate general principles of the law "encompass" more specific theories of liability and causation such as: Injury From Subsequent Treatment – IPI Civil No. 30.23, Contributory Negligence – IPI Civil No.11.01, Intoxication- IPI Civil No. 12.01, Concurrent Negligence Other Than Defendant's – IPI Civil No. 12.04, Negligence – Intervention of Outside Agency- IPI Civil No.12.05, Res Ipsa Loquitur and Specific Negligence as Alternative Theories of Recovery – IPI Civil No. 22.02, Aggravation of Pre-Existing Condition – IPI Civil No. 30.21. Yet, there

has never been any controversy about the jury receiving additional *distinct* instructions on these various theories, in addition to general principles of law. For example, on the issue of causation alone, a jury in a medical negligence case is usually instructed with IPI Civil No. 15.01, addressing the general principle of proximate cause. However, additional specific instructions are often given on distinct causation issues which comport with the litigants' framing of the issues and arguments in support of their positions. *Mikolajczyk*, 231 Ill. 2d at 549, 901 N.E.2d at 348-49. A jury in a medical malpractice trial will often be instructed by IPI Civil No. 15.01, *and* IPI Civil No. 30.23, IPI Civil No. 12.04, IPI Civil No.12.05 and IPI Civil No. 30.21.

The fact that a general instruction arguably encompasses a more specific concept does not justify denying a litigant the right to instruct the jury on his or her theory of the case. The most common example of this in practice is the use of IPI Civil No. 15.01 in addition to the use of IPI Nos. 12.04 and 12.05 regarding the theories of concurrent and sole proximate cause. Arguably, the long form of IPI Civil No. 15.01 encompasses the causation theories of concurrent negligence and intervening causes. The plain language of IPI Civil No.15.01 specifically refers to other causes and combined causes. IPI Civil No.15.01 also refers to the "only cause." When read with IPI Civil No. 21.01, these two instructions generally inform the jury regarding the proposition of proximate cause and the plaintiff's burden with respect each defendant on this issue.

Nonetheless, if the defendant puts forth even a *scintilla* of evidence regarding a "sole proximate cause" or there is evidence presented of a concurrent cause theory, it is well established that these litigants have a right for the jury to be instructed on this distinct theory of causation utilizing the long form of IPI Civil No. 12.04 and/or 12.05. As stated by this Court in *Leonardi v. Loyola Univ. of Chicago,* 168 Ill. 2d at 101, "a defendant has the right not

only to rebut evidence tending to show that defendant's acts are negligent and the proximate cause of claimed injuries, but also has the right to endeavor to establish by competent evidence that the conduct of a third person, or some other causative factor, is the sole proximate cause of plaintiff's injuries. Further, if the evidence is sufficient, the defendant is entitled to an instruction on this theory."

A plaintiff presenting a theory of loss of chance is no different. He or she has the same right regardless of how far IPI Civil No. 15.01 is stretched to "encompass" the theory of loss of chance. In the absence of a specific instruction on loss of chance, the jury is left to deal with evidence that the malpractice lessened the effectiveness of treatment or increased the risk of an unfavorable outcome in a critically ill patient in a vacuum.

D. The Plaintiff-Appellee's Nonpattern Jury Instruction Accurately Stated the Law on Loss of Chance in a Simple, Brief, Impartial, and Non-argumentative Manner

The Illinois Supreme Court Committee on Jury Instructions was created in 1957 as a part of a unanimous resolution of the Illinois Judicial Conference. See *Use of Non-Pattern Jury Instructions in Civil Cases,* Judge Lynn M. Egan (May 2013)[App.12-16]. After its survey of jury instruction practice throughout the United States, the Committee determined that certain basic concepts should form the basis of model instructions. *Id.* The Committee's goal was to incorporate these basic concepts into understandable and accurate instructions. *Id.* However, "Illinois pattern jury instructions were never meant to state the law of Illinois in all possible situations." *Id.* Moreover, while Supreme Court Rule 239(a) prescribes the use of Illinois Pattern Jury Instructions, an instruction is approved or rejected only after it has been judicially questioned and considered. *Powers v. Illinois Central Gulf Railroad Company,* 91 Ill. 2d 375 (1982). Therefore, in reviewing a tendered nonpattern jury instruction, the court is instructed to

consider (1) whether a pattern jury instruction exists regarding the issue and (2) whether the tendered instruction is simple, brief, impartial, and free from argument:

> 'In reviewing the adequacy of instructions, the court must consider the jury instructions as a whole to determine whether they fully and fairly cover the law.' The function of jury instructions is to convey to the jury the correct principles of law applicable to the evidence so the jury can apply the proper legal principles to the facts and arrive at a proper conclusion based on the law and the evidence. If an IPI instruction does not state the law, the proffered instruction given on that subject should be simple, brief, impartial, and free from argument. The decision to give or refuse a non-IPI instruction is a matter within the sound discretion of the trial court. An abuse of discretion occurs in refusing to give a non-IPI instruction where there is no IPI instruction applicable to the subject and the jury was left to deliberate without proper instructions. Refusal to give a non-IPI instruction does not constitute an abuse of discretion if there is an applicable IPI instruction and/or the essence of the refused instruction is covered by the instruction given. The trial court must give a non-IPI instruction if refusing to give a non-IPI instruction would result in the jury not being instructed as to a [defense] theory of the case 'which is supported by some evidence. *People v. Rebecca*, 2012 IL App (2d) 091259, ¶ 69, 969 N.E.2d 394, 414 (internal citations omitted).

Here, reviewing the instructions as a whole, the appellate court correctly noted that a distinct Illinois Pattern Jury Instruction on the loss of chance doctrine does not exist. As such, a simple, brief, impartial, and nonargumentative nonpattern jury instruction which accurately stated Illinois law as to the loss of chance doctrine was tendered by the plaintiff and was appropriate:

> If you decide or if you find that plaintiff has proven that a negligent delay in the diagnosis and treatment of sepsis in Jill Milton-Hampton lessened the effectiveness of the medical services which she received, you may consider such delay one of the proximate causes of her claimed injuries or death. *Bailey*, 2020 IL App (1st) 182702, ¶ 112

The plaintiff-appellee's well-crafted instruction strikes a delicate balance. The instruction informs the jury of plaintiff's theory of the case, accurately states the loss of chance standard under *Holton* and does not invade the issue of liability. Moreover, the instruction preserves plaintiff's burden of proof on all issues.

E. A Majority of States That Recognize the Loss of Chance Doctrine Have Adopted or Established a Pattern Jury Instruction On This Issue.

To date, twenty-four (24) states, including Illinois, recognize loss of chance as a separate theory of recovery. Of this group, a majority of states, fourteen (16), have adopted or developed a pattern instruction educating and directing the jury on this issue loss of chance or held that a nonpattern instruction on loss of chance must be given to avoid confusion:

> ***Adopted Loss of Chance (24):*** Arizona, Delaware, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming.[3]
>
> ***Adopted Jury Instruction on Loss of Chance (14):*** Indiana, Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Missouri, New Jersey, Ohio, Oklahoma, West Virginia, Washington, Wyoming[4]
>
> ***Endorsed a Nonpattern Instruction on Loss of Chance (2)***: Montana[5], Pennsylvania.[6]

Several other states have endorsed giving a nonpattern instruction. For example, this *amicus* has compiled a chart of all 14 states that have developed pattern or uniform instructions relating to loss of chance, attached in Appendix. [App 1 –11].

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[3] See Guest, Schap and Tran, T*he "Loss of Chance" Rule A Special Category of Damages in Medical Malpractice: A State-By-State Analysis,* 21-APR J. Legal Econ. 53

[4] See Appendix, [App.1-11]

[5] *Aasheim v. Humberger*, 215 Mont. 127, 133, 695 P.2d 824, 828 (1985), "We hold that under the facts of this case plaintiff is entitled to a "loss of chance" instruction. That instruction may in substance, reflect the substantive law found in Restatement (Second) of Torts § 323, supra. The trier of fact should determine whether defendant's negligence was a substantial factor in reducing plaintiff's chances of obtaining a better result."

[6] *Hamil v. Bashline*, 481 Pa. 256, 392 A.2d 1280 (1978) Holding that a jury instruction relating to the doctrine now known as loss of chance must be given to avoid confusion. Instruction to effect that unless plaintiff's decedent would have died without treatment, his chances for life were not terminated by any failure of defendant hospital created a confusion and unmistakable implication that defendant's negligence had to be sole cause of death in order to bring liability to defendant.

In Illinois the theoretical underpinnings of the lost chance doctrine flow from the standard articulated in the Restatement (Second) of Torts, section 323 (1965), "One who undertakes * * * to render services to another which he should recognize as necessary for the protection of the other's person * * * is subject to liability to the other for physical harm from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm." Restatement (Second) of Torts, § 323 (1965); *Meck v. Paramedic Servs. of Illinois,* 296 Ill. App. 3d 720, 726, 695 N.E.2d 1321, 1325 (1st Dist. 1998). Surveying the states, it appears that "[i]n other states where that cause of action for loss of chance is recognized under the same Restatement Second of Torts section as in Illinois, those courts use corresponding instructions including the language of the section out of necessity and fairness." See Lisa Petrilli, *Lost Chance in Illinois? That May Still Be the Case.,* 36 J. Marshall L. Rev. 249, 270 (2002). This is accomplished using a pattern or nonpattern jury instruction.

For example, in *DeBurkarte v. Louvar,* 393 N.W.2d 131, 134 (Iowa 1986) the Iowa Supreme Court affirmed a jury verdict against the defendant in a medical malpractice action using the loss of chance theory. The plaintiff alleged that the defendant failed to diagnose the victim's cancer, and that this failure to diagnose decreased her chance of survival. The jury found for the plaintiff and the defendant appealed. The defendant claimed that the plaintiff had failed to prove causation and the trial court erroneously instructed the jury on proximate cause. Applying section 323(a), the Iowa Supreme Court found that the plaintiff's injury was her loss of chance to survive the cancer and that the trial court did not err in instructing the jury on doctrine of lost chance. Years after *DeBurkarte*, the Iowa Special Committee on Uniform Court Instructions of the Iowa State Bar Association developed the following uniform instruction on loss of chance:

> **1600.16 - Lost Chance of Survival - Essentials for Recovery – Death.** [If you find that plaintiff has failed to prove the second proposition of [his] [her]

> claim for negligence as set forth in Instruction No. _____, you must then consider plaintiff's alternative claim for lost chance of survival. If you find that plaintiff has proven [his] [her] claim of negligence as set forth in Instruction No. _____, you should not consider plaintiff's alternative claim for lost chance of survival.]
>
> The plaintiff claims that the defendant caused [decedent] to lose a chance of survival. The plaintiff must prove all of the following propositions:
>
> 1. The defendant was negligent in one or more of the following ways: a. b. c.
>
> 2. The negligence caused a loss of a chance of survival.
>
> 3. The amount of damage.
>
> If the plaintiff has failed to prove any of these propositions, the plaintiff is not entitled to damages. If the plaintiff has proved all of these propositions, the plaintiff is entitled to damages in some amount. [If an affirmative defense is submitted, delete the second sentence and insert the following: If the plaintiff has proved all of these propositions, you will consider the defense of _____ as explained in Instruction No._____.]
>
> Authority: *Mead v. Adrian*, _____ N.W.2d _____ (Iowa 2003); *Wendland v Sparks,* 574 N.W.2d 327 (Iowa 1998); *Sanders v Ghrist,* 421 N.W.2d 520 (Iowa 1988); *DeBurkarte v Louvar*, 393 N.W.2d 131 (Iowa 1986); *Thompson v. Kaczinski*, 774 N.W. 2d 829, 836-39 (Iowa 2009) (causation)[7]

In states in which theoretical underpinnings of the loss of chance doctrine are a "separate injury," the courts have adopted an instruction the factoring of the probability of the loss of chance into the damage assessment. For example, in 1995, our sister state of Indiana recognized that the loss of chance doctrine, "has since become an established part of state tort law. The compensable injury is not the result, which is usually death, but the reduction in the probability that the patient would recover or obtain better results if the defendant had not been negligent." *Mayhue v. Sparkman,* 653 N.E.2d 1384, 1387 (Ind. 1995). Adopting the doctrine, the Indiana Supreme Court endorsed the reasoning of the Oklahoma

[7] Available at https://cdn.ymaws.com/www.iowabar.org/resource/resmgr/Files/06-16_Civil_Jury_Instruction.pdf

court that health care providers should not be given the benefit of uncertainty created by their own conduct:

> After a considered reading of those cases, we believe that the Restatement (Second) of Torts § 323 approach to be the preferable and most rational theory. We think in those situations where a health care provider deprives a patient of a significant chance for recovery by negligently failing to provide medical treatment, the health care professional should not be allowed to come in after the fact and allege that the result was inevitable inasmuch as that person put the patient's chance beyond the possibility of realization. Health care providers should not be given the benefit of the uncertainty created by their own negligent conduct. To hold otherwise would in effect allow care providers to evade liability for their negligent actions or inactions in situations in which patients would not necessarily have survived or recovered, but still had a significant chance of survival or recovery. *Id.* at 1388-1389 *quoting McKellips v. Saint Francis Hosp., Inc.,* 741 P.2d 467, 475 (Okl.1987).

Following its decision in *Mayhue*, the Indiana Judges Association drafted and adopted §1555 Loss of Chance, Ind. Model Civ. Jury Inst. 1555, which distinctly instructs the jury on the theory of loss of chance and instructs them to perform a damage assessment similar to risk of future harm:

> A physician may be liable to a patient for a loss of chance of survival resulting from the physician's failure to exercise reasonable care.
>
> To recover damages from *defendant*, *plaintiff* must prove that:
>
> (1) *defendant*'s care and treatment of *decedent* was not reasonably careful;
>
> (2) if *defendant* had been reasonably careful, *decedent* would have had a chance of survival;
>
> (3) *defendant*'s failure to meet the appropriate standard of care decreased *decedent*'s chance of survival; and
>
> 4) *defendant*'s failure to meet the appropriate standard of care was a substantial factor in causing the harm to *plaintiff*.
>
> To make this determination, consider the evidence presented about:
>
> (5) *decedent*'s percentage chance of survival before *defendant*'s alleged negligent acts or omissions, and

> (6) *decedent*'s percentage chance of survival after *defendant*'s alleged negligent acts or omissions.
>
> The difference between these percentages is the percentage value of *plaintiff*'s loss of chance of survival.
>
> After determining the percentage value of *decedent*'s loss of chance of survival, determine the value of the total damages based on the evidence presented.
>
> Multiply this dollar amount by the percentage value of *decedent*'s lost chance of survival.

Notwithstanding defendants-appellants' academic discussion, the right to have the jury distinctly informed on the loss of chance theory is not tethered to the determination of whether loss of chance is categorized as a "separate injury" or a "theory of causation." This issue before this Court is the right to have a jury instructed on a specific theory of causation. Without a loss of chance instruction, the jury is forced to understand a plaintiff's loss of chance theory argued at trial without an instruction to guide them on the law and how it should be applied to the general proximate causation concept described in IPI Civil No. 15.01. The lack of instruction creates confusion and is unfair to critically ill litigants.

The loss of chance theory is a distinct theory that requires a distinct instruction. Illinois should follow the trend of the majority of states that have adopted the doctrine by either allowing a nonpattern jury instruction or approving a pattern instruction for the doctrine of loss of chance doctrine.

F. Post-Holton Case Law Supports the Necessity of Instructing the Jury on Loss of Chance Doctrine.

Although the Defendant-Appellants cite numerous loss of chance cases wherein the issue is whether the plaintiff met her burden on the issue of causation, only four other post-

Holton cases have considered a tendered jury instruction on the loss of chance doctrine.[8] Since this is the issue before this Court, this Court need only consider that relevant precedent. Notably, none of these decisions has held that instructing the jury on the issue is improper or that it is not necessary. To the contrary, each of these cases has recognized in principle the need for an instruction, but each has rejected the language of the tendered instruction as inaccurate or misleading.

First, in *Henry v. McKechnie,* 298 Ill. App. 3d 268, 276, 698 N.E.2d 696, 701 (4th Dist. 1998) the Fourth District found that the following non-IPI and modified versions of Illinois Pattern Jury Instructions, Civil, No. 20.01 and IPI Civil 3d No. 21.02, were misleading and properly refused:

> Plaintiff's tendered instruction No. 11 (Non-IPI): "A person who undertakes to render services to another is liable for physical harm resulting from his failure to exercise reasonable care if that failure increased their [sic] risk of harm." Noting this is a nonpattern instruction, the trial court refused it but allowed plaintiff's attorney to argue his theory of the case to the jury.
>
> Plaintiff's Instruction No. 12 (Modified IPI No. 20.01): "The Plaintiff further claims that one or more of the foregoing proximately caused any increased risk of harm or lost chance of recovery. The defendant denies that he did any of the things claimed by the Plaintiff, denies that he was professionally negligent in doing any of the things claimed by the Plaintiff and denies that any claimed act or omission on the part of the defendant proximately caused any increased risk of harm or lost chance of recovery."

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[8] There was no non-IPI loss of chance instruction at issue in these cases:
Aguilar v. Mount Sinai Hosp. Med. Ctr., 293 Ill. App. 3d 967 (1st Dist. 1997)
Meck v. Paramedic Services, 296 Ill. App. 3d 720 (1st Dist. 1998)
Suttle v. Lake Forest Hosp., 315 Ill. App. 3d 96 (1st Dist. 2000)
Townsend v. University of Chicago Hosp., 318 Ill. App. 3d 406 (1st Dist. 2000)
Reed v. Jackson, 325 Ill. App. 3d 835 (1st Dist. 2001)
Scardina v. Nam, 333 Ill. App. 3d 260 (1st Dist. 2002)
Krivancec v. Abramowitz, 366 Ill. App. 3d 350 (1st Dist. 2006)
Perkey v. Portes-Jarol, 2013 Il. App (2d) 120470
Hemminger v. LeMay, 2014 Il App (3d) 120392
Vanderhoof v. Berk, 2015 Il App (1st) 132927

> Plaintiff's tendered instruction No. 14 (Modified IPI No. 21.02): "Third, that the professional negligence of the defendant proximately caused an increased risk of harm or lost chance of recovery."

Id. at 272

Rejecting the language of the tendered instruction, the Fourth District noted that its analysis turned solely on the language of the tendered instruction, *not* the propriety of instructing the jury on a loss of chance theory. The court concluded that an instruction on this issue must include a finding of the probability of causation:

> In this case, plaintiff did not offer an instruction that would so limit his recovery if defendant was found to be negligent. . . As an abstract principle, if plaintiff is entitled to an instruction, he must still submit an appropriately worded instruction. In cases discussing jury instructions on the lost chance doctrine, the courts have variously required a finding of probability of causation, a finding of substantial possibility of a better result, language based on section 323 of the Restatement of Torts, or modifying the substantial factor formula for causation.

Id. at 272 citing Annot., J. Hodson, *Medical Malpractice: "Loss of Chance" Causality,* 54 A.L.R.4th 10, 79–84 (1987 & Supp.1997).

A year after *Henry,* in *Lambie v. Schneider,* 305 Ill.App.3d 421 (4th Dist. 1999), the Fourth District again considered and rejected a tendered loss of chance instruction that was based on section 323 of the Restatement of Torts. In *Lambie*, plaintiffs' tendered instruction No. 17 read:

> Plaintiff's Instruction No. 17: A physician who undertakes to render medical services to a patient which he should recognize as necessary for the protection of the patient is subject to liability to the patient for physical harm resulting from this failure to exercise reasonable care to perform his medical services, if his failure to exercise such care increases the risk of harm to the patient.

Id. at 427.

Again, the appellate court affirmed the decision of the trial court rejecting the language of the instruction as misleading, but did *not* address the propriety of instructing the jury on this accepted theory. With respect to the proposed language the court found:

> [E]ven if the "lost chance" doctrine is accepted, the language of section 323(a) of the Restatement is still misleading in that it indicates a defendant may be found liable for any increased risk " resulting from" his conduct, regardless of whether that increased risk is foreseeable. While plaintiff attempts to distinguish the instruction tendered here from the instruction at issue in *Henry,* both instructions contain this language. The instructions tendered here also require the jury to define for itself what "subject to liability" means. This absolute language also suggests the jury could find defendant liable without finding his conduct was the legal cause of plaintiff's injury.
> *Id.* at 428–29.

Two years later in *Sinclair v. Berlin*, 325 Ill.2.3d 458 (1st Dist. 2001), the appellate court again affirmed the decision of a trial court refusing plaintiff's non-IPI instruction which stated: "Proximate causation may be established by proving or showing that Defendant's conduct increased the risk of harm to the Plaintiff, or lessened the effectiveness of the Plaintiff's treatment." *Id.* at 466. The court concluded that although this instruction was an accurate statement of the law pursuant to *Holton*, the trial court was required by Supreme Court Rule 239(a) to use an IPI instruction wherever applicable. *Id.* at 467. The *Sinclair* court concluded that plaintiff's tendered instruction was encompassed within the long-form of IPI 15.01:

> Although Sinclair's proposed lost chance instruction may be an accurate statement of law, the trial court is required by Supreme Court Rule 239(a) (134 Ill.2d R.239(a)) to use the IPI instruction whenever it is applicable. . . Here, the long-form IPI instruction informed the jury that proximate cause was any cause that, whether by itself or with some other cause, produced Sinclair's injury. The lost chance doctrine, as a form of proximate cause, was encompassed within the instruction given to the jury. Further, the trial court permitted Sinclair to urge her lost chance theory to the jury during closing arguments. *Id.* at 467 (internal citations omitted).

Nine (9) years later in *Cetera v. DiFilippo,* 404 Ill.App.3d 20 (1st Dist. 2010), the First District affirmed the rejection of a tendered non-IPI on the issue of loss of chance based on the same reasoning applied in Sinclair. Unfortunately, the language of the tendered IPI was not included as part of the appeal.

Last and most recently in *Gretencord-Szobar v. Kokoszka,* 2021 Ill.App. (3d) 200015, the court affirmed the trial court's finding that plaintiff's evidence at the time of trial did not support giving of plaintiff's tendered non-IPI instruction stating:

> "If you decide or if you find that the plaintiff has proven that one or more of the negligent acts claimed, deprived Stephen Szobar of a chance at a better recovery or deprived him of a chance of a better outcome, you may consider such a delay in treatment a proximate cause of the damages in this case." *Id.* at ¶ 46

Affirming the decision of the trial court to refuse the instruction, the appellate court did not comment on the language of the proposed instruction or the propriety of instructing the jury on the loss of chance. Rather, the appellate court affirmed that the underlying evidence presented at trial did not support *any* instruction or argument on a loss of chance theory stating, "[w]e find *Bailey* distinguishable. The *Bailey* case involved an allegation that defendants' negligent delay reduced the effectiveness of later treatment. Such is not the case here. Plaintiff's theory of this case is that defendants negligently failed to perform surgery; that is, it was defendants' failure to perform surgery that proximately caused plaintiff's damages." *Id.* at ¶ 49

This Court is the sole and ultimate arbiter of the appropriate language to be given to the jury to ensure that justice is done for all sides on this issue. Until the appellate court's decision in *Bailey*, no tendered instruction has accurately conveyed the law of *Holton*, while balancing litigants' concerns of full recovery. The *Bailey* court astutely recognized that the tendered instruction was legally sound and supported by the evidence, and the court's decision that the refusal to give the instruction was error should thus be affirmed.

G. Loss of Chance is a Distinct Theory Similar to Risk of Future Harm Which Requires a Distinct Jury Instruction.

In 2002, five years after the decision in *Holton* recognizing loss of chance as a valid theory of recovery, this Court recognized that risk of future harm was a theory of recovery

upon which the jury required instruction. *Dillon,* 199 Ill. 2d at 504, 771 N.E.2d at 370. Drawing on the analysis of the Connecticut Supreme Court in *Petriello v. Kalman*, 215 Conn. 377, 576 A.2d 474 (1990), the *Dillon* court recognized the problems inherent in an "all-or-nothing" approach to this category of injury.

This "all-or-nothing" approach is inconsistent with the goal of the tort system to compensate victims for all of the injuries suffered, "[i]n essence, if a plaintiff can prove that there exists a 51 percent chance that his injury is permanent or that future injury will result, he may receive full compensation for that injury as if it were a certainty. If, however, the plaintiff establishes only a 49 percent chance of such a consequence, he may recover nothing for the risk to which he is presently exposed." Id. at 499–500 quoting *Petriello,* 215 Conn. at 393–94, 576 A.2d at 482–83. To resolve this inconsistency, the *Dillon* Court adopted risk of future harm as a compensable element of damages to be calculated based on the probability of occurrence:

> Accordingly, we hold simply that a plaintiff must be permitted to recover for all demonstrated injuries. The burden is on the plaintiff to prove that the defendant's negligence increased the plaintiff's risk of future injuries. A plaintiff can obtain compensation for a future injury that is not reasonably certain to occur, but the compensation would reflect the low probability of occurrence. See *Feist v. Sears, Roebuck & Co.*, 267 Or. 402, 410, 517 P.2d 675, 679 (1973) (" 'Admittedly the probability of [plaintiff] getting epileptic seizures is low and it should be weighed by the jury accordingly' "), quoting *Schwegel v. Goldberg*, 209 Pa.Super. 280, 287–88, 228 A.2d 405, 409 (1967). This "fits comfortably within traditional damage calculation methods." Anderson, 669 A.2d at 78, citing Petriello, 215 Conn. at 397–98, 576 A.2d at 484; accord 2 *G. Boston, Stein on Personal Injury Damages* § 9:16, at 9–30 through 9–31 (3d ed.1997) (stating that the solution is not in denying recovery, but in "letting the jury determine on a common sense basis the amount of damages which will reasonably compensate the plaintiff"). "The defendant's proper remedy lies in objecting to the excessiveness of the verdict in an appropriate case." 2 J. Nates, C. Kimball, D. Axelrod & R. Goldstein, *Damages in Tort Actions* § 13.02, at 13–9 (2001).
>
> Having determined that this element of damages is compensable, we now consider whether the jury was properly instructed thereon. *Id.* at 504.

In so holding, the *Dillon* Court cited to its decision in *Holton* finding that, "[t]he theories of lost chance of recovery and increased risk of future injury have similar theoretical underpinnings." 199 Ill. 2d at 503, citing *Anderson*, 669 A.2d at 75–76; 2 D. Dobbs, *Remedies* § 8.1(7), at 408 (2d ed.1993).

Like an award of damages for an increased risk of future injury, a loss of chance theory of recovery or survival is proper only if it can be shown to a reasonable degree of certainty that the loss was proximately caused by the defendant's negligence. Therefore, there is no element of speculation or conjecture in awarding damages based on a loss of chance. The plaintiff's burden on the issue of causation is not lowered or relaxed under a loss of chance theory. Rather, the plaintiff must present competent evidence that more likely than not the negligence was a proximate cause of the loss of chance. It follows that a plaintiff must present competent evidence as to the extent or percentage of the loss, similar to the risk of future harm.

Instructing the jury on loss of chance as a separate theory achieves the goal of compensating tort victims fairly for all consequences of their injuries without "relaxing" their burden of proof. Properly instructing the jury on this element of damages allows the jury to consider evidence presented on the actual loss of chance.

H. Defendants-Appellants' Rhetoric Regarding "Defensive Medicine" and "Speculative Lawsuits" Should be Disregarded.

Professor Stephan Landsman of DePaul University College of Law is a nationally renowned expert on the civil jury system. Professor Landsman and his colleague, Michael J. Saks, performed a study of alleged evidence behind claims that medical malpractice lawsuits "fuel defensive medicine." The study included direct physician surveys, clinical scenario studies, and multivariate analyses of actual case data. In his paper, published in Health Matrix: The Journal of Law and Medicine, Professor Landsman noted that for decades "defensive

medicine" rhetoric "has been the leading argument driving reforms of medical malpractice laws throughout the United States." Michael J. Saks and Stephan Landsman, *The Paradoxes of Defensive Medicine*, 30 Health Matrix 25 (2020)[9] The term "defensive medicine" is used in tort reform propaganda and refers to an alleged practice of administering excessive tests and treatments as a stratagem for reducing healthcare providers. *Id; See also Peter Dizikes, "Moving beyond 'defensive medicine,'" MIT News, March 11, 2020, discussing Jonathan Gruber and Michael Frakes, "Defensive Medicine and Obstetrics Practices: Evidence from the Military Health System," 17 J. Empirical Legal Stud. 4 (March 2020).*[10] [11] After a review of the alleged evidence behind the belief, Professor Landsman and Saks concluded there was little support for and numerous paradoxes to this claim. *Id.* At the end of the day, the term "defensive medicine" is merely "a useful trope for healthcare industry lobbyists can be readily understood. Beyond this, as will be demonstrated, little else about defensive medicine is clear." *Id.*

Medical negligence is a leading cause of serious accidental injury and death in the United States. "The healthcare industry collects 17.9% of our nation's GDP while causing more serious accidental injuries and deaths than *all other human activity combined*." *Id.* at 27-28. "Despite the enormous expenditures Americans make for healthcare, preventable medical error and injury have emerged as extremely serious problems in the United States." *Id.* at 29. As reported by Johns Hopkins to the CDC, annual deaths due to medical error by itself, separate from other causes of accidental death, would rank third after heart disease and cancer. *Id.* at 30.[12] Professor Landsman noted that Donald Berwick, former administrator of the Centers for Medicare and Medicaid Services (CMS) was quoted saying, "[i]n almost no other

[9] Available at: https://scholarlycommons.law.case.edu/healthmatrix/vol30/iss1/4
[10] Available at: https://news.mit.edu/2020/csections-doctor-liability-grubner-0912,
[11] Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/jels.12241
[12] *See* https://assets.documentcloud.org/documents/2822345/Hopkins-CDC-letter.pdf

field would consumers tolerate the frequency of error that is common in medicine." *Id.* at 37. "Mark Chassin, President and CEO of the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)), made a similar point: If the performance of certain high-reliability industries, whose standards of excellence we take for granted, suddenly deteriorated to the level of most health care services, some astounding results would occur. . . . the credit card industry would make daily mistakes on nine million transactions; banks would deposit 36 million checks in the wrong accounts every day; and deaths from airplane crashes would increase one thousand-fold." *Id.* at 33-34. An error rate of this magnitude would be intolerable in most business settings. Yet, the Illinois State Medical Society and the American Medical Association argue that the "fear of being sued" is the problem.

As noted by Professor Landsman:

> The notion of defensive medicine presents a series of paradoxes. The most aggressive advocates on behalf of the healthcare industry insist that healthcare workers routinely behave unethically, by lying to patients and insurers; recklessly, by subjecting patients to needless tests and treatments; wastefully and fraudulently, by redistributing wealth from patients, insurers, and taxpayers to themselves by ordering inappropriate procedures. They insist, however, that potential remedies should not be focused on the actors who engage in such behavior because their actions are motivated by fear—a fear of being compelled by the law to reimburse patients for losses resulting from preventable iatrogenic harms. Instead, healthcare advocates argue that the solution is to remove the source of the fear by further insulating the healthcare industry from legal accountability. Doing so, they promise, will make the evils of defensive medicine and the wasteful spending that results from it disappear. *Id.* at 75

Defendants-Appellants' *amici* have no support for their claim that the loss of chance doctrine has resulted in or will result in the practice of "defensive medicine" or the filing of "frivolous lawsuits." To the contrary, it is well established that, "[c]ontrary to many doctors' beliefs, there is no epidemic of frivolous lawsuits" and "when doctors make an actual mistake, the system is slightly biased in their favor." Darshak Sanghavi, *Medical malpractice: Why is it so*

hard for doctors to apologize?, Boston Globe Magazine, at 2, (January 27, 2013).[13] Given the time, expense and investment required by medical negligence lawsuits, it is " 'rare or unusual' for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring." Mark A. Hofmann, "White House open to medical liability changes," Business Insurance, at 2, (January 30, 2011)[14] Defendants-appellants *amici's* portrayal of a malpractice system that is overrun with "speculative claims" and "frivolous lawsuits" is overblown. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,* 354 N Engl J Med 2024, at 3, (2006).[15]

De-bunking this myth that the court systems are rank with speculative claims, David Studdert, Associate Professor of Law and Public Health at Harvard School of Public Health stated, "Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random 'lottery,' virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit." Harvard School of Public Health press release, *Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued By Frivolous Lawsuits,* at 3, (May 10, 2006).[16]

Any insinuation by the defendants-appellants' *amici* that the loss of chance doctrine will create a malpractice insurance crisis are similarly baseless and overblown. A survey of malpractice verdicts up to 2021 has found that insurers such as The Doctors Company, have

[13] Available at: http://www.bostonglobe.com/magazine/2013/01/27/medical-malpractice-why-hard-for-doctorsapologize/c65KIUZraXekMZ8SHlMsQM/story.html
[14] Available at: http://www.businessinsurance.com/article/20110130/ISSUE01/301309974
[15] Available at: https://www.nejm.org/doi/full/10.1056/NEJMsa054479
[16] Available at: https://www.sciencedaily.com/releases/2006/05/060511084336.html

"seen a drop from a high of 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians today." Richard E. Anderson, *Outlier Malpractice Verdicts Were Rising Pre-Pandemic. What's Next?*, at 3, Medical Liability Monitor (January 2021).[17]

A majority of States adopted the loss of chance doctrine prior to 2009. Since the adoption of the loss of chance doctrine by a majority of states, the filing of malpractice lawsuits has been on a steady downturn: "Fewer cases are being asserted relative to the physician population. The 2016 rate, 3.7 cases per 100 physicians, reflects a steady downward trend." *Medical Malpractice in America: A 10-Year Assessment with Insights*, CRICO Strategies, at 3, (2019).[18] Specifically, "[f]or ob/gyns (whose rate is historically higher than the average for all MDs), the risk of having [a medical malpractice] case filed against them dropped 44% from 2007–2016." *Id.* at 4.

CONCLUSION

This *amicus curiae*, the Illinois Trial Lawyers Association, respectfully requests that this Court affirm the decision of the appellate court on the issue of instructing the jury on loss of chance.

Respectfully submitted,

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[17] Available at: https://www.businessinsurance.com/article/20210712/NEWS06/912342941/View-from-the-top-Richard-E-Anderson,-The-Doctors-Company

[18] Available for free download at: https://www.rmf.harvard.edu/mplAmerica; also included in Appendix at App. 17-44.

CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rules 341(a), (b) and 345. The length of this brief, excluding the 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), contains 9,663 words.

/s/ Sarah F. King
Sarah F. King

APPENDIX

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State Survey on Loss of Chance Pattern/Uniform Jury Instructions

State	Citation to Pattern Jury Instruction	Instructions
Indiana	1555 Loss of Chance, Ind. Model Civ. Jury Inst. 1555	A [*type of health care provider*] may be liable to a patient for a loss of chance of survival resulting from the [*type of health care provider*]'s failure to exercise reasonable care. To recover damages from [*defendant*], [*plaintiff*] must prove by the greater weight of the evidence that: (1) [*defendant*]'s care and treatment of [*plaintiff*] fell below the appropriate standard of care; (2) if [*defendant*] had met the appropriate standard of care, [*plaintiff*] would have had a [chance of survival] [chance of avoiding the (*describe specific harm)*]; (3) [*defendant*]'s failure to meet the appropriate standard of care decreased [*plaintiff*]'s [chance of survival] [chance of avoiding the harm]; and (4) [*defendant*]'s failure to meet the appropriate standard of care was a substantial factor in causing the harm to [*plaintiff*]. In determining the amount of damages to award [*plaintiff*] for a [loss of chance of survival] [loss of chance of avoiding harm], if any, first decide the percentage value of the [lost chance of survival] [lost chance of avoiding harm] to [*plaintiff*]. To make this determination, consider the evidence presented about: (5) [*plaintiff*]'s percentage [chance of survival] [chance of avoiding the harm] before [*defendant*]'s alleged negligent acts or omissions, and (6) [*plaintiff*]'s percentage [chance of survival] [chance of avoiding the harm] after [*defendant*]'s alleged negligent acts or omissions. The difference between these percentages is the percentage value of [*plaintiff*]'s [loss of chance of survival] [loss of chance of avoiding harm]. After determining the percentage value of [*plaintiff*]'s [loss of chance of survival] [loss of chance of avoiding harm],

		determine the value of the total damages based on the evidence presented. Multiply this dollar amount by the percentage value of [*plaintiff*]'s lost chance of survival. I will give you a verdict form that will help guide you through this process. Note: See Indiana Civil Jury Instructions here
Iowa	1600.16 Lost Chance of Survival-Essentials for Recovery- Death	[If you find that plaintiff has failed to prove the second proposition of [his] [her] claim for negligence as set forth in Instruction No. _____, you must then consider plaintiff's alternative claim for lost chance of survival. If you find that plaintiff has proven [his] [her] claim of negligence as set forth in Instruction No. _____, you should not consider plaintiff's alternative claim for lost chance of survival.] The plaintiff claims that the defendant caused [decedent] to lose a chance of survival. The plaintiff must prove all of the following propositions: 1. The defendant was negligent in one or more of the following ways: a. b. c. 2. The negligence caused a loss of a chance of survival. 3. The amount of damage. If the plaintiff has failed to prove any of these propositions, the plaintiff is not entitled to damages. If the plaintiff has proved all of these propositions, the plaintiff is entitled to damages in some amount. [If an affirmative defense is submitted, delete the second sentence, and insert the following: If the plaintiff has proved all of these propositions, you will consider the defense of _____ as explained in Instruction No._____.] See Iowa Pattern Jury Instructions here
Iowa (cont.)	1600.17 - Lost Chance of Survival – Causation – Death	Lost chance of survival means a reduction in the chance to survive the underlying [injury] [condition] [disease] because [decedent] failed to receive earlier diagnosis or treatment. Regarding the second proposition of Instruction No. ____, plaintiff must prove that defendant's negligence, if any, proximately caused a loss of a chance of survival. To prove a loss of a chance of survival, the plaintiff must show, by a preponderance of the evidence, that there is a causal connection between the defendant's negligence, if any, and the loss of a chance to survive the harm.

Iowa (cont.)	1600.18 Lost Chance of Survival – Damages – Death	You must determine the value of the harm suffered by plaintiff and determine the percentage of lost chance to avoid that harm which defendant caused. I will use your answers to the special interrogatories in the verdict form to calculate the appropriate amount of damages recoverable by plaintiff. You should determine the value of the harm suffered by plaintiff in accordance with Instructions No. ____ through ____ (traditional damages instructions). To determine the percentage of lost chance to avoid the harm, caused by the defendant, you must determine the difference between (decedent)'s chance of avoiding the harm in the absence of any negligence on the part of the defendant and (decedent)'s chance of avoiding the harm following any negligence on the part of the defendant which you have found.
Kansas	Pattern Inst. Kan. Civil 123.21	The plaintiff has claimed that *(he)(she)* was denied a substantial chance of survival due to the fault of the defendant. Before you can find the defendant to be at fault, you must find: 1. That would have had a substantial chance of survival if the _____ had been *(diagnosed)(treated)* in a timely manner and under the applicable standard of care. 2. That the defendant failed to *(diagnose)(treat) (in a timely manner) (under the applicable standard of care)*; and 3. That the defendant's failure was a substantial factor in causing the death of _____. As used in this instruction, a "substantial chance of survival" is one which is capable of being estimated, weighed, judged, or recognized by a reasonable mind. As used in this instruction, a "substantial factor" must be distinguished from a factor which had a merely negligible effect in causing _____'s death.

Kansas (cont.)	Pattern Inst. Kan. Civil 123.22	dThe plaintiff has claimed that *(he)(she)* was denied a substantial chance of survival due to the fault of the defendant. Before you can find the defendant to be at fault, you must find: 1. That _____ would have had a substantial chance of survival if the _____ had been *(diagnosed)(treated)* in a timely manner and under the applicable standard of care. 2. That the defendant failed to *(diagnose)(treat) (in a timely manner) (under the applicable standard of care)*; and 3. That the defendant's failure was a substantial factor in causing the death of _____. As used in this instruction, a "substantial chance of survival" is one which is capable of being estimated, weighed, judged, or recognized by a reasonable mind. As used in this instruction, a "substantial factor" must be distinguished from a factor which had a merely negligible effect in causing _____'s death.
Louisiana	18 La. Civ. L. Treatise, Civil Jury Instructions § 13:25 (3d ed.)	To establish causation in a situation in which the patient dies, the plaintiff only must prove that the physician's malpractice resulted in the patient's loss of a chance of survival, rather than having to prove the patient would have survived if properly treated. The plaintiff has the burden of establishing by a preponderance of the evidence that the defendant's conduct denied the patient a chance of survival.
Massachusetts	§ 4.2."Loss of chance", 51 Mass. Prac., Professional Malpractice § 4.2	Until 1983, Massachusetts followed the traditional rule of causation with respect to a plaintiff who had less than a fifty-one percent chance of survival or better outcome at the time of negligent treatment. That rule provided that unless it was more probable than not that the plaintiff would have survived or obtained a more favorable result absent the negligence, there could be no recovery.1 In *Glicklich v. Spievack*, 2 the Appeals Court, upholding a jury verdict for the plaintiff, held that the testimony of an

		expert that the plaintiff would have had a much improved chance of survival or longer life if properly treated was sufficient to meet the plaintiff's burden of proof as to proximate cause.3 Although it did not mention or discuss the doctrine of loss of chance by name, the Court, by upholding the verdict against one of the defendant physicians as to whom there was testimony that his negligence occurred at a time that the plaintiff had a "50 percent or less chance of 10-year survival with proper treatment," in effect applied a version of that doctrine.4 Until at least 1993, the Appeals Court adhered to the *Glicklich* formulation both in testing the sufficiency of an offer of proof 5 and reviewing a judgment entered after a trail on the merits. 6
Minnesota	CIVJIG80.11Loss of a Chance of (Survival) (More Favorable Outcome), 4A Minn. Prac., Jury Instr. Guides--Civil CIVJIG 80.11 (6th ed.)	The term "loss of a chance" applies when an already-(ill) *(injured)* patient suffers *(a reduced chance of survival (a reduced chance of a more favorable outcome)* from *(his/her) (disease)(injury)*. If you decide that *(Plaintiff)(decedent)* had a chance of (surviving) (a more favorable outcome) from *(his/her) (disease)(injury)* and that *(Defendant's)* negligence was a direct cause in decreasing that chance, then you must decide the percentage of that loss of chance. To determine *(Plaintiff's)(decedent's)* loss of chance, consider the evidence as to what *(his/her)* chances of a recovery from *(his/her)* disease would have been if the alleged negligent acts or omissions had not occurred compared to *(his/her)* chances of a recovery after the alleged negligent acts or negligent acts or omissions as shown by the evidence. In determining any loss of chance, you may consider the medical and statistical evidence the parties have submitted.
Missouri	21.08 [1995 Revision] Verdict Directing—Lost Chance of Survival—No Comparative Fault—Multiple Negligent Acts	Your verdict must be for plaintiff *(state name of plaintiff ad litem or personal representative)*, if you believe: First, defendant *(state the name)* either: *(here set out act or omission complained of)*, or *(here set out alternative act or omission complained of)*, and Second, *(state name of decedent)* then had a material chance of [survival] [recovery][1], and Third, defendant, in any one or more of the respects submitted in paragraph First, was thereby negligent[2], and

		Fourth, as a direct result of such negligence[2], *(state name of decedent)* lost [all] [or] [a material part of][3] such chance of [survival] [recovery][1]. * [unless you believe plaintiff is not entitled to recover by reason of Instruction Number *(here insert number of affirmative defense instruction)*].
Missouri (cont.)	21.09 [1996 Revision] Damages—Lost Chance of Survival—No Comparative Fault	If you find in favor of plaintiff *(state name of plaintiff ad litem or personal representative)*, then you must determine the total amount that you believe will fairly and justly value any damages *(state name of decedent)* sustained before death as a direct result of the absence of recovery[1], and any damages *(state name of decedent)* survivors sustained after the death [and are reasonably certain to sustain in the future][2] as a direct result of the death of *(state name of decedent)*. You must state such total amount in your verdict, and you must itemize that total amount by the categories of damages set forth in the verdict form. In your verdict, you must also state, as a percentage, the chance of [recovery] [survival][3] that you find *(state name of decedent)* lost. In determining the total amount of damages, you must not reduce such damages by the percentage you assess as the lost chance of [recovery] [survival].[3] The judge will compute the final award by multiplying the total amount you find as damages by the percentage you assess as the lost chance of [recovery] [survival][3]. You must not consider grief or bereavement suffered by reason of the death.
Missouri (cont.)	21.10 [1993 New] Verdict Directing—Lost Chance of Survival—Comparative Fault—Multiple Negligent Acts	In your verdict you must assess a percentage of fault to defendant *(state the name)* [whether or not *(state name of decedent)* was partly at fault][1] if you believe: First, defendant *(state the name)* either: *(here set out act or omission complained of)*, or *(here set out alternative act or omission complained of)*, and Second, *(state name of decedent)* then had a material chance of [survival] [recovery][2], and Third, defendant, in any one or more of the respects submitted in paragraph First, was thereby negligent[3], and Fourth, such negligence[3] directly caused or directly contributed to cause *(state name of decedent)* to lose [all] [or] [a material part of][4] such chance of [survival] [recovery][2]. * [unless you believe you must not assess a percentage of fault to defendant by reason of Instruction Number *(here insert number of complete affirmative defense instruction)*].

Missouri (cont.)	21.11 [1996 Revision] Damages—Lost Chance of Survival—Comparative Fault	If you assess a percentage of fault to [any][1] defendant, then, disregarding any fault on the part of *(state name of decedent)*, you must determine the total amount that you believe will fairly and justly value any damages *(state name of decedent)* sustained before death as a direct result of the absence of recovery[2], and any damages *(state the name of decedent)* survivors sustained after the death [and are reasonably certain to sustain in the future][3] as a direct result of the death of *(state name of decedent)*. You must state such total amount in your verdict, and you must itemize that total amount by the categories of damages set forth in the verdict form. In your verdict, you must also state, as a percentage, the chance of [recovery] [survival][4] that you find *(state the name of decedent)* lost. In determining the total amount of damages, you must not reduce such damages by the percentage you assess as the lost chance of [recovery] [survival].[4] In determining the total amount of damages, you must not reduce such amount by any percentage of fault you may assess to *(state name of decedent)*. The judge will compute the final award by: First, multiplying the amount you find as total damages by the percentage you assess as the lost chance of [recovery] [survival][4]; and Second, making a reduction by any percentage of fault you assess to *(decedent's name)*. You must not consider grief or bereavement suffered by reason of the death.
New Jersey	NJ J.I. CIV 5.50E PRE-EXISTING CONDITION -- INCREASED RISK/LOSS OF CHANCE -- PROXIMATE CAUSE	**CHARGE 5.50E - INTERROGATORIES** **(Approved 04-2014)** **JURY INTERROGATORIES** 1) Has the Plaintiff proven by the preponderance of the evidence that Dr. _____ deviated from accepted standard of medical practice? Yes _____ If your answer is “Yes” proceed to question 2. No _____ If your answer is “No” return your verdict for th defendant.

		2) Has the Plaintiff proven that Dr. _____'s deviation from accepted standard of medical practice increased the risk of harm posed by the plaintiff's pre-existing condition? Yes _____ If your answer is “Yes” proceed to question 3. No _____ If your answer is “No” return your verdict for th defendant. 3) Was the increased risk a substantial factor in causing the Plaintiff's ultimate injury?6 Yes _____ If your answer is “Yes” proceed to question 4. No _____ If your answer is “No” return your verdict for th defendant. 4) Has the Defendant met his burden of proving that some portion of the ultimate injury was a result of the pre-existing condition? Yes _____ If your answer is “Yes” proceed to question 5. No _____ If your answer is “No” proceed to question 6. 5) State in percentages, what portion of the ultimate injury is a result from: Table: A. The pre-existing condition. _____ B. Dr. _____'s deviation from the accepted standard of medical practice _____ Total 100 **The total must equal 100%.** 6) What amount of money would fairly and reasonably compensate the plaintiff for plaintiff's injuries?7 Total Damages: $_____

		7) What amount of money would fairly and reasonably compensate the plaintiff's spouse [per quod claimant] for plaintiff's loss of services? $_____
Ohio	CV 417.17 Loss of less-than-even chance of survival/recovery [Rev. 2/27/21], 1 CV Ohio Jury Instructions 417.17	1. GENERAL. The plaintiff claims that (he/she lost a less-than even chance of recovery) (_____[*insert name of decedent*] lost a less-than-even chance of surviving) from his/her pre-existing (condition) (disease) as a result of the defendant‘s medical negligence. The law recognizes that even though (the plaintiff's loss of chance of recovery) (_____[*insert name of decedent's*] loss of chance of survival) from his/her preexisting (condition) (disease) was less than fifty percent, the plaintiff is entitled to compensation for the loss of any portion of that chance of (recovery) (survival) from the preexisting (condition) (disease) proximately caused by the defendant's medical negligence.
Oklahoma	Instruction No. 4.11 Measure of Damages—Medical Malpractice—Loss of Chance	A patient who faced a risk of death *[or disability]* at the time of treatment is entitled to recover damages for an increase in the risk of death *[or disability]* caused by the treatment *[or failure to treat]*. In order to recover damages for an increased risk of death *[or disability]*, the patient must have had a significant chance of survival *[or recovery]* before the treatment *[or failure to treat]*, even if the original chance of survival *[or recovery]* was less than 50 percent. If you decide that the treatment *[or failure to treat]* caused an increased risk of death *[or disability]* for *[Plaintiff]*, you must determine the following in order to fix the amount of damages: 1. *[Plaintiff]*'s percentage of original chance of survival *[or recovery]* before the treatment; and 2. The percentage reduced chance of survival *[or recovery]* after the treatment *[or failure to treat]*; and 3. The total amount of damages that would be allowed under the *[following]* instruction on account of *[Plaintiff]*'s death *[or disability]*. I will make the final calculation of the damages to award to *[Plaintiff]* by taking the difference between these two percentages and multiplying that by the total amount of damages.

West Virginia	§ 504. LOSS OF A CHANCE, W.V. Pattern Jury Instr. Civil. § 504	Sometimes the cause of a patient's [*injury/death*] can be defined by the loss of a chance of [*recovery/survival*]. Where a [*insert type of health care provider*]' s breach of the standard of care increased the risk of harm to the patient and the increased risk was a substantial factor in bringing about the [*injury/death*], you may find causation. Therefore, if you find that [*name of plaintiff*] established, by the greater weight of the evidence, that [*name of defendant*]'s breach of the standard of care resulted in the loss of more than a twenty-five percent chance that [*name of plaintiff*] [*would have had an improved recovery/would have survived*], then you may find there was causation. If you believe that the failure to follow the standard of care resulted in a twenty-five percent or less chance of [*name of plaintiff*]'s [*improved recovery/survival*], then you should not find causation.
Washington	WPI 105.09 Loss of Chance	If you find that the defendant was negligent, you may consider whether such negligence was a proximate cause of damages to *[plaintiff in the form of a loss or reduction of a 50% or less chance of a better outcome] [decedent in the form of a loss or reduction in a 50% or less chance of survival]*. If you find that such negligence was a proximate cause of a loss or reduction of a 50% or less chance of [a better outcome] *[survival]*, then you should determine the amount of the loss or reduction by comparing two percentages: (1) *[plaintiff's chance of a better outcome] [decedent's chance of surviving the condition which caused death]* if the defendant had not been negligent; and (2) *[plaintiff's chance of a better outcome] [decedent's chance of surviving]* as reduced by the negligence of the defendant. The difference in the two percentages, if you find any, is the percentage of the loss or reduction in the chance of [a better outcome] *[survival]*. The total amount of damages you find to have been proximately caused by [the injury to plaintiff] [the death of the decedent] will be reduced by multiplying those damages by the percentage of the loss or reduction of the chance of [a better outcome] *[survival]*. Note: See Washington Civil Jury Instructions here

Wyoming	WCPJI (Civil) 14.14 LOSS OF CHANCE Loss of Chance (Wyoming Civil Pattern Jury Instructions (2020 Edition))	If you find from the evidence that the Defendant was negligent in the treatment of the Plaintiff and that this negligence was a substantial factor in reducing the Plaintiff's chances of obtaining a better result, then you should award such damages as will fairly compensate Plaintiff for this loss of chance of a better result. You should consider evidence of percentages of the lost chance in the assessment and apportionment of damages. The damages recoverable by the plaintiff equals the total sum of the damages for the underlying injury or death multiplied by the percentage of the lost chance you find. Note: See Wyoming Civil Jury Instructions here

USE OF NON-PATTERN JURY INSTRUCTIONS IN CIVIL CASES

By
Judge Lynn M. Egan
(May 2013)

Written instructions are given to the jury in order to provide guidance on the relevant issues, the applicable law and the requisite facts necessary to support a verdict.[1] Each party has the right to have the jury "clearly and fairly" instructed on each theory supported by the evidence.[2] In assessing whether a particular instruction is appropriate, the trial court must initially determine if it accurately states the law. If so, the court must also determine whether it "fairly" states the law. Such an assessment considers both the substance and form of an instruction. This is true for both pattern and non-pattern instructions.

Of course, this assessment is more challenging with non-pattern instructions. Thus, when presented with non-pattern instructions, it is helpful to understand the development of pattern instructions in Illinois, the criteria used in assessing the appropriateness of jury instructions and the special concerns raised when using non-pattern instructions.

The History of Illinois Pattern Instructions

The Illinois Supreme Court Committee on Jury Instructions was initially appointed in 1957 in response to a unanimous resolution of the Illinois Judicial Conference. This resolution was prompted by the results of a study on jury instruction problems, which ultimately led to the conclusion that there was a "shocking breakdown" in the jury instruction process that could only be remedied by a fundamental change in the way instructions were prepared and given.[3] Thus, the Committee began its work by analyzing jury instruction practice throughout the United States. Following this analysis, the Committee concluded that certain basic concepts should form the basis of model instructions. It declared that instructions should be "conversational," "understandable," "unslanted," and "accurate."[4]

The Committee then began the task of incorporating these basic concepts into pattern instructions. An important part of this process included the elimination of instructions the Committee decided should never be given. This was more significant than it sounds today since many instructions were used as the result of long standing practice.[5] Additionally, some of these instructions had received court approval. Nevertheless, the Committee declared its position that simply because it was "not error

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[1] *Mikolajczyk v. Ford Motor Co., 231 Ill.2d 516, 549 (2008).*
[2] *Stapleton v. Moore, 403 Ill.App.3d 147, 163 (1st Dist., 2010).*
[3] Illinois Pattern Jury Instructions, Civil, 2000 Edition (Foreword to the First Edition (1961)
[4] *Id.*
[5] *Id.*

to give a particular instruction does not necessarily mean that is one which should be retained."[6]

In deciding which instructions should not be given, the Committee developed the following criteria:

- It opposed instructions which tell the jury not to do something;
- It opposed instructions which single out a particular piece of evidence;
- It discouraged instructions that are only appropriate in exceptional cases; and
- It avoided creation of a large number of overly specific instructions. [7]

Significantly, the Committee noted that its ultimate goal was to "improve communication between court and jury."[8] It recognized that the use of understandable language is essential to this goal and that such language had to be used consistently when instructing the jury. The current Committee established a similar goal, noting that it "desires to produce an up-to-date, carefully drafted, brief, impartial and user-friendly set of instructions that even sleep-deprived, bleary-eyed attorneys will find indispensable while preparing for a jury instruction conference."[9] Of course, this means all parties have to tender IPI instructions. In order to compel uniform use of IPI, Supreme Court Rule 25-1(a) was adopted. It provided as follows:

> "Whenever Illinois Pattern Jury Instructions (IPI) contains an instruction applicable in a civil case, giving due consideration to the facts and the prevailing law, and the Court determines that the jury should be instructed on the subject, the IPI instructions shall be used unless the Court determines that it does not accurately state the law."

As a result of this rule, as well as the creation of pattern instructions, Illinois Appellate and Supreme Court decisions are replete with language about the presumption in favor of using IPI instructions. In fact, Illinois courts have consistently declared that IPIs must be used exclusively if they are correct and accurate statements of law.[10] Moreover, any instructions that depart from the IPI will be carefully scrutinized.[11] The rationale for such scrutiny was articulated by the Supreme Court when it noted that IPI instructions were "painstakingly drafted with the use of simple, brief and unslanted language so as to clearly and concisely state the law."[12] However, even though Supreme Court Rule 239(a) currently incorporates the mandatory language of Rule 25-1(a) regarding use of pattern instructions, the Illinois Supreme

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[6] Id.
[7] Id.
[8] Id.
[9] Id. at pp. v-vi.
[10] Perkey v. Portes-Jarol, 2013 IL App (2d) 120470, ¶ 69; Auten v. Franklin, 404 Ill.App.3d 1130, 1137 (4th Dist., 2010); Napcor Corp. v. JPMorgan Chase Bank, NA, 406 Ill.App.3d 146, 157 (2nd Dist., 2010); LaSalle Bank, N.A. v. C/HCA Development Corp., 384 Ill.App.3d 806, 816 (1st Dist., 2008); Studt v. Sherman Health System, 951 N.E.2d 1131, 1135 (2011); York v. Rush-Presbyterian-St. Luke's Medical Center, 222 Ill.2d 147, 204 (2006).
[11] Henry v. McKechnie, 298 Ill. App. 3d 268 (4th Dist., 1998).
[12] People v. Pollock, 202 Ill.2d 189, 212 (2002).

Court cautioned that "there has not been any advance approval of the IPI by this court. An instruction is approved or rejected only after it has been judicially questioned and considered."[13]

Nevertheless, the original Supreme Court rule governing jury instructions expressly directed that IPI should be used if it accurately states the law and included a requirement that "...all other instructions follow the IPI pattern and be simple, brief, impartial and free from argument."[14] Thus, even as the first pattern instructions were published, the standard for use of non-pattern instructions was also articulated.

Such a standard is an appropriate part of the Supreme Court rule, not only as an aid in drafting instructions, but also as a reminder that the IPI Committee never envisioned the pattern instructions as the exclusive source of appropriate jury instructions. However, the policy considerations and drafting criteria relied upon by the Committee in preparing the pattern instructions are equally instructive when evaluating non-pattern instructions. In fact, the language of Supreme Court Rule 239(a) makes clear that the IPI concepts of accurate, conversational, understandable and unslanted language must also be the basis of non-pattern instructions. While this mandate can be simply stated, review of the case law reveals its application can be quite challenging. As a result, it is essential that judges and lawyers appreciate the level of scrutiny and standard of review applicable to non-pattern instructions.

Use of Non-IPI Instructions

Significantly, it must be remembered that Illinois pattern instructions were never meant to state the law of Illinois in all possible situations. Nonetheless, a non-IPI instruction may only be used if the court determines that a pattern instruction does not exist or does not accurately state the law.[15] Therefore, any trial court faced with a unique factual situation or point of law should not give any instructions, regardless of source, without carefully evaluating their individual accuracy and cumulative effect upon the jury.[16]

Of course, the decision about whether to give a non-IPI instruction rests within the sound discretion of the trial court. Thus, a trial court decision to refuse a non-IPI instruction will be considered an abuse of discretion only where there is no IPI instruction that applies to the particular subject. Conversely, there is no abuse of discretion in refusing a non-IPI instruction if there is an applicable IPI instruction or the essence of the refused instruction is covered by other tendered instructions.[17]

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[13] *Powers v. Illinois Central Railroad Co., 91 Ill.2d 375, 385 (1982); Matarese v. Buka, 386 Ill.App.3d 176, 179 (1st Dist., 2008).*

[14] *See supra, note 3. (Emphasis added)*

[15] *Colella v. JMS Trucking Company of Illinois, 403 Ill.App.3d 82, 96 (1st Dist., 2010).*

[16] *People v. Murray, 364 Ill.App.3d 999, 1006 (4th Dist., 2006).*

[17] *People v. Rebecca, 2012 IL App (2d) 91259, ¶ 69.*

The trial court must determine, after considering the facts and applicable law, whether the jury should be instructed on a particular subject.[18] If the trial court decides to use non-IPI instructions, it must next determine whether such an instruction is an accurate statement of the law. Once again, such a determination is within the trial court's discretion.[19]

Trial Court Evaluation of Non-IPI Instructions

When non-IPI instructions are used, they should be accurate, simple and brief statements of the law.[20] They must also be impartial and free of argumentative language.[21] As with pattern instructions, non-IPIs should not be misleading or confusing.[22] Commonly used words do not need to be defined.[23]

Although there are numerous cases that hold for these general propositions, there is little case law guidance about the format of instructions drafted by the parties in the absence of an IPI. This is problematic because there are no pattern instructions applicable to certain complex types of cases, including defamation, civil rights violations, invasion of privacy claims, breach of warranty and numerous other commercial transactions. Moreover, the pattern contract instructions are frequently abandoned in favor of non-IPI versions. As a result, practitioners feel compelled to draft instructions that quote or paraphrase appellate and Supreme Court decisions. Even though this practice is quite common, it is not recommended as it often leads to serious error.[24]

It is easy to understand why this occurs. An appellate court's holding is simply its application of established law to the particular facts of the case before it. The language was never intended for lay people; instead, the decisions are written for lawyers. Additionally, reviewing courts commonly modify their articulation of the law. Consequently, while the general rules may be settled, the words or expressions used by reviewing courts change frequently. As a result, rather than being a reliable source, appellate decisions can be a source of conflicting language. Moreover, lawyers do not choose neutral language from the decisions. Instead they choose language that favors their theory of the case.

Additional concerns with non-IPI instructions are raised when the parties view them as an opportunity to persuade the jury, rather than an opportunity to improve communication with the jury as originally intended by the Supreme Court Committee. A common result is that the trial court is left in the position of ruling on instructions that differ significantly in style, rather than substance, but which all find general case law

[18] *Studt v. Sherman Health Systems, 2011 IL 108182, ¶ 14.*
[19] *Id. at ¶ 13.*
[20] *Surestaff, Inc. v. Open Kitchens, Inc., 384 Ill.App.3d 172, 175 (1st Dist., 2008).*
[21] *People v. Bannister, 232 Ill.2d 52, 81 (2008).*
[22] *Id.*
[23] *Simmons v. Garces, 319 Ill. App. 3d 308 (1st Dist., 2001), affirmed 198 Ill.2d 541 (2002).*
[24] *Wilkerson v. Pittsburgh Corning Corp., 276 Ill.App.3d 1023, 1033 (4th Dist., 1995); Spain v. Owens Corning Fiberglass Corp., 304 Ill.App.3d 356, 366 (4th Dist., 1999)(overruled on other grounds by Nolan v. Weil-McLain, 233 Ill.2d 416 (2009)).*

support. This is not always an insignificant problem because even slight differences in word choice can convey a different meaning to the jury.

Thus, even though stylistic differences may not initially appear significant, judges and lawyers must be vigilant to assess such differences in the context of the instructions as a whole, rather than individually, since conflicting instructions, even when one is a correct statement of law, are not harmless error.[25] In fact, such conflict can prevent the jury from performing its constitutionally appointed function.[26] Thus, the test is whether the tendered instructions, considered as a whole and read as a series, fairly and accurately state the principles of law that pertain to the case and are sufficiently clear so as not to mislead the jury.[27]

Although complex factual scenarios can greatly complicate this determination, reliance on the guidelines articulated by the original Supreme Court Committee on Jury Instructions is helpful. Keep all jury instructions accurate, understandable, unslanted and conversational. Additionally, be careful to ensure the instructions do not overemphasize any particular point and are not repetitious.[28]

Objections and Non-IPI Instructions

The adequacy of objections to non-pattern instructions is no different from those raised about IPIs. They must be stated with particularity.[29] In fact, if a party believes certain instructions are incorrect, incomplete or otherwise inadequate, a specific objection must be raised and a remedial version of the instruction must be offered.[30] In fact, Supreme Court Rule 239(b) expressly provides that "objections shall be particularly specified" at the instruction conference.[31] Thus, in order to preserve an issue on appeal concerning jury instructions, the appellant must establish that it raised that argument at the instruction conference.[32] Although the plain error rule may be applied in civil cases, at least one appellate opinion has declared this will be "exceedingly rare and limited to circumstances amounting to an affront to the judicial process."[33] Needless to say, therefore, a judgment will not be reversed due to an erroneous instruction unless the complaining party can demonstrate prejudice as a result of the instruction.[34]

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[25] *People v. Murray, 364 Ill.App.3d 999, 1007 (4th Dist., 2006).*
[26] *Id.*
[27] *Oldenstedt v. Marshall Erdman & Associates, Inc., 381 Ill.App.3d 1, 13 (1st Dist., 2008).*
[28] *Paz v. Commonwealth Edison, 314 Ill.App.3d 591, 601 (2nd Dist., 2000).*
[29] Illinois Supreme Court Rule 239(b)
[30] *Hudson v. City of Chicago, 378 Ill.App.3d 373, 406 (1st Dist., 2007).*
[31] *See supra, note 28.*
[32] *Colella v. JMS Trucking Company of Illinois, 403 Ill.App.3d 82, 95 (1st Dist., 2010).*
[33] Palanti v. Dillon Enterprises, 303 Ill. App. 3d 58 (1st Dist., 1999); *accord, Wilbourn v. Cavalenes, 398 Ill.App.3d 837, 856 (1st Dist., 2010).*
[34] *Robinson v. Boffa, 402 Ill.App.3d 401, 406 (1st Dist., 2010).*

CRICO 2018 CBS BENCHMARKING REPORT

Medical Malpractice in America

A 10-YEAR ASSESSMENT WITH INSIGHTS

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A division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated

"Knowing is not enough; we must apply. Willing is not enough; we must do."

—JOHANN WOLFGANG VON GOETHE

Shared Data and a Common Mission

The knowledge of what happened to one patient (no matter how tragic), or one physician (no matter how distraught), is rarely enough to understand the systemic risks underlying adverse events. Health care and insurance leaders must determine what goes wrong repeatedly, gauge concerning trends, spot emerging risks, and compare that information over time and across peer groups.

Twenty years ago, CRICO Strategies' national Comparative Benchmarking System (CBS) was developed to gain those insights. Health care providers and medical professional liability (MPL) insurers began to engage in collaborative efforts to apply that knowledge toward risk reduction. Capitalizing on the intrinsic value of malpractice cases—including open cases, cases with zero indemnity, and case management information—required larger data sets than were available to any individual organization. Sharing data was essential to making sound decisions and initiating effective actions.

Twenty years later, CBS represents 30% of U.S. MPL cases, the industry's most robust coding taxonomy, and risk-related data unavailable elsewhere. CBS offers insurers and insureds unique data tools and unmatched analytic power.

And, as CBS has become an essential learning platform, its value has grown beyond the big numbers. The organizations that have shared their data also come together to share solutions, and form a community of members with a common mission to improve patient safety and reduce MPL losses.

OVER VIEW

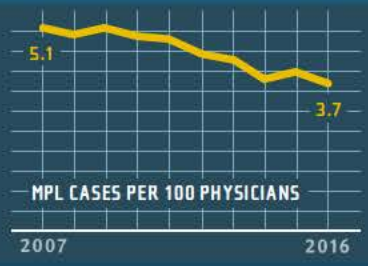
CRICO Strategies' Comparative Benchmarking System (CBS) contains 30% of the medical professional liability (MPL) cases filed from across the U.S., and reflects the experience of more than 500 health care entities and 180,000 physicians from commercial and captive insurers.

This Report analyzes 124,000 MPL cases with claim-made dates or indemnity close dates between 2007–2016.

Medical Malpractice in America

A 10-Year Assessment with Insights: Top Takeaways

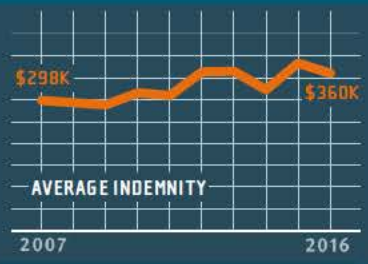
1



Case frequency went down.

see CASE FREQUENCY page 4

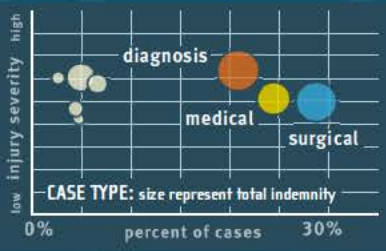
2



Expenses and indemnity payments (especially $1M+ payments) rose, but not beyond expectations.

see CASE MANAGEMENT page 6
INDEMNITY page 8

3

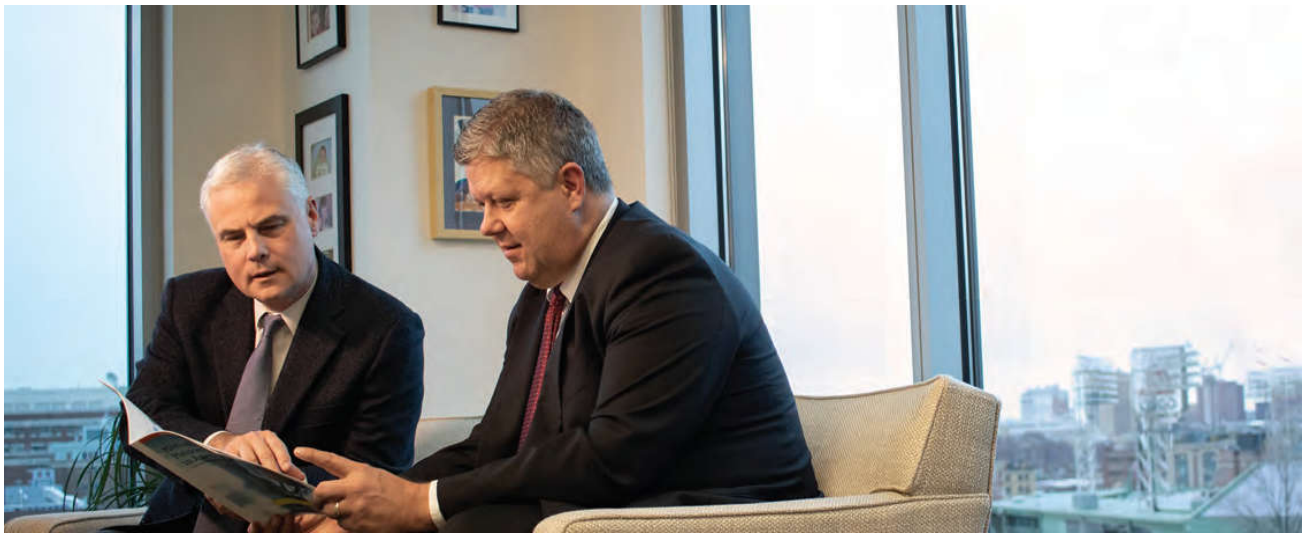


The more deeply coded clinical components of MPL cases provide actionable insights.

see CLINICAL SEVERITY page 10
CASE TYPE page 12
RESPONSIBLE SERVICE page 14
NURSING page 17
CONTRIBUTING FACTORS page 18
THE DIAGNOSTIC PROCESS page 20

There's safety in numbers.

see MPL DATA ACCELERATE PRACTICAL SOLUTIONS page 23



MARK E. REYNOLDS, PRESIDENT & CEO, CRICO
MICHAEL PASKAVITZ, ASSISTANT VICE PRESIDENT, CRICO STRATEGIES

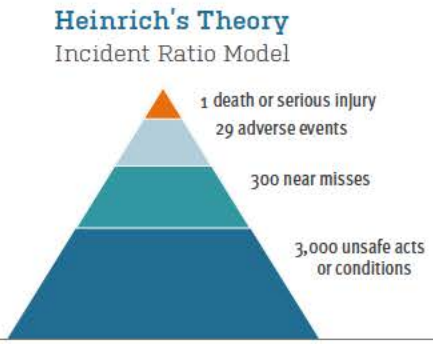
Analyzing Medical Malpractice in America

Medical malpractice devastates individuals and exposes weaknesses… and it is uncomfortable to talk about. But discussing and analyzing malpractice cases is essential to bringing about the changes necessary to prevent similar injuries. Indeed, the human tragedy of malpractice cases drives our mission to turn that data into credible evidence: what failed, why, and changes in vulnerabilities over time. This Report, covering 2007–2016, analyzes events that affected 124,000 patients, their families, and the health care providers involved; we hope our findings prompt frank discussions that change lives.

Among the findings, analysis of the 10 years from 2007 to 2016 reveals:

- a 27% drop in the frequency of malpractice claims and suits being asserted, with downward trends in the rate of cases per 100 physicians across virtually all specialties
- for obstetricians/gynecologists, the risk of having a claim or suit filed against them has dropped 44%
- case management expenses increased an average 3.5% annually (4.7% annually for zero-indemnity cases)
- the volume of indemnity payments of $3M–11M increased 7% annually

These macro-trends, and the micro-learnings within them, are increasingly employed by actuaries writing reinsurance, health



care executives assessing business plans, and claims managers establishing defense strategies.

Perhaps the most poignant value of MPL data can be found in the patient safety movement. The 2016 National Academies of Sciences report, *Improving Diagnosis in Health Care*, recommended that health care providers work directly with their malpractice insurers to learn about diagnostic failure. That put the value of malpractice data on a national stage, a platform upon which a forward-thinking MPL community armed with credible data is eminently qualified to stand.

Heinrich's Theory—a near 100-year-old framework for safety programs worldwide—illustrates the extraordinary power of deeply-coded MPL cases. CRICO's 20-year-old Comparative Benchmarking System (CBS), upon which this Report is based, contains 30% of all U.S. MPL claims and suits: the top of Heinrich's pyramid. Further down the pyramid, incident and near-miss data are more frequent, but the sources are uncoordinated, data quality is inconsistent, learning is less shared at scale, and analyses are rarely actionable. Clearly, MPL data are a foundation for understanding vulnerabilities and an essential tool for reducing those risks.

As an organization, CRICO Strategies believes there's safety in numbers. The big numbers behind this Report reflect the commitment of our partners in the CBS database. We are indebted to the commercial and captive insurers who have helped turn the notion of an MPL community into a dynamic reality. When like-minded leaders use data together to solve problems, health care providers are better protected and their patients are safer.

As an MPL insurer, we recognize that there are inherent risks in the complex world of health care. Our mission is to advance, protect, and reward the practice of good medicine. Over the years, we have gained extraordinary insights for supporting that mission from studying patient harm—primarily through CBS data. We share that information with anyone who desires to learn, and use data to advocate for the health care providers and organizations we insure. We partner with physician experts to make our findings and publications relevant to practicing clinicians. Increasingly, this data is becoming more relevant to other disciplines within our company. Actuaries, underwriters, claims professionals, and marketing and communications professionals are accessing and using data in their decision-making.

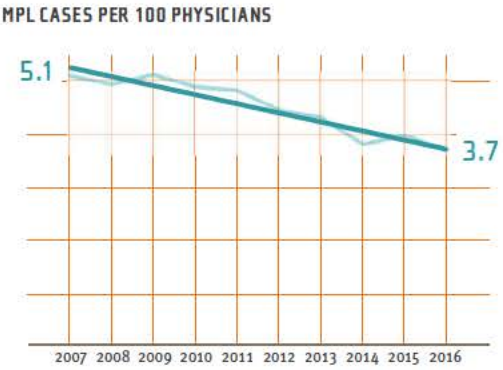
The road ahead has many uncertainties. We are learning that collaboration with reliable partners and the use of data enhance our ability to be prepared.

DARRELL RANUM
VICE PRESIDENT PATIENT SAFETY, THE DOCTORS COMPANY

Case Frequency

Overall MPL case frequency dropped 27% from 2007–2016, with an especially compelling trend for obstetrician-gynecologists.

Fewer cases are being asserted relative to the physician population.
The 2016 rate, 3.7 cases per 100 physicians, reflects a steady downward trend.



27%
DECREASE IN THE CASE RATE OVER TEN YEARS

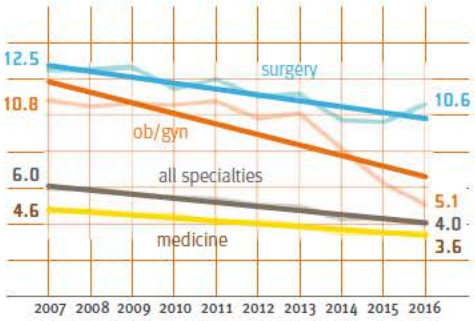
From 2007 to 2016, the rate of MPL cases asserted per 100 physicians dropped 27%—from 5.1 to 3.7. For the roughly one million physicians across the country, this trend signals a dramatic change in their risk of being named in an MPL case. While no single factor can be aligned with an across-the-board reduction, changes in the tort environment, improved patient safety, and increasing financial risks for plaintiffs' attorneys likely contributed.

MPL experience fluctuates across legal jurisdictions and health care delivery structures, but the breadth and depth of the CBS database helps smooth variation. The downward trend in case frequency seen from 2007–2016 was universal across the many segments of health care delivery. Of course, a physician's risk of being named in an MPL case varies considerably by clinical area of practice, but for obstetrics/gynecology and the primary subspecialties within medicine and surgery, MPL case frequency declined steadily.

For ob/gyns (whose rate is historically higher than the average for all MDs), the risk of having an MPL case filed against them dropped 44% from 2007–2016. Such sustained results demonstrate that initiatives such as training to improve team communication during labor and delivery, and

Defendant rates declined most steeply in obstetrics/gynecology.
These declines correlate with long-term safety interventions in these areas.

DEFENDANTS PER 100 PHYSICIANS



CHANGE IN THE DEFENDANT RATE

SPECIALTY	10-YEAR CHANGE*
OB/GYN	-44%
MEDICINE	-29%
SURGERY	-23%

* based on the linear trend

multidisciplinary education on fetal heart rate tracings, are being rewarded.

Medical subspecialties, whose case rate historically falls well below the rates for surgeons and ob/gyns, experienced a modest decline from 2007–2016. A heightened awareness of diagnosis-related trouble spots (see page 20)—and efforts to "close the loop" for test results and referrals—may be gaining traction.

The combined case rate for the surgical subspecialties, historically highest among all physicians, also declined at a modest rate (3% per year). Initiatives to reduce the risk of harm to surgery patients have aimed at pre-, intra- and post-operative vulnerabilities. Those interventions (e.g., more holistic pre-op assessment, patient-centered consent, simulation-based drills, timeouts and debriefs, and teamwork training) appear to be impacting MPL case frequency.

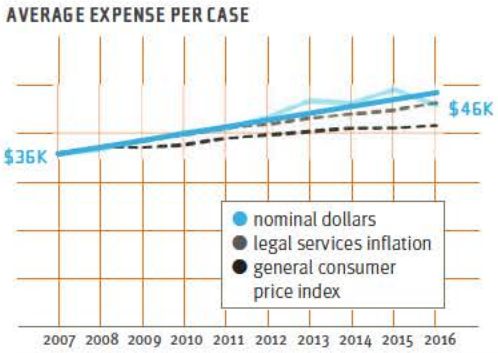
OTHER PERSPECTIVES

- Claims frequency overall and for physicians remains at a historic low
  [Willis Towers Watson, Health Trek, May 2017]
- Frequency of health care professional liability claims is showing a stable trend over recent years
  [Aon/ASHRM, Hospital and Physician Professional Liability, October 2017]
- From 1992–1996 to 2009–2014, the rate of paid claims decreased by 55.7%
  [JAMA Internal Medicine, 2017;177(5):710–718]

Case Management

From 2007–2016, MPL closed-with-pay rates held steady, but expenses (especially for zero indemnity cases) rose faster than inflation.

Case management expenses outpaced both consumer and legal inflation indices.



$42K
TEN-YEAR AVERAGE EXPENSES PER CASE

+$1.5K
AVERAGE CHANGE PER YEAR

+3.5%
AVERAGE PERCENT CHANGE PER YEAR

0.7%
ABOVE LEGAL INFLATION

1.8%
ABOVE CPI INFLATION

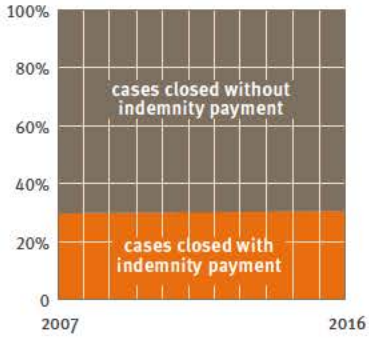
A frequency decrease (page 4), and an unchanged rate of closings with payment, meant a drop in both zero-indemnity and paid MPL case volume from 2007–2016. The cost to manage those cases—with or without indemnity payments—increased steadily and outpaced inflation. Concurrently, the average number of defendants per case rose significantly. Cases with multiple defendants reflect both the complexity of team-based care (patients encounter more clinicians) and policy limit "stacking" (plaintiffs adding policy holders to an MPL case to increase potential indemnity). Typically, cases with more defendants require individual legal representation, adding complexity and cost to case management. Beyond legal fees, the use of MPL defense tools (mock trials, computerized renderings, jury studies, witness preparation) is increasing, as are their costs.

An upward trend in expenses is seen for all MPL cases. The fastest growth was for cases closed without an indemnity payment, which incur expenses comparable to any case up until they are dropped, denied, dismissed, or adjudicated in the defendant's favor. Of note, the average time to resolve for cases with indemnity dropped from 29 to 27 months between 2007 and 2016. That trend may indicate that strategies to expedite resolution (e.g., disclosure and apology) are having an impact, and are, perhaps, slowing the growth of case management expenses.

Case disposition was static.

The percent of cases closed with payment was virtually unchanged from 2007–2016.

PERCENT OF CASES

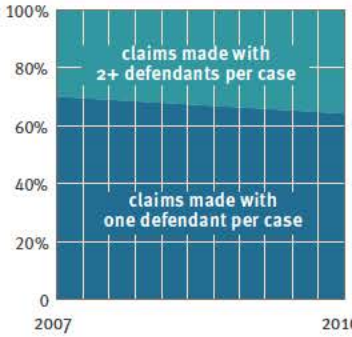


cases closed...	TEN-YEAR AVERAGE	AVERAGE PERCENT CHANGE PER YEAR
...with payment	30%	+0.6%
...without payment	70%	-0.3%

The proportion of cases naming multiple defendants is growing.

This drove an increase in the overall number of defendants.

CASES BY NUMBER OF DEFENDANTS



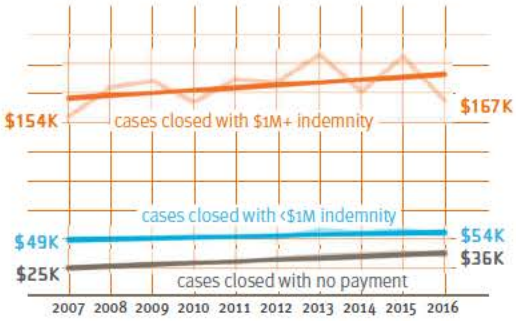
For the cases studied, the total number of defendants grew on average 257 per year. With the average expense per defendant being $25K (and rising, as seen below), this added about $6.5M to expenses per year.

	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR		AVERAGE PERCENT CHANGE PER YEAR
number of defendants	17K	—	+257 DEFENDANTS	+1.5% DEFENDANTS
cases with 1 defendant	63% OF CASES	-79 CASES	-79 DEFENDANTS	-1.2% DEFENDANTS
cases with 2+ defendants	37% OF CASES	+96 CASES	+348 DEFENDANTS	+3.3% DEFENDANTS

Total expenses rose fastest for cases closed without an indemnity payment.

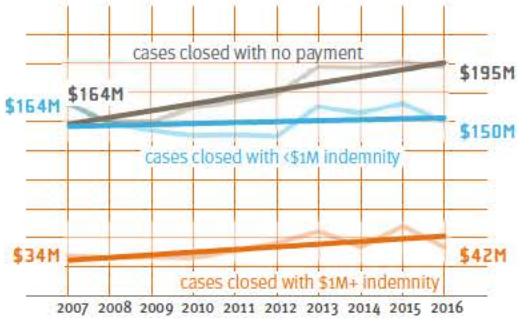
Average per case expenses increased most dramatically for cases closed with a $1M+ payment.

AVERAGE EXPENSE PER CASE
(NOT INFLATION ADJUSTED)



Cases closed...	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR	AVERAGE PERCENT CHANGE PER YEAR
...with no payment	$31K	+$1.5K	+4.7%
...under $1M	$52K	+$0.7K	+1.4%
...$1M+	$180K	+$2.3K	+1.3%

TOTAL EXPENSES
(NOT INFLATION ADJUSTED)

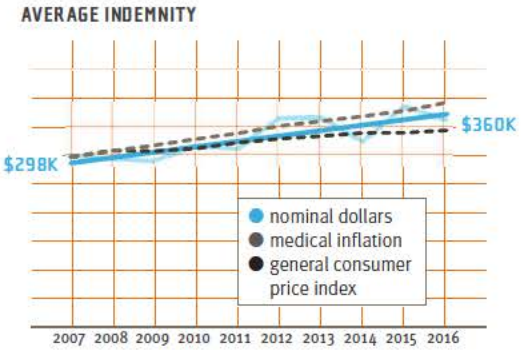


Cases closed...	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR	AVERAGE PERCENT CHANGE PER YEAR
...with no payment	$175M	+$6.0M	+3.4%
...under $1M	$150M	+$0.8M	+0.6%
...$1M+	$41M	+$2.4M	+5.7%

Indemnity

$1M+ payments drove an overall increase in both average and total indemnity paid.

The 10-year profile for average indemnity matches inflation-based expectations.
Indemnity's position above the general CPI demonstrates the influence of future medical expenses on payment amounts.



$330K
TEN-YEAR AVERAGE INDEMNITY PAYMENT

+3%
AVERAGE CHANGE PER YEAR

0.1%
BELOW MEDICAL INFLATION

1.3%
ABOVE CPI INFLATION

MPL indemnity payment trends for the 10-year study period were not dramatic. The median payment increased in line with inflation (from $110K in 2007, to $120K in 2016). The average payment, even though distorted by a few atypical payouts, grew on average 3% annually (from $298K to $360K). While that outpaced the consumer price index, it fell below medical inflation, a fair proxy for medical expenses which, along with policy limits, heavily influence payments.

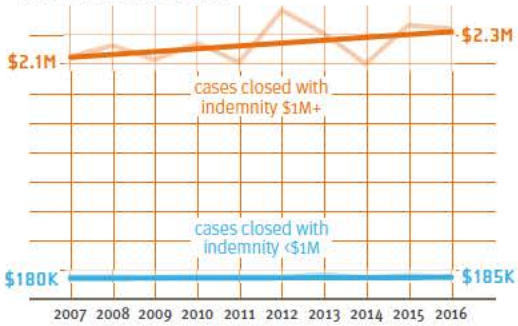
Total MPL losses were extremely concentrated in cases with $1M+ payments, especially those paying $1M–3M. This analysis found that 2.2% of all cases had $1M+ payments, but the volume of such cases rose (on average) 4.4% annually from 2007–2016. In aggregate, $1M+ payments accounted for 49% of MPL losses. Meanwhile, the volume of cases closing under $1M dropped, as did their share of total indemnity.

Certainly, extraordinary jury awards draw media attention, pique the interest of reinsurers, and can skew the focus of patient safety improvements, but they remain rare. Per 1,000 cases closed, only one or two cases closed with more than $5 million indemnity. Outlier payments (those exceeding $11M) had a minimal impact on overall indemnity trends.

Cases paying $1M+ drove an overall growth in indemnity.

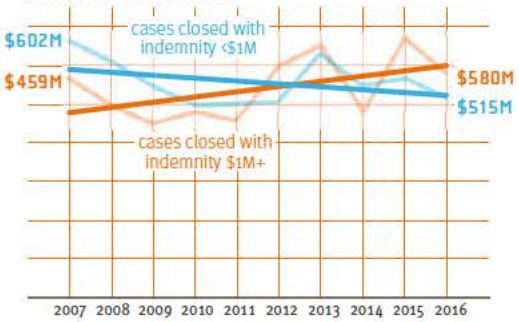
The majority of indemnity paid now accrues from $1M+ cases.

AVERAGE INDEMNITY
(NOT INFLATION ADJUSTED)



CASES CLOSED...	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR
...under $1M	$183K	+0.6%
...$1M+	$2.2M	+1.1%

TOTAL INDEMNITY
(NOT INFLATION ADJUSTED)

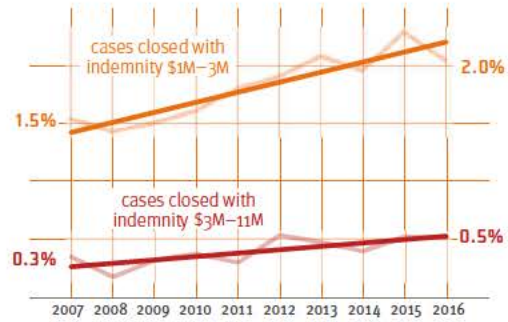


CASES CLOSED...	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR
...under $1M	$525M	-0.3%
...$1M+	$496M	+5.5%

$1M+ payments are changing the indemnity landscape

The volume of cases closed with $1M+ payments rose an average of 4.4% per year from 2007–2016; payments below $1M dropped. Although $3M–11M cases are still rare, the cumulative indemnity for these cases grew the fastest and outpaced medical cost inflation. For a case set of 102,000, the 24 payments above $11M, while non-trivial, did not affect the overall indemnity growth trend.

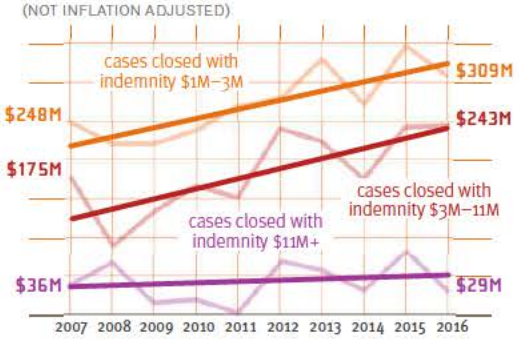
PERCENT OF CASES CLOSED



Cases closed...	TEN-YEAR AVERAGE	AVERAGE CHANGE PER YEAR	AVERAGE PERCENT CHANGE PER YEAR
...$1M–3M	1.8%	+0.09%	+5.0%
...$3M–11M	0.4%	+0.03%	+8.6%
...$11M+*	0.02%	—	—

*The incidence of cases with greater than $11M indemnity paid is too small to graph or determine trends.

TOTAL INDEMNITY
(NOT INFLATION ADJUSTED)

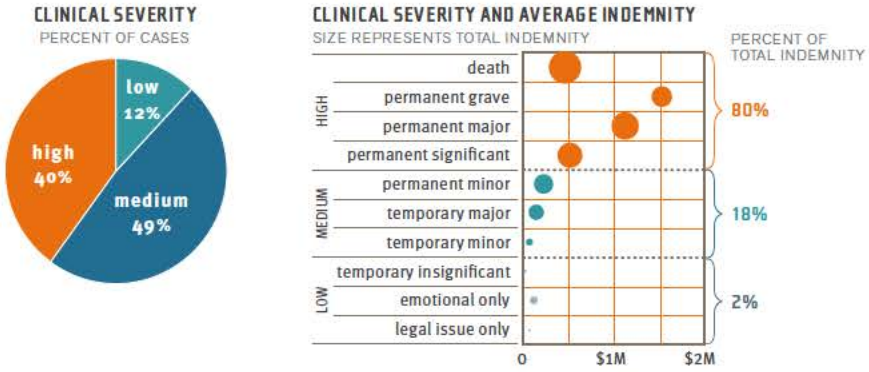


Cases closed...	PERCENT OF ALL INDEMNITY 2007	PERCENT OF ALL INDEMNITY 2016	AVERAGE CHANGE PER YEAR	AVERAGE PERCENT CHANGE PER YEAR
...$1M–3M	23%	28%	+$12M	+4.4%
...$3M–11M	17%	22%	+$15M	+7.9%
...$11M+	3%	3%	–	–

Clinical Severity

MPL cases compensating future medical expenses for younger patients with severe permanent injuries drive indemnity costs.

High-severity injuries are more likely to result in indemnity payment.
The increasing cost of long term life-care plans are reflected in the average indemnity for patients with severe, but non-fatal outcomes of care.



41%

HIGH-SEVERITY INJURIES ARE 41% MORE LIKELY TO LEAD TO AN INDEMNITY PAYMENT

Although occasional case results seem random or arbitrary, the primary determinant of financial damages in MPL cases is injury severity. High-severity injury cases closed more often with an indemnity payment, and those payments were, on average, four times higher than for medium and low severity cases.

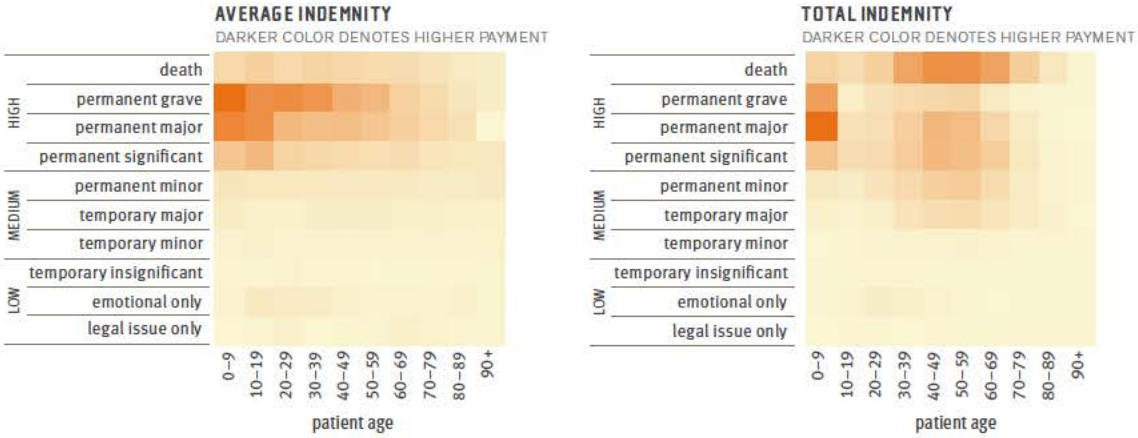
Over the 10-year study period, nearly two-thirds of obstetrics-related cases and 63% of those alleging a diagnostic error involved high-severity injuries. On the other hand, 72% of surgery-related cases involved medium or low severity injuries. Many of the latter were relatively moderate injuries with a finite recovery period.

Patients with severe, permanent (non-fatal) injuries seek compensation—in addition to pain and suffering—to cover the health care costs and lost income of their remaining years (sometimes decades). Thus, for the 22% of cases involving a patient's death, the average payment ($453K) was just over half the average payment for patients with permanent severe injuries.

Tragic outcomes and a greater likelihood of closing with high payments elevate severe-injury cases to focal points for both claims management and risk management. Effective risk reduction efforts targeting the root causes of high-severity cases should help to reduce less severe events as well.

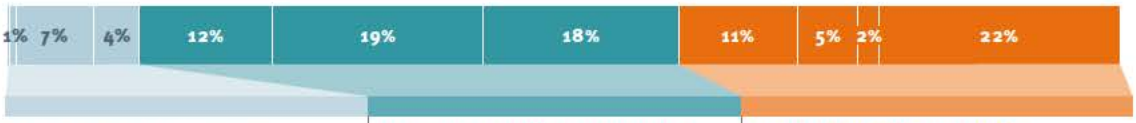
Indemnity was impacted most by injury severity and patient age.

Death-related cases accounted for the largest amount of total indemnity, but severely-injured patients under age 40 received the highest average payment.



Examples of clinical injuries by severity level

MPL injuries are assigned to one of 10 categories grouped into low, medium, and high severity.



LOW-SEVERITY INJURIES

Legal Issue Only: 1%
Illegal access of patient's medical record without necessity, resulting in HIPAA violation and invasion of privacy allegation.

Emotional Only: 7%
After the loss of a biopsy specimen, a patient with a strong family history of skin cancer required ongoing monitoring to ensure areas around her initial lesion did not worsen.

Temporary Insignificant: 4%
Complaints of pain during IV insertion, dismissed as patient's fear of needles, resulted in IV infiltration.

MEDIUM-SEVERITY INJURIES

Temporary Minor: 12%
Patient burned by malfunctioning part of intraoperatively used warming blanket. Failure to monitor patient's skin during procedure resulted in second degree burn.

Temporary Major: 19%
A cerclage stitch was not located after a cesarean delivery. Failure to document and follow up on this retained foreign body resulted in abdominal pain, infection, and additional surgery.

Permanent Minor: 18%
Misread CT resulted in delayed diagnosis of appendicitis (mistaken for kidney infection) leading to ruptured appendix, large abscess, sepsis, need for additional surgery, and prolonged hospitalization.

HIGH-SEVERITY INJURIES

Permanent Significant: 11%
Sub-optimal management of a non-English speaking patient's compliance with specialty consults delayed the diagnosis of a brain tumor, resulting in permanent vision loss.

Permanent Major: 5%
Patient with vascular occlusions required bilateral leg amputations after a requested vascular consult was unreasonably delayed.

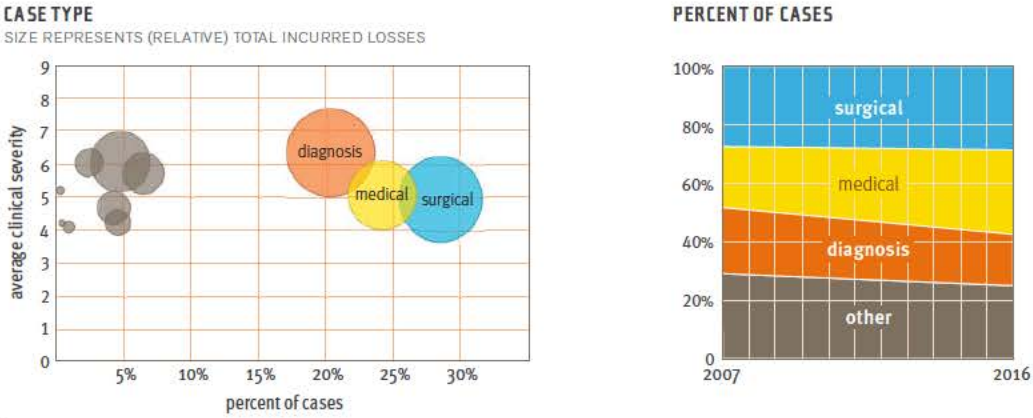
Permanent Grave: 2%
Patient suffered a stroke following a heart attack. Mismanagement of anticoagulants was tied to gaps in clinical monitoring and communication.

Death: 22%
Patient with history of aortic dissection complained to PCP of chest pain. After an X-ray, the patient died at home. Posthumous reading of the X-ray showed an enlarged aorta, which ultimately ruptured.

Case Type

The vast majority (73%) of MPL cases stem from three categories of health care: surgical treatment, medical treatment, and the diagnostic process.

Surgical treatment remains the most common source of MPL cases.
Allegations of a medical treatment failure are becoming more common.



Examining MPL cases for shared components consolidates risk reduction interventions and defense strategies. CBS case types comprise adverse events with similar profiles, e.g., failure to diagnose, patient monitoring, medication management, technical performance. Even though like cases might derive from care in disparate settings or involve a mix of clinical services, they lend themselves to comparable mitigation strategies. For example, failure to detect a post-operative complication shares some diagnostic missteps with a missed myocardial infarction in the Emergency Department. Protocols to prevent recurrence in both settings could be based on a common framework. Case typing is also key to defense and settlement strategies.

From 2007–2016, diagnostic issues demonstrated a downward shift in the MPL case mix. That trend aligns with widespread attention on diagnostic errors (see page 20) and some concerted efforts to reduce them. Concurrently, the proportion of cases alleging errors during medical treatment (i.e., non-surgical procedures and ongoing care management) moved upward, perhaps signaling the need for similar scrutiny.

Surgical Cases

A substantial share (44%) of surgical cases involve ambulatory care patients.

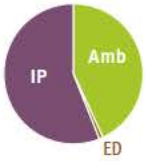
TOP PROCEDURES

- 28% orthopedic
- 17% gastrointestinal
- 11% skin
- 9% gynecologic
- 8% nervous system
- other

TOP INJURIES

- 17% perf./laceration
- 11% infection
- 8% nerve damage
- 7% hematologic
- 6% retained foreign body
- other

CARE SETTING



SURGICAL CASES	
28%	of all cases
24%	of all losses
29%	closed with payment
$347K	average indemnity
$152K	median indemnity

ODDS RATIO FOR SURGICAL CASES (compared to non-surgical cases)	
0.49	to involve a high-severity injury
0.82	to close with payment
0.78	to close with payment $1M+

Medical Cases

Medical cases are evenly divided between improper management of ongoing care and improper performance of a procedure.

RESPONSIBLE SERVICES

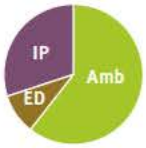
IMPROPER MANAGEMENT OF A MEDICAL PATIENT

- 48% medicine
- 15% surgery
- 9% emergency medicine
- 7% dentistry
- 7% nursing
- other

IMPROPER PERFORMANCE OF A MEDICAL PROCEDURE

- 30% medicine
- 25% dentistry
- 15% surgery
- 7% nursing
- 7% radiology
- other

CARE SETTING



MEDICAL CASES	
24%	of all cases
16%	of all losses
28%	closed with payment
$265K	average indemnity
$69K	median indemnity

ODDS RATIO FOR MEDICAL CASES (compared to non-medical cases)	
0.80	to involve a high-severity injury
0.77	to close with payment
0.47	to close with payment $1M+

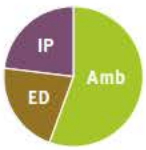
Diagnosis Cases

Among a wide range of missed or delayed diagnoses, cancers were consistently most prevalent.

FINAL DIAGNOSES IN MISSED/DELAYED DIAGNOSIS CASES

- 30% cancers
  - top cancers
    - 16% breast
    - 14% lung
    - 10% colorectal
    - 7% uterine & ovarian
    - 6% skin
- 18% cardiac/stroke
- 17% complications of care
- 7% digestive system
- 7% nervous system
- other

CARE SETTING



DIAGNOSIS CASES	
21%	of all cases
28%	of all losses
35%	closed with payment
$472K	average indemnity
$213K	median indemnity

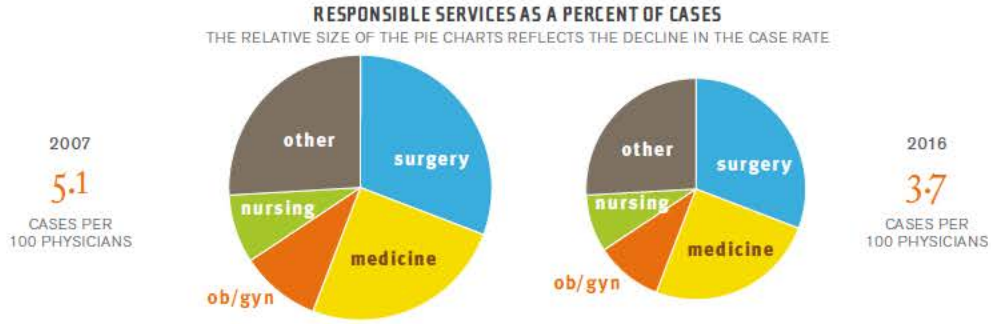
ODDS RATIO FOR DIAGNOSIS CASES (compared to non-diagnosis cases)	
3.43	to involve a high-severity injury
1.16	to close with payment
1.72	to close with payment $1M+

Care settings are Ambulatory, Inpatient, and Emergency Department

Responsible Service

One-third of MPL cases involved clinicians from a surgical service, one-quarter involve clinicians from a medical service. Those proportions remained constant during the 10-year study period.

The 10-year decline in overall case rate was distributed evenly among the top responsible services.



Most patients interact with a team of caregivers from one or more clinical service, and not every MPL case names a physician defendant. To reduce the risk of patient harm and litigation, analysts need to look beyond physician specialty to understand which clinical service was responsible for a patient at the crux of an adverse event. Responsible service designations incorporate all staff and functions involved in patient care. Engaging all segments of a given service in efforts to address recurring patient safety issues, as a team, boosts effectiveness.

For some services, injury severity has a greater influence on overall MPL exposure than does case volume. Neurosurgery and obstetrics—where the consequences of medical errors are often permanent and devastating—incur significantly disproportionate financial losses when compared to their shares of total cases. Alternately, nursing and orthopedics have a higher frequency of cases with less severe–and often temporary—injuries.

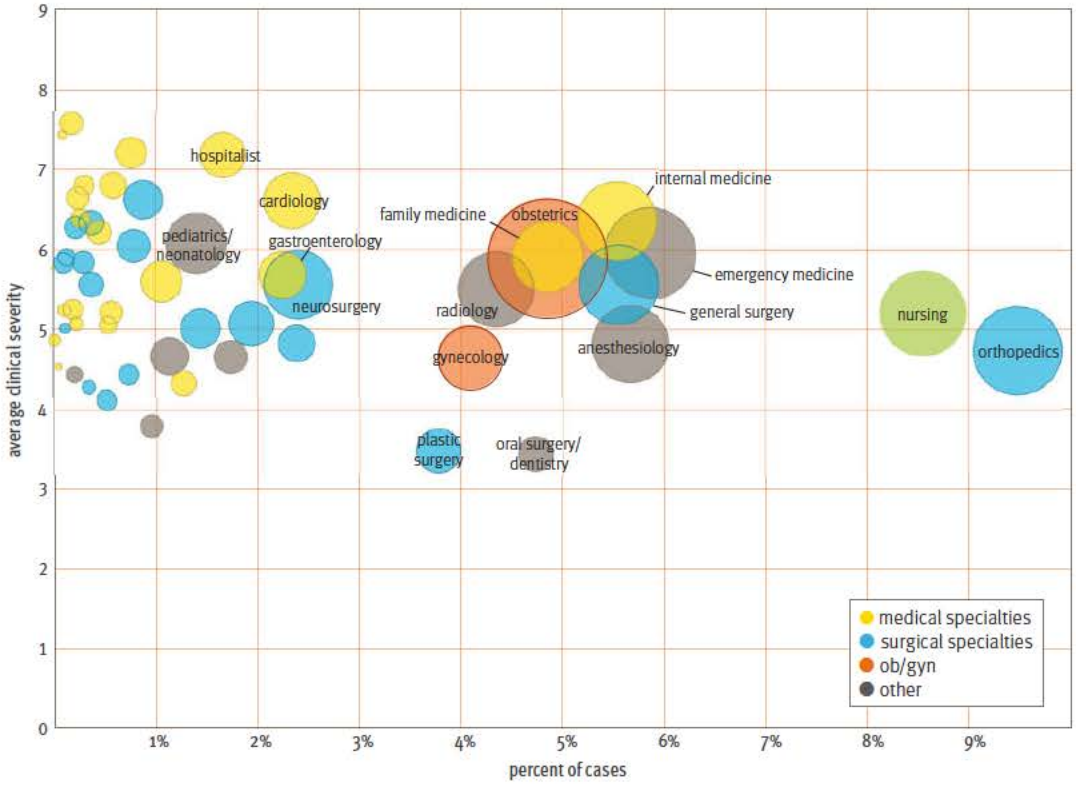
Over the recent decade, the distribution of cases across medicine, surgery, nursing, and obstetrics/gynecology was unchanged. Drilling down to more specific services also indicates few dramatic shifts. Deeper analyses of individual organizations or smaller volume specialties may expose more subtle trends.

Case frequency and average injury severity vary considerably by service.

More cases does not necessarily mean more losses.

RESPONSIBLE SERVICE DETAILS

SIZE REPRESENTS (RELATIVE) TOTAL INCURRED LOSSES

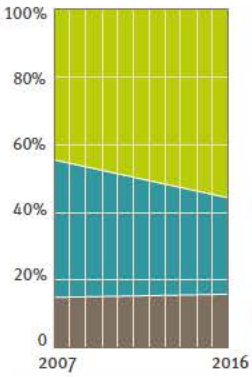


Proportionate shifts among sub-specialty services are evident.

Over the 10-year study period, downward (blue) trends can be identified among medical and surgical sub-specialties.

SURGERY: DISTRIBUTION OF CASES

PERCENT OF SURGERY CASES



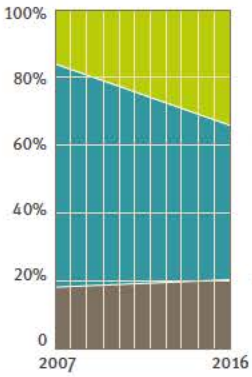
PROPORTION INCREASING
colorectal surgery, ENT without plastic, ophthalmology, orthopedic, podiatry, urology surgery

PROPORTION DECREASING
bariatric surgery, cardiac surgery, ENT with plastic, general surgery, neurosurgery, transplant, vascular surgery

MINIMAL OR NO CHANGE
hand surgery, pediatric surgery, plastic surgery, thoracic surgery, surgical oncology

MEDICINE: DISTRIBUTION OF CASES

PERCENT OF MEDICINE CASES



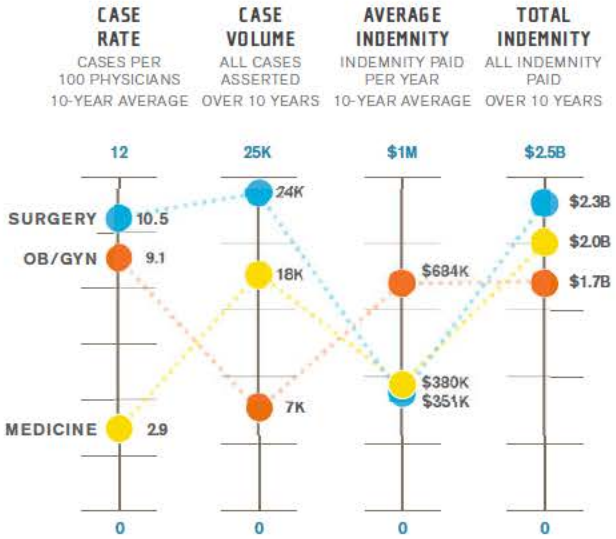
PROPORTION INCREASING
gastroenterology, hospitalist, intensivist, neurology

PROPORTION DECREASING
cardiology, family medicine, internal medicine

MINIMAL OR NO CHANGE
dermatology, infectious disease, medical oncology, pulmonary disease, physical medicine/rehabilitation, etc.

COMPARING SERVICES

Surgery-related cases dominated case volume and total losses, despite having the lowest average indemnity.



The total indemnity incurred by the three prominent service categories accumulates from strikingly different patterns. Medicine's case rate (2.9 per 100 physicians) is below the average for all services (4.5) despite case volume proximate to surgery, reflecting a high volume of health care providers in that discipline. Medicine cases most commonly involve diagnostic challenges, treatment complications, and medication errors, and patients with high-severity injuries. However, the odds of a medicine case closing with pay are 14% lower than for other services.

The case volume for surgery is 34% greater than medicine, but impacts a smaller population of clinicians. Surgery cases tend toward less severe (and often temporary) injuries and lower average indemnity. The total indemnity for obstetrics is carried by considerably fewer but significantly more severe cases that often include extraordinary lifetime medical and home care costs.

Academic medical centers had lower case rates.

CASES PER 100 PHYSICIANS (10-YEAR AVERAGE)

	ACADEMIC MEDICAL CENTERS	ALL OTHERS
ALL	3.7	4.8
MEDICINE	1.7	3.2
SURGERY	6.6	11.9
OB/GYN	7.8	9.8

For surgery and obstetrics, practice volume impacts case rate.

SURGERY CASES PER 10K SURGERIES

SURGERIES PER YEAR	CASE RATE
<10K	1.5
10K–20K	2.9
20K+	4.2

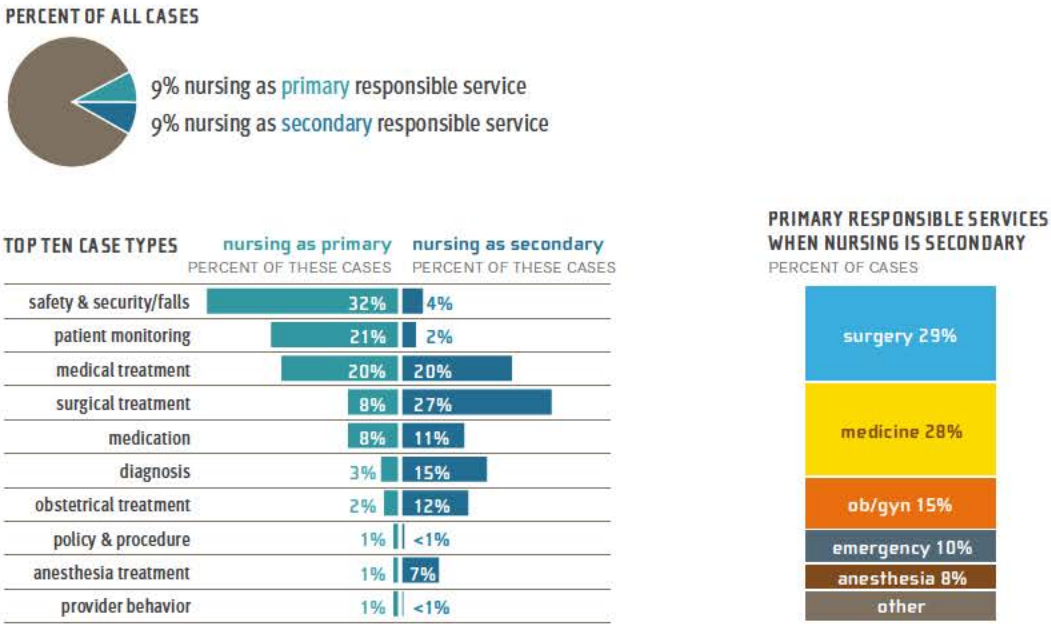
OB/GYN CASES PER 10K BIRTHS

BIRTHS PER YEAR	CASE RATE
<1K	3.5
1K–2K	6.8
2K+	9.5

Non-academic settings experienced more cases per physician than academic medical centers. For medicine services, the case rate was 87% higher than for AMCs; surgery was 81% higher. One factor impacting those differences: AMC-based physicians often split their professional time with non-clinical activities. Analyses of case rate by patient volume (for surgeries and births) point to greater risks in larger capacity settings, possibly a result of a more complex patient mix.

NURSING

MPL cases with nursing identified as the secondary responsible service closed with indemnity more often than when nursing was the primary service (and with higher average payments).



For cases in the CBS database, a clinical service is identified as having been primarily responsible for the patient when the alleged malpractice occurred. Cases with nursing deemed primarily responsible cluster around "bedside" skills, (e.g., medication administration and monitoring, IVs, catheters, wound care) as well as clinical assessment and monitoring activities (e.g., minimizing fall risks and maintaining skin integrity). The odds of a case with nursing as the primary service closing with a payment are 56% higher than all other cases. The average for those payments ($243K) is, however, 38% lower than for all other cases.

In 31% of CBS cases, a second service sharing responsibility for the patient at the time of the adverse event was recorded. Most commonly, the secondary service was nursing. Those cases frequently involved inadequate patient assessment or provider-provider communication breakdowns in care related to diagnosis, surgery, or obstetrics. Injuries from those events and the other cases within that subset were, overall, more severe than for all other CBS cases. That, in large part, contributes to cases with nursing as the secondary service having double the odds of other cases to close with a payment. In this analysis, those payments averaged $570K, 54% higher than the average for all other payments.

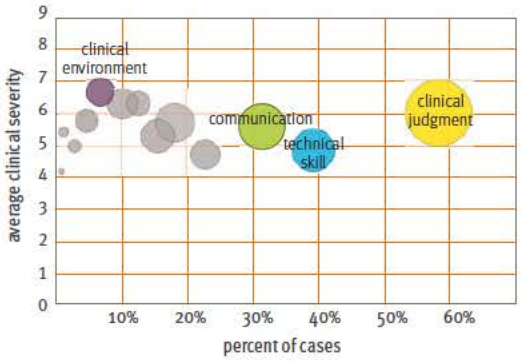
Contributing Factors

The most prevalent factors in MPL cases pertain to a provider's clinical judgment, in particular, patient assessment.

Contributing factors in MPL cases predominantly reflect breakdowns in clinical judgment, procedural skills, and communication.

CONTRIBUTING FACTOR CATEGORIES

SIZE REPRESENTS (RELATIVE) TOTAL INCURRED LOSSES



3.3
AVERAGE CONTRIBUTING FACTORS PER CASE

ODDS RATIOS FOR CLINICAL JUDGMENT CASES
compared to cases without these issues

3.76	to involve a high-severity injury
2.80	to close with payment
5.63	to close with payment $1M+

The critical factors that triggered an allegation of malpractice are coded at a level of detail that enables precise analysis of why things go wrong (on average, 3–4 contributing factors per case). Within CBS, specific factors can be grouped at a higher level to help identify predominate vulnerabilities. In addition to judgment issues, the most common and costly missteps seen in MPL cases are poor technical performance (surgical and non-surgical procedures), and miscommunication (between clinicians and with patients). Both are prevalent across care settings. From this broad perspective, variation over the 10 years studied were, generally, modest.

Shifts reflective of changes in the health care environment are better identified at the more granular coding levels. At the most detailed layer, variations among the key factors seen in different care settings emerge. There, distinct areas for risk reduction efforts (e.g., responding to unresolved complaints, sponge/needle counts, premature discharge from the ED) become more evident. And, because high-risk systems and processes are often shared across settings, services, and case types, those improvement strategies can be disseminated throughout an organization.

The top contributing factors in MPL cases were found in all care settings.

Judgment, technical, and communication issues were pervasive.

			PERCENT OF CASES* IN THE SETTING
AMBULATORY CARE	Clinical Judgment 52% of ambulatory cases*	patient assessment e.g., inadequate history and physical	35%
		selection and management of therapy e.g., failure to order appropriate medication	20%
		failure/delay in obtaining consult/referral e.g., despite symptoms or clinical findings	10%
	Technical Skill 40%	technical performance e.g., incorrect body position/site	36%
		retained foreign body e.g., intentionally retained objects forgotten	2%
	Communication 31%	communication between patient/family and providers e.g., inadequate consent; medication risks	22%
		communication among providers e.g., unprofessional; responsibility unclear	11%
INPATIENT CARE	Clinical Judgment 63% of inpatient cases*	patient assessment e.g., premature discharge; failure to rescue	38%
		selection and management of therapy e.g., inappropriate procedure, candidate, or medication	29%
		patient monitoring e.g., response to clinical alarm; failure to monitor physiological status	16%
	Technical Skill 43%	technical performance e.g., inexperience with procedure	39%
		retained foreign body e.g., tools, devices, sponges, etc.; broken fragments	3%
	Communication 31%	communication among providers e.g., reading the medical record, reaching consensus	18%
		communication between patient/family and providers e.g., discharge/follow-up instructions; notification of adverse event	15%
EMERGENCY DEPARTMENT CARE	Clinical Judgment 76% of ED cases*	patient assessment e.g., inadequate triage	65%
		selection and management of therapy e.g., most appropriate medication not used	21%
		failure/delay in obtaining consult/referral e.g., despite symptoms or clinical findings	18%
	Communication 32%	communication among providers e.g., hierarchical issues	19%
		communication between patient/family and providers e.g., language barrier, follow-up instructions	15%
	Clinical Environment 21%	shift/off hours conditions e.g., busyness	13%
		workflow/workload e.g., busyness, weekend/night shift/ holiday	8%

Examining Patient Assessment

At the detail level, contributing factors pinpoint specific opportunities for care improvement and MPL risk reduction.

PATIENT ASSESSMENT CASES

38%

of all MPL cases involved patient assessment issues

44%	closed with payment
$523K	average indemnity
$222K	median indemnity

AMONG CASES INVOLVING A PATIENT ASSESSMENT FAILURE

	PERCENT OF CASES*
failure/delay in ordering diagnostic test	33%
failure to appreciate and reconcile relevant signs or symptoms	33%
failure to establish differential diagnosis	20%
misinterpretation of diagnostic studies (X-rays, slides, film)	17%
inadequate history and physical	14%

*Cases may have multiple issues.

MPL Risks During the Diagnostic Process

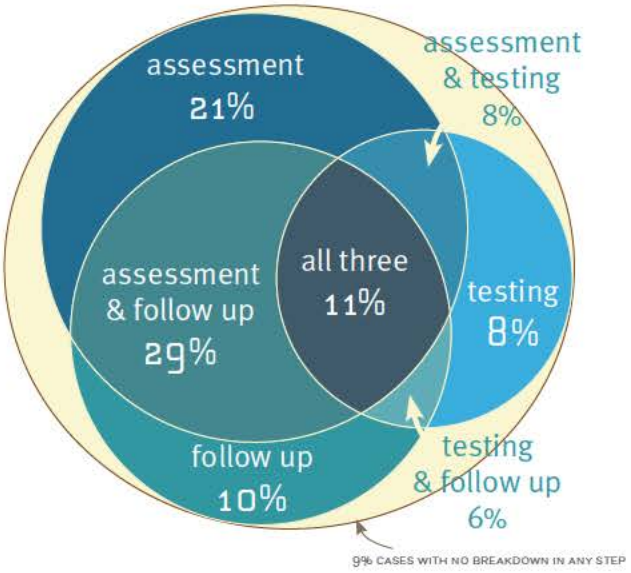
The majority of (ambulatory care) patients in diagnosis-related MPL cases encountered problems at multiple points along the diagnostic process.

DIAGNOSTIC PROCESS OF CARE	% DIAGNOSIS CASES*
PHASE 1: INITIAL DIAGNOSTIC ASSESSMENT	
1. **Problem Noted, Care Sought** Access issues impede the patient from seeking care.	1%
2. **History and Physical Conducted** Patient's history is not updated; physical examination is absent or inadequate.	10%
3. **Patient Assessed and Symptoms Evaluated** Patient's complaints or symptoms are not thoroughly addressed.	35%
4. **Differential Diagnosis Established** Narrow diagnostic focus, failure to establish a differential diagnosis.	39%
5. **Diagnostic Test(s) Ordered** Ordering of appropriate tests/imagings is impeded by an incomplete or biased assessment.	36%
PHASE 2: TESTING AND RESULTS PROCESSING	
6. **Test Performed** Ordered test/imaging not performed, performed incorrectly, or mislabeled/mishandled.	4%
7. **Test Interpreted** Incomplete or inaccurate reports; abnormal findings not ruled out.	26%
8. **Test Results Transmitted to/Received by Ordering Physician** Receipt/review of test result by ordering clinician incomplete or delayed.	5%
PHASE 3: FOLLOW UP AND COORDINATION	
9. **Physician Follows Up with Patient** Findings not communicated to patient, follow up not arranged or not documented.	21%
10. **Referrals/Consults** Appropriate referrals not made or adequately managed.	24%
11. **Patient Information Communicated Among Care Team** Failure to fully review/share information that influences ongoing diagnostic process.	16%
12. **Patient and Providers Establish Follow-up Plan** Patient fails to adhere to the follow-up plan, appointments, or treatment regimen.	17%

*Diagnosis cases in the ambulatory care setting. Cases may have multiple issues.

Reducing diagnostic errors requires attention to all phases of the process.
Clinical judgment is the key component of missteps during the assessment and follow up phases.

OVERLAP OF ERRORS IN INDIVIDUAL CASES
PERCENT OF CASES*



PHASE 1
INITIAL DIAGNOSTIC **ASSESSMENT**
68% OF CASES, 79% OF LOSSES
Covers the patient's presentation with a complaint, through the physician's assessment, differential diagnosis, and test orders.

PHASE 2
TESTING AND RESULTS PROCESSING
32% OF CASES, 38% OF LOSSES
From the scheduling, performance, and interpretation of diagnostic tests, through the management of the test results.

PHASE 3
FOLLOW UP AND COORDINATION
54% OF CASES, 61% OF LOSSES
Encompasses decisions made and actions taken after assessment and testing, including consultations and communication.

Eleven percent of the 62,000 fully-coded cases studied alleged misdiagnosis during ambulatory care. Mapping the contributing factors to a 12-step diagnostic process of care (POC) model identified 91% of cases with breakdowns within one or more of the three POC phases: assessment, testing, and follow up. Negligible change among the three phases was noted over the 10 years studied.

In 68% of these cases, at least one misstep in patient assessment was identified. As shown on page 20, three of the five assessment steps were particularly problematic, highlighting a focal point for risk reduction efforts. Test-related errors (primarily interpretation) were found in 32% of the cases, and patient follow up issues (including mismanaged referrals) showed up in 54%.

A majority of the 6,700 ambulatory diagnosis cases involved errors from two or all three POC phases. Clinician overreliance on cognitive and intuitive skills can narrow the diagnostic focus, obscuring contrary signals, inhibit test or consult orders, and limit their ability to interrupt a cascade of missed opportunities. In aggregate, multi-phase cases involve more severe injuries, more often close with an indemnity payment, and resolve with average indemnity payments higher than cases with less complex scenarios.

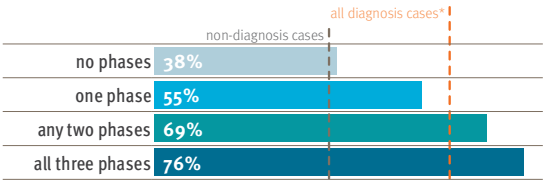
MULITIVARIATE ANALYSIS OF PHASES & OUTCOMES

Complex diagnosis-related cases are more severe and costlier.

Ambulatory care cases involving multiple diagnostic missteps are more likely to close with payment and for higher amounts.

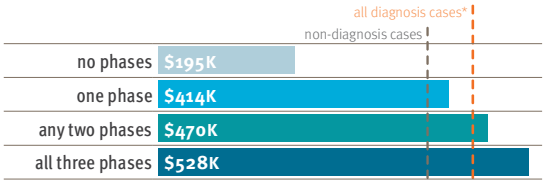
PERCENT OF CASES INVOLVING A HIGH-SEVERITY INJURY

WHEN THE DIAGNOSTIC PROCESS OF CARE BREAKS DOWN IN...



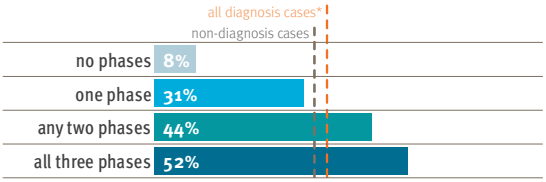
AVERAGE INDEMNITY

WHEN THE DIAGNOSTIC PROCESS OF CARE BREAKS DOWN IN...



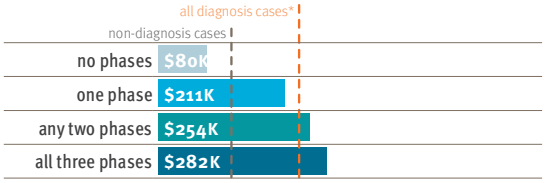
PERCENT OF CASES CLOSED WITH PAYMENT

WHEN THE DIAGNOSTIC PROCESS OF CARE BREAKS DOWN IN...



MEDIAN INDEMNITY

WHEN THE DIAGNOSTIC PROCESS OF CARE BREAKS DOWN IN...



*Diagnosis cases in the ambulatory care setting. Cases may have multiple issues.

BREAKDOWNS IN ONE PHASE

ODDS RATIOS when failures occurred in one phase only	HIGH-SEVERITY INJURY[1]	CLOSING WITH PAYMENT[2]
assessment vs testing	1.90	0.65
testing vs follow up	0.71	2.69
assessment vs follow up	1.35	1.74

When breakdowns occur in one phase only, assessment failures have greater odds for incurring high-severity injuries. Cases involving testing failures have greater odds of resulting in indemnity payment.

BREAKDOWNS IN TWO PHASES

ODDS RATIOS when failures occurred in pairs of phases			HIGH-SEVERITY INJURY[3]
assessment & testing	vs	testing & follow up	1.31
assessment & follow up	vs	assessment & testing	1.36
assessment & follow up	vs	testing & follow up	1.78

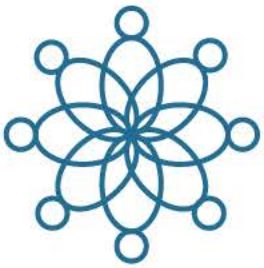
Any pair of phases amplifies the consequences (see graphs above). In addition, those involving assessment had greater odds of high-severity injury. However, no single pair of phases changed the odds of payment more than any other.

BREAKDOWNS IN ALL THREE PHASES

ODDS RATIOS compared to no phase failures	HIGH-SEVERITY INJURY[4]	CLOSING WITH PAYMENT[5]
breakdown in one phase	1.99	4.32
breakdown in any two phases	3.42	7.26
breakdown in all three phases	5.13	9.33

Any breakdown in the diagnostic process of care increases the odds for negative outcomes, both clinical and financial. When errors occur in all three phases, the odds are greatly magnified. Error reduction in any phase can contribute to an overall amelioration of risk.

Controlled for: 1. service and phase 2. severity, service, and phase 3. service and phase pairs 4. service and number of phases 5. severity, service, and number of phases



Safety in Numbers

MPL Data Accelerate Practical Solutions

MPL data are employed as evidence supporting risk reduction efforts for both the insurance and health care delivery industry. A small set of department or specialty-level cases can raise awareness about very specific risks. Analyses of an organization's total MPL experience help leadership understand with precision what went wrong and why. The ability to tap into the analytic power of hundreds of thousands of cases from across the country—including open cases and cases closed without a payment—gives business leaders unprecedented views into trends and emerging risks that will shape the future.

CBS data regularly serve as the underpinning of strategic initiatives to improve patient safety and reduce the likelihood of malpractice allegations. Some notable examples are outlined below.

CONSTELLATION

CONCERN: Underlying factors for missed or delayed diagnoses

FINDING: Outpatient diagnosis cases had the most breakdowns in the assessment phase (58%), along with 35% during the testing phase, and 45% during follow up.

ACTIONS:
- web-based suite of bundled solutions for preventing diagnostic error
- clinic risk reports that highlight key vulnerabilities in outpatient practices
- individualized tracks for policyholders for preventing diagnostic error

FOJP/HOSPITALS INSURANCE COMPANY

CONCERN: Permanent injuries and MPL cases related to shoulder dystocia

FINDING: While clinical judgment factors were trending downward in Labor & Delivery cases, technical issues were trending upward.

ACTIONS:
- teamwork training
- simulation course

CRICO

CONCERN: Anesthesia MPL cases occurring in endoscopy units

FINDING: Of malpractice cases involving anesthesia, 19% providers were associated with ERCP; 91% of those cases resulted in a payment.

THE DOCTORS COMPANY

CONCERN: Events that place cardiologists and their patients at risk

FINDING: Patient assessment issues are the most frequent cause of patient injury for cardiologists, especially failing to establish a differential diagnosis or ignoring available clinical information.

ACTIONS:
- specialty-specific site assessments with study findings incorporated
- on-demand education featuring lessons from the analysis

MEDSTAR

CONCERN: Misdiagnosed spinal injuries in the Emergency Department

FINDING: The misdiagnoses of injuries from atraumatic spinal cord compression were traced to communication challenges between ED physicians and the MRI suite.

ACTIONS:
- system-wide interventions to support clinical judgment and improve communication
- web-based learning program to enhance diagnostic accuracy
- clinical pathway triggered in EHR when preliminary assessment suggests spinal cord compression

THE DOCTORS COMPANY

CONCERN: Undetected cardiac issues in the primary care setting

FINDING: Misdiagnosis of cardiovascular issues in outpatient general medicine predominantly involve patients with typical cardiac risk factors, rather than low-risk patients.

CRICO

CONCERN: Efficacy of simulation training aimed at reducing cast-saw injuries.

FINDING: The anticipated savings from averted cast-saw injuries and associated medicolegal payments in the 2.5 years post-simulation is an 11-to-1 return on investment.

MEDPRO GROUP

CONCERN: Unique contributing issues to ED claims

FINDING: 55% of ED triage cases (versus 37% of non-triage-related ED cases) involve a communication failure, with 80% resulting in high-severity injuries.

ACTIONS:
- focused data analysis published

Large cases have always been a major driver of our system, but in recent years we've had an increase in severity. One or two catastrophic cases every 5–6 years can extract a tremendous cost and threaten the availability of excess insurance. Hospitals operate on small margins; an eight figure exposure can affect overall organizational financial success.

Our focus on quality and safety must more fully engage our finance, audit, administrative, and Board leadership in the finances of our MPL program.

The plaintiff bar has retooled to routinely produce $20M–50M life care plans. Along with the disruption, potential adverse publicity, and reputational issues caused by MPL cases, we now have to consider potential balance sheet impact: how many big hits can we absorb before it would impact financial viability?

The frequency of catastrophic losses across the country has caused organizations to view their MPL program as one of the critical issues to consider when assessing their financial success.

LARRY SMITH
VICE PRESIDENT
RISK MANAGEMENT
MEDSTAR HEALTH

As a tool to improve health care, MPL data has two key values: qualitative details and financial context.

The clinical and systemic factors that can be extracted from malpractice cases are far more actionable, than when you look at incidents that don't become cases.

Documents (e.g., medical records, depositions) accessible via an MPL investigation offer insight into what individuals were thinking, how they were communicating, and what else was going on relative to the care in question. To get buy-in from providers on efforts to improve care—to prevent the recurrence of a bad outcome—such insight is crucial.

The financial context (often really big numbers) makes it easier to find support for spending organizational resources on fixing the specific problems behind large payouts. A colleague labeled initiatives based on use of MPL data as pay-for-performance on steroids.

Demonstrating that we've spent millions on cases related to a given problem over the last five years, makes it easier when asking that we spend one-tenth of that to fix it.

DAVID L. FELDMAN, MD
SENIOR VP AND CMO
FOJP/HOSPITALS INSURANCE COMPANY

Our Data

CBS

The Comparative Benchmarking System (CBS) receives medical professional liability (MPL) cases from 18 MPL insurers including open cases and cases closed without an indemnity payment. Each case is coded under a common (proprietary) taxonomy by clinical coding experts who receive ongoing training and auditing to ensure consistency and currency. The clinical coders have access to all records and documents produced for the management of the case, including medical records, expert review, depositions, and court proceedings. The CBS database contains cases from all 50 U.S. states and several territories (representing 30% of U.S. MPL cases) and adds roughly 9,000 new cases per year.

THIS REPORT

Cases with claim-made dates or indemnity close dates from January 1, 2007 through December 31, 2016 were included.

The analyses in this Report were based on 123,512 partially or fully coded MPL cases.

Selected analyses were based on subsets of the primary study group, including:

- 101,752 claims made
  - of which 61,862 are fully coded
- 102,017 closed cases

Glossary

Ambulatory cases constitute non-emergency care provided to patients without a hospital admission.

Asserted cases includes both open and closed cases, selected by claim-made date.

Case refers to a claim or a suit, comprising all named defendants.

Case disposition can either be closed with pay (settlements and plaintiff verdicts via trial or arbitration) or closed without pay (cases dropped, denied, dismissed, and trials or arbitrations resulting in a defense verdict).

Case duration is measured from the date a claim or suit is made to the date that case is closed.

Case rates are calculated as the number of cases asserted per 100 physician coverage years (PCY), unless otherwise specified. PCY accounts for the length of time a physician is covered in one year: e.g., two MDs, each covered for six months, equal one PCY.

Case type is determined by the coding specialists, who review the claimant's allegation and the available facts.

Contributing factors are based on aspects of care that directly or indirectly impacted the care in question. There is no limit to the number of contributing factors that may be coded for a single case (the average is 3.3).

Defendants include organizations/entities, licensed clinicians, and non-licensed employees.

Emergency Department cases constitute care provided within the ED setting prior to discharge or admission to the hospital.

Expenses represent non-indemnity costs, including legal fees, expert reviews, testimony, jury studies, mock trials, and defendant support services.

Frequency is based on cases asserted per year.

Fully-coded cases have all legal, financial, and clinical components coded.

Indemnity payments are exclusive of case management expenses. They are based on the total amount paid to a plaintiff, regardless of reinsurance caps.

Inflation calculations are based on the general U.S. consumer price index (16% increase from 2007–2016). In the same time period, the medical care inflation rate rose 32% and the legal services inflation rate rose 29%. Inflation data sourced from the U.S. Bureau of Labor Statistics at www.bls.gov.

Injury severity coding is based on a scale originated by the National Association of Insurance Commissioners.

Inpatient cases constitute care rendered during admission to a hospital or other overnight care facility.

An **odds ratio** represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure. An odds ratio less than 1.0 indicates lower odds of an outcome for one group compared to another group; a ratio above 1.0 indicates higher odds. The odds ratios included in the Report are statistically significant at $p<0.05$ level. The exception is "assessment & testing vs. testing & follow up" (p 22) for a high-severity outcome, where the $p=0.0548$.

Patient age is recorded as of the loss date, i.e., when the event(s) triggering an MPL case occurred.

Responsible service is determined by the coding specialist as the clinical service primarily responsible for the patient when the event(s) triggering an MPL case occurred.

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To join our community, contact Michael Paskavitz at mpaskavitz@rmf.harvard.edu or 617.450.5500

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NOTICE OF FILING and PROOF OF SERVICE

In the Supreme Court of Illinois

JILL M. BAILEY, as Independent Representative of the Estate of JILL M. MILTON-HAMPTON, Deceased, *Plaintiff-Appellee,*	)	
v.	)	No. 126748
MERCY HOSPITAL AND MEDICAL CENTER, et al., *Defendants-Appellants.*	)	

The undersigned, being first duly sworn, deposes and states that on July 14, 2021, there was electronically filed and served upon the Clerk of the above court the *Amicus Curiae* Brief of Illinois Trial Lawyers Association in Support of Plaintiff-Appellee. On July 14, 2021, service of the Brief will be accomplished by email as well as electronically through the filing manager, Odyssey EfileIL, to the following counsel of record:

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Within five days of acceptance by the Court, the undersigned states that thirteen copies of the Brief bearing the court's file-stamp will be sent to the above court.

/s/ Sarah F. King
Sarah F. King

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.

/s/ Sarah F. King
Sarah F. King