No. 128651

IN THE SUPREME COURT OF ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of Donald Cleeton, Deceased, *Plaintiff-Appellee,* v. SIU HEALTHCARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., SIU PHYSICIANS & SURGEONS, INC. d/b/a SIU MEDICINE, an Illinois Corporation, and ASHLEY KOCHMAN, R.N., *Defendants,* and MEMORIAL MEDICAL CENTER, MOUHAMAD BAKIR, M.D., JESSICA FARLEY, NAUMAN JAHANGIR, M.D., HANNAH PURSEGLOVE, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHIPLA CHAKU, M.D., *Respondents in Discovery,* (Mouhamad Bakir, M.D., Appellee)	Appeal from the Illinois Appellate Court Fourth Judicial District No. 04-21-0284 There Heard on Appeal from the Circuit Court of the Seventh Judicial Circuit, Sangamon County, Illinois, No. 2016 L 002470 The Honorable Raylene Grischow, Judge Presiding.

BRIEF AND APPENDIX OF APPELLANT

Timothy M. Shay
Katherine E. Perry
SHAY & ASSOCIATES LAW FIRM
1030 Durkin Drive
Springfield, Illinois 62704
(217) 523-5900
timothyshay@shayandassociates.com; kperry@shayandassociates.com

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NATURE OF THE CASE

This case questions the proper evidentiary standard required to establish probable cause pursuant to section 2-402 of the Illinois Code of Civil Procedure (735 ILCS 5/2-402 (West 2006)) as it applies to converting a respondent in discovery to a defendant in a medical malpractice case. Section 2-402 allows a plaintiff to designate individuals or entities who may have information pertinent to the discovery of additional proper defendants as respondents in discovery, rather than as defendants, to require them to participate in the formal discovery process. *Id.* Section 2-402 further allows the plaintiff to convert a respondent in discovery to a defendant for a period after the expiration of the statute of limitations if "evidence discloses the existence of probable cause for such action." *Id.*

Prior appellate court decisions are clear that the threshold to convert a respondent in discovery to defendant is low. The plaintiff must only present evidence which would lead a man of ordinary caution and prudence to entertain an honest and strong suspicion that the respondent in discovery is liable. *Ingle v. Hospital Sisters Health System,* 96 Ill. Dec. 325, 330 (1986).

The plaintiff alleges she has provided sufficient evidence to establish proximate cause to convert respondent in discovery Mouhamad Bakir, M.D. to a defendant. However, both the trial court and court of appeals denied plaintiff's motion to convert, finding the plaintiff had not provided sufficient evidence to establish probable cause. However, both lower courts incorrectly interpreted the evidentiary standard required to establish proximate cause as far higher than the burden the legislature intended to place upon plaintiffs to establish a right to assert a meritorious claim against a respondent in discovery

and convert him to a defendant.

The opinion of the Court of Appeals, Fourth District is contrary to the well settled law in the State of Illinois and, if upheld, will set a precedent abrogating the spirit and reasonable application of Section 2-402.

ISSUE PRESENTED

Whether the Circuit Court for the Seventh Judicial Circuit, Sangamon County and the Court of Appeals, Fourth District erred in finding plaintiff failed to presented sufficient evidence to establish that a man of ordinary caution and prudence would entertain an honest and strong suspicion that the negligence of Mouhamad Bakir, M.D., was a proximate cause of the death of plaintiff's decedent, Donald Cleeton, and thereby failed to establish probable cause to convert Mouhamad Bakir, M.D. from a respondent in discovery to a defendant, pursuant to section 2-402 of the Illinois Code of Civil Procedure (735 ILCS 5/2-402 (West 2006)).

STATEMENT OF JURISDICTION

The court has jurisdiction to hear this appeal pursuant to Illinois Supreme Court Rule 304(a) (eff. Mar. 8, 2016)), which allows for interlocutory appeal of a final judgment applicable to one party in a multi-party action upon express written finding by the trial court "that there is no just reason for delaying either enforcement or appeal or both." *Id.*

On May 3, 2021, the circuit court entered an order finding its denial of plaintiff's motion to convert Bakir from a respondent in discovery to a defendant and dismissal of Bakir as a respondent in discovery was a final and appealable order pursuant to Rule 304(a) and there was no just reason for delaying enforcement or appeal. C932. Plaintiff timely filed her appeal with the Court of Appeals, Fourth District, which affirmed the circuit

court's decision by written order on June 2, 2022. On June 30, 2022, plaintiff filed her petition for leave to appeal with the Illinois Supreme Court, which granted plaintiff leave to appeal on September 28, 2022.

STATUTES INVOLVED

Section 2-402 of the Illinois Code of Civil Procedure (735 ILCS 5/2-402 (West 2006).

> "The plaintiff in any civil action may designate as respondents in discovery in his or her pleading those individuals or other entities, other than the named defendants, believed by the plaintiff to have information essential to the determination of who should properly be named as additional defendants in the action.
>
> Persons or entities so named as respondents in discovery shall be required to respond to discovery by the plaintiff in the same manner as are defendants and may, on motion of the plaintiff, be added as defendants if the evidence discloses the existence of probable cause for such action.
> ***
> A person or entity named as a respondent in discovery in any civil action may be made a defendant in the same action at any time within 6 months after being named as a respondent in discovery, even though the time during which an action may otherwise be initiated against him or her may have expired during such 6 month period. ***
>
> 735 ILCS 5/2-402 (West 2006).

STATEMENT OF FACTS AND PROCEEDINGS

A. Donald Cleeton's Medical History and Pre-October 2017 Care

Donald Cleeton (hereinafter "Donald") was a 25-year-old man diagnosed with quadriplegia after sustaining a traumatic injury to his C5-C6 vertebral column in 2009. C38. From the age of seventeen until his death, Donald was wheelchair bound. C38.

Due to the trauma to his spine, Donald developed significant spasticity, an abnormal increase in muscle tone or stiffness in the muscle, typically caused by nerve damage in the brain or spinal cord, which caused Donald discomfort and pain. C38. To treat his spasticity, Donald underwent surgical implantation of a Medtronic SynchroMed

II Infusion System by Dr. Jose Espinosa on December 10, 2014. The purpose of the infusion system was to provided regular doses of Lioresol, a brand name of the drug baclofen, into the intrathecal space of the spine, where the drug would enter the cerebrospinal fluid and control spasticity generating from the damaged nerves. C38. The infusion system consisted of two parts: the pump itself which held and systematically dispersed baclofen, and a catheter which delivered baclofen from the pump to the intrathecal space. C354.

Both the pump and the catheter were implanted entirely within Donald's body. C693. As the pump held a finite amount of baclofen, it required regular refills, which were performed by a medical provider by inserting a needle through the skin and subcutaneous tissue to access the refill septum. C38.

B. The October 25, 2017 Baclofen Pump Refill

During October 2017, Donald's pump was managed by the Southern Illinois University (SIU) Department of Neurology; specifically, by Charlene Young, F.N.P and her clinic nurse, Ashley Kochman, R.N. C38. On October 25, 2017, Donald and his mother presented to the SIU Department of Neurology for a scheduled pump refill. C38. Nurse Kochman and Nurse Practitioner Young each made multiple failed attempts to access the refill septum with a needle before Nurse Practitioner Young ultimately accessed the septum and completed the refill procedure. C38.

Plaintiff alleged in her complaint that during their failed attempts to access the pump septum, Nurse Kochman, Nurse Practitioner Young, or both, upon missing the septum punctured the catheter leading to the intrathecal space of Donald's spine, preventing the proper dose of baclofen from reaching the intrathecal space, and resulting

in increased spasticity and baclofen withdrawal. C38-39.

C. Emergency and Hospital Care of October 29 and 30, 2017

On October 29, 2017, Donald presented to the emergency department of Memorial Medical Center, arriving at approximately 8:00 p.m. At 8:19 p.m., Donald was evaluated by Dr. Richard Austin, an emergency room physician. SC23-29. Donald reported he had recently undergone a baclofen pump refill and had experienced pain and increased spasms since. SC 23. He further reported abdominal pain, headache, and a recent urinary tract infection (UTI). *Id.* On exam, Dr. Austin found Donald alert and oriented. SC 26. However, Dr. Austin noted Donald was tachycardic, with heart beats per minute elevated into the 120s to 130s that further increased into the 170s during periods of spasm. *Id.* Dr. Austin further noted Donald's blood pressure fluctuated drastically from a low of 97/43 to a high of 231/105. SC23-24.

Dr. Austin's impression was sepsis and acute UTI. C611. He ordered a urinalysis with culture, blood culture, and two intravenous antibiotics: cefepime and vancomycin. SC 27. Dr. Austin further consulted the on-call neurology resident, Dr. Nauman Jahangir, who recommended having the device interrogated, or tested for proper pump function, by the manufacturer. C611. Interrogation was performed that evening and the pump was found to be working properly and distributing the proper dosage. C618.

The urinalysis ordered by Dr. Austin was drawn on October 29, 2017 at 10:10 p.m. SC33. The urinalysis showed amber cloudy urine with greater than 500 milligrams per deciliter of protein, moderate urine hemoglobin, positive nitrates, moderate leukocyte esterase, 242 per high powered field white blood cells, and 335 per high powered field red blood cells, as well as the presence of many bacteria. SC33. Around the same time, a urine

culture was drawn, which subsequently showed moderate probable contaminants and growth of 100,000 colony forming units per milliliter klebsiella pneumoniae, a bacteria. SC34. At 10:05 p.m., Nurse Keith Gennicks reported catheter urine output of purulent, dark yellow, foul-smelling urine containing visible sediment. SC 36.

Donald was administered cefepime at 10:50 p.m. and vancomycin at 11:21 p.m. on October 29, 2017. SC32. Subsequently, at 12:06 a.m. on October 30, 2017, a blood culture was drawn, which was subsequently found to show growth of coagulase negative staphylococcus, another bacteria. SC37. A second blood culture was drawn the same day at 1:20 a.m., which resulted in no growth after five days incubation. SC37.

Initially, Donald was admitted to the intermediate care unit at Memorial Medical Center. At 4:45 a.m. on October 30, 2017, Nurse Jessica Farley noted urine output was cloudy, purulent, dark yellow, and foul-smelling. SC36. Donald was evaluated by Dr. Jan Rakinic, a colorectal surgeon, who ruled out colitis as a source of sepsis. SC82, 68: 1-15. During the morning hours of October 30, 2017, Donald exhibited a decreased level of consciousness and a heart rate elevated to the 190s, followed by a rapid response call. SC43. Upon stabilization, Donald was transferred to the intensive care unit (ICU). SC43.

Donald arrived in the ICU at approximately 10:00 a.m. on October 30, 2017 and fell under the care of Dr. Mouhamad Bakir (hereinafter Bakir), the appellee, as well as resident Dr. Hannah Purseglove and pulmonary fellow Dr. Keivan Shalileh. SC43. Donald's differential diagnoses upon ICU admission were septic shock secondary to urosepsis (UTI); possible baclofen withdrawal/pump malfunction; elevated troponin, possibly secondary to severe tachycardia versus sepsis versus myocarditis versus pulmonary embolism; decubitus ulcers with possible osteomyelitis; and cardiac arrest.

SC39. Dr. Shalileh confirmed there were concerns Donald was experiencing either baclofen withdrawal or overdose. SC117, 19:4-17. Dr. Shalileh further indicated that baclofen withdrawal syndrome can resemble sepsis, which is why it remained part of the differential diagnosis in the ICU. SC124, 45: 16-21.

Donald's urine catheter output was recorded by Nurse Amber Brown at 10:00 a.m. to be clear yellow urine, without notation of foul odor. SC35. A history and physical was performed by Dr. Purseglove, who noted Donald had entered supraventricular tachycardia (SVT) with a heart rate in the 180s, that he had been coded and administered adenosine which temporarily reduced his heart rate to the 120s, and that he had returned to sinus tachycardia in the 170s to 180s. SC39. Dr. Purseglove further noted several episodes of decreased responsiveness where Donald's eyes rolled back. *Id.* Dr. Purseglove indicated Donald continued to have spasms, most prominently in the abdomen. *Id.*

Bakir became involved with the patient within fifteen minutes of his admission to the unit. SC73, 55:3-13. In his attending note addendum to the ICU admission history and physical, Bakir noted Donald had been admitted to the hospital the day prior for spasms, fever, and leukocytosis or high white blood cell count. SC43. Bakir further noted the decreased level of conscious, heart rate in the 190s, and rapid response which triggered transfer to the ICU. *Id.* During his initial evaluation of Donald, Bakir spoke with his mother, who reported a history of quadriplegia, muscle spasms, and baclofen pump placement. SC 43. She further reported a difficult refill taking two hours to access the pump on October 25, 2017, which was followed by increased spasms that worsened over the prior three to four days. *Id.*

Bakir testified in his discovery deposition that Donald's mother's statements "gave

[him] concern about the pump." SC90, 99:4-8. Bakir had training and knowledge regarding baclofen and the presentation, symptomatology, and concurrent morbidities associated with baclofen withdrawal syndrome. SC60, 15:11-15. He further understood a baclofen pump infuses baclofen to the intrathecal area. SC69, 16:22-24; SC70, 17:1-4. Bakir further was aware baclofen withdrawal may cause high fever, altered mental status, exaggerated rebound spasticity, and in rare cases rhabdomyolysis, multiple organ system failure, and death. SC70, 19:10-24; SC70, 20:1-2.

Bakir confirmed Dr. Purseglove's findings of decreased responsiveness and increased spasms. SC43. Specifically, Bakir testified Donald was rolling his eyes and fluttering his eyelids in an unusual manner which resembled seizure activity and displayed spasticity throughout the course of his care, particularly in the abdomen. SC81, 61:2-7; SC71, 21:1-13. Additionally, Bakir testified Donald exhibited some symptoms of autonomic dysreflexia, a nervous system response to stimulation causing large variation in heart rate and blood pressure. SC 61; 24:7-24. Baclofen withdrawal can resemble autonomic dysreflexia. SC71, 24:7-9. Bakir testified he was aware of the temporal relationship between the onset of increased spasticity and Donald's other symptoms and the recent, difficult pump refill. SC74, 36:6-12. Bakir never eliminated baclofen withdrawal syndrome from his differential diagnosis. SC72, 27:6-8.

Bakir noted Donald had been seen by neurology and Medtronic staff the previous night for pump interrogation. SC 43. Nevertheless, he ordered contact with SIU Neurology and Medtronic to investigate pump function. SC39.

At 10:44:52 a.m., a copy of the baclofen withdrawal emergency procedures was received at Memorial Medical Center from Medtronic via facsimile. SC63. The emergency

procedures were not immediately scanned into the electronic record and were not available for Bakir's review during Donald's ICU course. However, Donald's mother had given Dr. Shalileh, Bakir's pulmonary fellow, a Medtronic underdose/withdrawal emergency procedure card, which appears in the Memorial records with notations in Dr. Shalileh's handwriting. SC124, 47:7-22; SC146.

Dr. Abdullah Al Sawaf and resident Dr. Shipla Chaku were called for neurology consult by Bakir. SC45-50. The neurological exam revealed spastic contractures in Donald's bilateral upper extremities and abdominal spasms. SC49. During the neurological exam, Donald's eyes rolled back and fluttered, however he was responsive with verbal coaching from his mother. SC49. The differential diagnosis from neurology included baclofen withdrawal verses sepsis as the cause of increased spasms and autonomic dysreflexia. SC45.

As of 11:51 a.m. on October 30, 2017, Bakir was aware the second blood culture drawn early that morning showed no growth and revealed no persistent bacteremia. SC85, 78:1-4. Further, the klebsiella infection identified in Donald's urine was being appropriately addressed with cefepime and urine output was showing visible improvement. SC84, 77:16-24; SC35. While no additional urinalysis or culture was drawn, Donald was administered a second dose of cefepime at 12:01 p.m. SC30. However, Donald's condition continued to worsen.

At 12:09 p.m., approximately two hours after Donald fell under Bakir's care, a code was started due to loss of pulse. SC52. The code was continued for a period of three hours, involving cardiology, neurology, and neurosurgery teams. At 2:05 p.m., over to hours into the code, intrathecal baclofen was administered due to "concern for baclofen withdrawal

secondary to possible pump *catheter* malfunction." SC39, SC55 (emphasis added). The administration of intrathecal baclofen had no apparent effect on Donald's condition. SC53. At 2:58 p.m. resuscitation efforts were stopped, and Donald subsequently expired at 3:06 p.m. on October 30, 2017. SC52-53.

D. Post-Mortem Testing and Evaluations

On October 31, 2017, Dr. Nathaniel Patterson performed an autopsy on Donald. SC56-60. The final autopsy diagnoses were (1) brain with mild chronic meningitis and focal, mild perivascular chronic inflammation; (2) sacral decubitus ulcers with exposed bone; and (3) evidence of resuscitative efforts. SC56. Neither the autopsy diagnoses nor cause of death included urinary tract infection, sepsis, or other infectious process. SC56, SC60. Cultures of the lung and splenic tissues taken as part of the autopsy showed no bacterial growth over a four-day period. SC60. The urinary bladder contained no urine, preventing further urinalysis or culture. SC58. Dr. Patterson further explanted the baclofen pump and catheter and sent both to Medtronic for evaluation. SC58.

Medtronic personnel performed a detailed evaluation of Donald's pump and catheter as part of their adverse event investigation. SC61. Testing of the pump confirmed it was functioning properly; however, analysis of the catheter identified "user related holes in the catheter body" and pressure testing resulted in leaking from the holes. SC62.

E. History of Proceedings

On February 13, 2019, plaintiff filed a multi-count complaint at law in the Seventh Judicial Circuit Court, Sangamon County against multiple defendants based on Donald's medical treatment and hospitalization on October 25, 2017 and from October 29, 2017 until his death on October 30, 2017. C37-55. Additionally, the plaintiff named Bakir as a

respondent in discovery pursuant to Section 2-402 of the Illinois Code of Civil Procedure (735 ILCS 5/2-402 (West 2006)) as he had treated Donald in the intensive care unit on October 30, 2017. C52.

Subsequently, on November 13, 2019, the plaintiff filed a motion to convert Bakir from a respondent in discovery to a defendant, pursuant to Section 2-402. In support of her motion, plaintiff attached proposed counts XXII and XXIII against Bakir, constituting wrongful death and survival actions. C121-125. In both counts, plaintiff alleged Bakir owed a duty to Donald to "provide adequate medical care, diagnosis, and treatment***within the standard of care of a reasonably careful Critical Care Physician." C124, C125. Plaintiff alleged Bakir breached the duty of care owed to Donald by (1) failing to timely recognize the differential diagnosis of baclofen withdrawal syndrome; (2) failing to order treatment consistent with Medtronic emergency procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017; and (3) failing to order the administration of intrathecal baclofen in a timely manner. C124-125.

The plaintiff attached an attorney affidavit to her motion to convert in compliance with the Healing Art Malpractice Act (735 ILCS 5/2-622 (West 2013)) attesting plaintiff's counsel had consulted with Dr. William Stephen Minore to determine a reasonable and meritorious cause existed for filing a cause of action against Bakir. C561-63. Dr. Minore's certificate of merit was likewise attached to plaintiff's motion to convert. C580-82. Dr. Minore is a board-certified anesthesiologist specializing in pain management who is "well-versed on the care and treatment of patients who have undergone Baclofen pump implantation similar to that of [Donald]." C580. Dr. Minore reviewed the relevant medical records, autopsy report, toxicology screens, records from Medtronic regarding the

SyncroMed II pump and associated catheter, and the post-explantation studies and testing performed on the catheter. C580.

Dr. Minore opined "Based upon a review of the tests performed, the presentation of symptoms, and the Emergency Procedures faxed by Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome." C581. Dr. Minore further stated "It is my opinion within a reasonable degree of medical certainty based upon a review of the medical records***that [Bakir] deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner." C581.

On May 3, 2021, the circuit court entered an order denying the plaintiff's motion to convert Bakir from a respondent in discovery to a defendant and terminating Bakir as a respondent in discovery. C916-932. The court held the plaintiff failed to establish the standard of care to be applied to Bakir and failed to establish that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Bakir was guilty of an unskilled or negligent failure to comply with the applicable standard of care. C931. The court included a finding pursuant to Illinois Supreme Court Rule 304(a) (eff. Mar. 8, 2016) that no just reason existed for delaying enforcement or appeal of the order.

Plaintiff subsequently brought an interlocutory appeal before the Appellate Court of Illinois, Fourth District, who affirmed the circuit court's ruling. In doing so, the court stated while Dr. Minore's opinion "sets forth the ways in which Dr. Bakir allegedly deviated from the standard of care, it does not set forth the *actual* standard of care to which

Dr. Bakir's conduct is to be measured." A-13. Further, the court focused on the fact that Bakir was the managing physician for Donald in the ICU, working with other teams, including defendant neurologist Dr. Al Sawaf, who advised Bakir he did not believe the decedent was suffering from baclofen withdrawal syndrome. *Id.* The court stated, "plaintiff did not set forth any expert testimony addressing Dr. Bakir's role as a managing physician with multiple teams of specialists working on decedent's complex medical case in the ICU." A-14.

STANDARD OF REVIEW

A trial court is only entitled to deference to its ruling on a motion to add a respondent in discovery as a defendant where "the court heard testimony and made determinations regarding conflicting evidence." *Jackson-Baker v. Immesoete,* 272 Ill. Dec. 688, 691 (2003). In such case, the standard of review is abuse of discretion. *Id.* However, where there is no dispute as to the facts, credibility of the witnesses is not an issue, and the court heard no in-court testimony, whether plaintiff is entitled to convert a respondent in discovery to a defendant is a question of law, and the reviewing court may consider the question *de novo. Id.*

In this case, the circuit court for the court for the Seventh Judicial Circuit did not hear testimony or make determinations regarding conflicting evidence. There was no dispute with regards to facts. While there were certainly disputes as to how the various medical providers involved interpreted the significance of certain facts, there was no actual dispute as to how events unfolded. C204-301, SC6-13, C916-923. No issue was presented regarding the credibility of witnesses. Further, the Seventh Judicial Circuit considered no in-court testimony. R2-63. As the trial court did not hear testimony or make determinations

regarding conflicting evidence, its ruling regarding plaintiff's motion to convert Bakir from a respondent in discovery to a defendant is subject to *de novo* review, which was applied by the court of appeals.

ARGUMENT

I. Plaintiff Presented Sufficient Evidence to Establish Probable Cause to Convert Bakir From a Respondent in Discovery to a Defendant

Contrary to the rulings of the circuit and appellate courts, plaintiff presented ample evidence to establish she was entitled convert Bakir from a respondent in discovery to a defendant. Section 2-402 of the Illinois Code of Civil Procedure (735 ILCS 5/2-402 (West 2006)), governs matters pertaining to respondents in discovery. Section 2-402 provides in relevant part:

> "The plaintiff in any civil action may designate as respondents in discovery in his or her pleading those individuals or other entities, other than the named defendants, believed by the plaintiff to have information essential to the determination of who should properly be named as additional defendants in the action.
>
> Persons or entities so named as respondents in discovery shall be required to respond to discovery by the plaintiff in the same manner as are defendants and may, on motion of the plaintiff, be added as defendants if the *evidence discloses the existence of probable cause for such action*.
> ***
> A person or entity named as a respondent in discovery in any civil action may be made a defendant in the same action at any time within 6 months after being named as a respondent in discovery, even though the time during which an action may otherwise be initiated against him or her may have expired during such 6 month period. ***
>
> 735 ILCS 5/2-402 (West 2006).

Therefore, pursuant to Section 2-402, in order to convert a respondent in discovery to a defendant, a plaintiff must establish by evidence that probable cause exists for filing an action against the respondent in discovery. It has been well established by Illinois courts

that a plaintiff meets the probable cause burden of Section 2-402 by presenting evidence that would lead a person of ordinary caution and prudence to entertain an honest and strong suspicion that the purported negligence of the respondent in discovery was a proximate cause of the plaintiff's injury. *Ingle v. Hospital Sisters Health System*, 98 Ill. Dec. 325, 329 (1986).

For reasons set forth below, both the trial court and appellate court incorrectly interpreted section 2-402 and defined the probable cause requirement as far more burdensome than that required by any prior court or intended by the legislature. Utilizing the appropriate evidentiary burden for probable cause, plaintiff herein met the burden of showing probable cause to convert Bakir from a respondent in discovery to a defendant.

A. The Evidentiary Burden Required to Establish Proximate Cause is Low, and Should Be Considered Similar to That Required for Certification of a Meritorious Cause of Action Under the Healing Arts Malpractice Act, 735 ILCS 5/2-622

There is no definitive, bright line rule that denotes the quantum of evidence required to show a person of ordinary caution and prudence would entertain an honest and strong suspicion a respondent in discovery's negligence caused a plaintiff's injury. The language of Section 2-402 does not specify the amount of evidence required. *Williams v. Medenica*, 211 Ill. Dec. 619, 620-21 (1995). Illinois courts have consistently held the burden of proof necessary to establish probable cause under section 2-402 is not high. *Moscardini v. Neurosurg, S.C.,* 205 Ill. Dec 855, 860 (1994). Showing probable cause does not require evidence sufficient to present a question of fact for the trier of fact. *Ingle v. Hospital Sisters Health System*, 95 Ill. Dec. 325, 329 (1986). Nor does probable cause require evidence necessary to survive a motion for summary judgment against the respondent in discovery. *Id.* at 330. Plaintiff is further not required to present a *prima facie* case against the

respondent in discovery to convert the respondent to a defendant. *Id.* Rather, probable cause under 2-402 is to be liberally construed, to allow controversies to be determined according to the substantive rights of the parties. *Coley v. St. Bernard's Hosp.*, 217 Ill. Dec. 404, 409 (1996).

While section 2-402 requires a respondent in discovery to comply with formal discovery from the plaintiff, the plaintiff is not required to conduct discovery with the respondent or gain new evidence through discovery prior to moving to convert. *Long v. Mathew*, 270 Ill. Dec. 776, 781 (2003). A plaintiff is not even required to file an affidavit and certificate of merit as required by the Healing Arts Malpractice Act (735 ILCS 5/2-622 (West 2013)) in conjunction with a motion to convert a respondent in discovery to a defendant. *Jackson-Baker v. Immesoete,* 272 Ill. Dec. 688, 693 (2003).

The language of section 2-402 does not define the term "evidence." *Moscardini,* 206 Ill. Dec. at 859. A trial court's interpretation of the term "evidence" is a legal issue subject to *de novo* review. *Coley,* 217 Ill.Dec. at 409.

It is a fundamental principle of statutory construction that courts are to give effect to the intent of the legislature. *Long*, 270 Ill. Dec. at 782. If the legislature's intent is unclear based on the statutory language, or where the statutory language is subject to multiple interpretations, the court should look elsewhere to determine legislative intent. *Moscardini*, 206 Ill. Dec. at 858. The court may find guidance in construing legislative intent from similar statutes. *Id.* Where multiple statues are part of a comprehensive legislative scheme and address the same subject matter, such statues may be read *in pari materia* and the court may rely upon these related statutes for interpretive guidance. *Id. In pari materia* statutes are governed by the same spirit and, therefore, should be read consistently to avoid

injustice. *Id.* at 859.

The court in *Moscardini v. Neurosurg, S.C.*, intensely examined the legislative intent of section 2-402, finding the term "evidence" as used in section 2-402 was susceptible to more than one meaning. *Moscardini*, 206 Ill. Dec. 855, 859 (1995). The court therein noted the evidence a court may consider differs based on context; evidence the court may consider for purposes of a probable cause hearing, where evidentiary standards are relaxed, may not otherwise be admissible at trial, where the rules of evidence strictly apply. *Id.* Due to the ambiguous definition of "evidence" in section 2-402, the court looked to its language, purpose, and statutes relating to similar subject matter. *Id.* Specifically, the court examined the Healing Arts Malpractice Act (735 ILCS 5/2-622 (West 2013)) in interpreting "evidence" pursuant to 2-402. *Id.*

The Healing Arts Malpractice Act (hereinafter "section 2-622") requires a plaintiff in any medical malpractice action to attach an attorney affidavit to the complaint attesting he has consulted with a healthcare professional who has opined there is a "reasonable and meritorious" cause for filing an action against the defendant. 735 ILCS 5/2-622(a) (West 2013). Further, the complaint must be accompanied by a written report form the consulted healthcare professional indicating the basis for his determination and his qualifications. *Id.*

The court in *Moscardini v. Neurosurg, S.C.* found examination of the purposes behind sections 2-402 and 2-622 revealed important similarities. *Moscardini*, 206 Ill. Dec. at 859. The legislature enacted section 2-622 to eliminate frivolous medical malpractice lawsuits, but did not intend "to burden the plaintiff with insurmountable hurdles prior to filing." *Id.* citing *Comfort v. Wheaton Family Practice*, 171 Ill. Dec. 529, 594 (1992). Rather, section 2-622 was created as a technical pleading requirement to deter frivolous

lawsuits, not to impose a substantive defense. *Moscardini*, 206 Ill.Dec. at 859. Similarly, section 2-402 was enacted to prevent medical malpractice litigation from becoming overly burdensome to non-negligent medical professionals, while allowing plaintiffs to obtain relevant information from such parties. *Id.* Particularly, the court noted section 2-402 was intended to curb costs of malpractice insurance by reducing the number of medical providers named as defendants. *Id.*

The court in *Moscardini v. Neurosurg, S.C.* further found the burdens placed on plaintiffs by sections 2-402 and 2-622 were similar. The standard of proof under section 2-622 is a "reasonable and meritorious cause for filing," which was liberally construed to prevent depriving a plaintiff of a trial on the merits and only required the medical report to set forth the records reviewed, the actions which were inappropriate or unnecessary, and an opinion as to a defendant's negligence with accompanying reason for the opinion. *Id.* Similarly, the court found, section 2-402 allows conversion of respondents in discovery to defendants where the evidence presented shows probable cause for an action against him. *Id.* at 860. The court noted the burden of proof for probable cause under section 2-402 was not high. *Id.*

After reviewing the similarities between section 2-402 and section 2-622, the court in *Moscardini v. Neurosurg, S.C.* held the two statutes were enacted for a similar purpose; "to maintain a balance between the right of an aggrieved plaintiff to bring a medical malpractice action and the right of physicians***to be free from the burden of defending groundless suits." *Id.* Specifically, the court found "Section 2-402's probable cause requirement is intended to ensure that when a plaintiff attempts to convert a respondent in discovery to a defendant, he has a *meritorious reason* for doing so." *Id.* (emphasis added).

The court therefore held sections 2-402 and 2-622 should be read *in pari materia*, further holding based on the similarity of the provisions, it was "virtually inconceivable" that the legislature intended production of evidence greater than that required to file a malpractice suit under section 2-622 in order to convert a respondent in discovery to a defendant pursuant to section 2-402. *Id.*

Moscardini v. Neurosurg, S.C. was subsequently followed by *Williams v. Medenica,* 211 Ill. Dec. 619 (1995). In that case, the plaintiff filed a medical malpractice case naming several respondents in discovery, whom he subsequently sought to convert to defendants. *Id.* at 620. The only evidence presented in support of plaintiff's motion to convert was a section 2-622 physician report, which indicated "the plaintiff's medical records fail to reveal appropriate antibiotic coverage for any ongoing infectious process reflecting a similar deficiency in the care afforded to the plaintiff resulting in an infection of his knee" and that a reasonable and meritorious cause existed for filing against the respondents in discovery. *Id.* at 620, 622. The trial court found that the section 2-622 report did not satisfy the probable cause requirement of section 2-402, denied the plaintiff's motion, and dismissed the respondents in discovery. *Id.* at 620.

On appeal, the appellate court questioned the type and amount of evidence *minimally necessary* to satisfy the probable cause burden under section 2-402. *Id.* at 621. Applying the reasoning of the court in *Moscardini v. Neurosurg, S.C.* (206 Ill.Dec. 855 (1994)), the court liberally construed the probable cause burden of section 2-402, holding that while the affidavit of the physician as "not as precise and skillfully drafted as it might have been" he stated his opinions, within a reasonable degree of medical certainty, which formed the basis of his conclusion a reasonable and meritorious cause existed for filing of

an action against the respondents in discovery. *Id.* at 621-22. The court further stated:

> "Whether the charting deficiencies noted in [physician's] affidavit are, in fact, indicative of similar deficiencies in care or whether the respondents in discovery breach any standard of care owed to the plaintiff is a factual determination that must be made by the trier of fact. Suffice it to say, we find that [physician's] affidavit would engender, in an ordinary and prudent person, an honest and strong suspicion that the respondents in discovery breached the applicable standard of care and that their breach proximately resulted in injury to the plaintiff." *Id.* at 622.

The preponderance of prior Illinois case law regarding this matter supports the contention that the evidentiary burden required by section 2-402 is the same or similar to the requirement a physician certify the merit of the case pursuant to section 2-622. In *Long v. Mathew*, the plaintiff filed a timely motion to convert against a radiologist, relying upon the section 2-622 medical report of a non-radiologist. *Long,* 270 Ill. Dec. 776, 779 (2003). With regards to a cause of action against the radiologist, the physician stated only (1) that x-rays were interpreted by the radiologist, (2) the x-ray interpretation was not noted by any of the physicians who subsequently treated the patient, (3) "there is reasonable and meritorious evidence for pursuing a cause of action against [radiologist]," and (4) the radiologist failed to interpret and/or report the x-ray studies independently, which would have revealed the cause for the decedent's symptoms. *Id.* at 784.

The court of appeals found, in reversing the circuit court's denial of the plaintiff's motion to convert, that the physician's report "although not artfully phrased" was "*minimally sufficient*" to convert the radiologist from a respondent in discovery to a defendant. *Id.* (emphasis added). Specifically, the court found the fact the certifying physician was not a radiologist was irrelevant; rather, he was qualified to render expert opinion that there was a reasonable and meritorious cause of action because the allegations of the plaintiff "concern[ed] matters within his knowledge and observation." *Id.* at 783.

In *Ingle v. Hospital Sisters Health System*, the plaintiff moved to convert several respondents in discovery to defendants. *Ingle,* 96 Ill. Dec. 325, 326 (1986). The trial court allowed the motion as to some respondents in discovery, but denied as to two radiologists. *Id.* Plaintiff alleged the radiologists had been negligent in failing to report certain anomalies on the x-ray films, which would have revealed improper placement of a venous catheter. *Id.* at 329. On review, the court of appeals noted the plaintiff had supported her motion to convert with a physician affidavit, discovery depositions of various respondents in discovery, and relevant records. *Id*. The court found testimony of the radiologists was sufficient to show the standard of care required they report anything about the x-rays which would be significant to plaintiff's treatment to the treating physician. *Id.* at 330. The court further held the opinion of the section 2-622 physician noting anomalies on the x-ray films along with the testimony of several treating radiologists that the films were difficult to read with certainty, was "as a matter of law" enough evidence to establish a reasonable person would have a strong and honest suspicion that a failure made by the radiologists proximately caused the plaintiff's injury. *Id.*

With the exception of the present matter, no Illinois court of appeals has upheld a denial or reversed a grant of a motion to convert a respondent in discovery to a defendant where the plaintiff followed the proper procedure and presented any, even minimal, evidence in support of their motion.

As set forth by prior appellate court opinion, the evidentiary burden required of the plaintiff to establish proximate cause pursuant to section 2-402 is extremely low and requires presentation of little more evidence, if any, than she would have been required to present if she had named the respondent in discovery as a defendant in her initial complaint

pursuant to the Healing Arts Malpractice Act. The plaintiff need only show evidence that the claim against the respondent in discovery is meritorious, not evidence significant enough to prove each element of plaintiff's claim against such respondent in discovery.

B. Plaintiff Presented Sufficient Evidence to Establish Proximate Cause to Convert Bakir from a Respondent in Discovery to a Defendant

When the evidence presented by the plaintiff in support of her motion to convert Bakir from a respondent in discovery to a defendant is considered as a whole, and compared with the evidence found sufficient in prior cases, it is clear a person of ordinary caution and prudence would entertain an honest and strong suspicion that Bakir's negligence was a proximate cause of the plaintiff's injury.

The plaintiff provided evidence sufficient to cause a man or ordinary caution and prudence to have a strong and honest suspicion the standard of care required Bakir to timely diagnose and treat Donald for baclofen withdrawal syndrome. In his certificate of merit, Dr. Minore opined Bakir "deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner." C113. Dr. Minore based his opinion on Donald's hospital records, which in his opinion clearly indicated Donald was suffering from baclofen withdrawal syndrome. C112-13. Dr. Minore is a board-certified anesthesiologist specializing in pain management and is experienced treating patients with intrathecal baclofen pumps. C112. Dr. Minore is more than qualified to opine as to the standard of care of a physician treating a patient with a potential baclofen pump related condition.

In rendering his opinion, Dr. Minore relied upon on Donald's signs and symptoms,

as well as the studies performed, as set forth in the Memorial Medical Center records, to determine the standard of care required Bakir to diagnose baclofen withdrawal syndrome. C112. The records set forth the following relevant information.

On October 30, 2017, both prior to and during his admission to the intensive care unit, Donald experienced periods of altered mental status, including decreased responsiveness, eyes rolling back, and eyes fluttering in a manner Bakir testified resembled seizure activity. SC81, 61:2-7. Donald further experienced increased spasticity, particularly in the abdomen and arms. SC81, 21:1-13. Donald also experienced continuous autonomic dysreflexia, or fluctuating, uncontrolled heart rate and blood pressure, from the time he was initially evaluated by Dr. Austin in the emergency department on October 29, 2017, throughout his care with Bakir in the intensive care unit, and up until he lost pulse and was coded. SC26, SC23-24, SC43, SC39, SC43. Altered mental status, increased spasticity, and symptoms of autonomic dysreflexia are all symptoms consistent with baclofen withdrawal syndrome. SC 70, 19:10-24; SC 70, 20:1-2. Bakir knew baclofen withdrawal could cause these symptoms. *Id.* Further, Bakir had training and knowledge regarding baclofen, including the presentation, symptomatology, and concurrent morbidities associated with baclofen withdrawal syndrome. SC60, 15:11-15.

Further, Bakir was aware baclofen withdrawal was a potential source of Donald's symptoms. Bakir had been advised by Donald's mother within fifteen minutes of his arrival in the ICU that Donald's spasms had increased following a difficult refill. SC43. Bakir testified in his deposition that he was concerned about the pump as he was aware of the temporal relationship between the onset of increased spasticity and Donald's other symptoms and the recent pump refill. SC90, 99:4-8. While a temporal relationship between

an event and an injury cannot, on its own, be used as probative evidence the event caused the harm (*Hussung v. Patel*, 308 Ill. Dec. 347, 355 (2007))[1], because of the lowered standard of evidence used when considering a motion to convert pursuant to section 2-402, evidence of the temporal relationship should be considered appropriate "evidence" to be considered in tandem with other evidence presented to determine whether a man of ordinary caution and prudence would have a strong and honest suspicion that Bakir breached a duty owed to Donald, which resulted in his death.

Under the ruling of *Williams v. Medenica,* plaintiff was not required to prove that the deficiencies indicated by Dr. Minore were, in fact, a deviation from the standard of care; rather, the issue of whether Bakir actually had a duty, as a reasonably well qualified critical care specialist, to diagnose and treat Donald for baclofen withdrawal syndrome, under the totality of the circumstances, is an issue of fact to be determined by the trier of fact. *Williams,* 211 Ill. Dec. at 622. The expert opinion of Dr. Minore as set forth in his section 2-622 certificate of merit is sufficient meet the evidentiary burden of showing proximate cause under section 2-402. *Id.*

Additionally, plaintiff established evidence via Bakir's own testimony that failure to diagnose and treat Donald for baclofen withdrawal syndrome caused or contributed to Donald's death. In his discovery deposition, Bakir admitted that, despite his own concerns regarding potential baclofen withdrawal, Donald was not given any treatment for baclofen withdrawal syndrome prior to the administration of intrathecal baclofen at 2:09 p.m. on

[1] While *Hussung v. Patel,* cited by Bakir in previous briefs, addresses whether temporal relationship may stand in for expert opinion, the issue was address by the court on appeal of a summary judgement order, which has a higher standard of proof than that required by section 2-402 for a motion to convert. *Hussung v. Patel,* 308 Ill.Dec. 374 (2007).

October 30, 2017. SC88, 90:3-13; SC85, 88:1-3. Bakir testified administration of baclofen so late into Donald's care, and two hours into the code, was unlikely to change his outcome. SC53; SC93, 112:2-9. Bakir further opined that baclofen withdrawal may have contributed to Donald's death. SC92, 107:9-14.

Both the trial and appellate court based their decisions on an incorrect interpretation of the requirements of section 2-402, as well as an erroneous application of caselaw addressing the proof required to establish the elements of a medical malpractice case at more advanced stages of litigation. Both courts cited cases setting forth the elements of a medical malpractice case. C924, citing *Mayer v. Baisier,* 100 Ill. Dec. 649, 652 (1986), A-10, citing *Sullivan v. Edward Hospital,* 209 Ill. 2d 100, 112 (2004). *Mayer v. Baisier*, cited by the trial court, involved an appeal from a directed verdict in favor of a defendant at trial. *Mayer,* 100 Ill. Dec. at 650. Similarly, *Sullivan v. Edward Hospital*, cited by the court of appeals, involved an appeal of a directed verdict in favor of one defendant and a jury award in favor of a second defendant. *Sullivan*, 209 Ill. 2d at 103. While these cases accurately set forth the elements of a medical malpractice claim, neither case sets forth the appropriate amount or type of evidence required to establish probable cause pursuant to section 2-402. Section 2-402 does not require evidence sufficient to present a question of fact to for the trier of fact, evidence required to survive a motion for summary judgment, or presentation of a *prima facie* case. *Ingle,* 95 Ill. Dec. at 329.

Based upon the cited elements of a medical malpractice claim, the trial court held:

> "[I]n context of a motion to convert pursuant to Section 2-402, the Court must examine the evidence and determine (1) the proper standard of care against which Dr. Bakir's conduct is to be measured and (2) whether a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir's guilty of an unskilled or negligent failure to comply with the applicable standard; and (3) a resulting injury proximately

caused by his want of skill or care." C924.

As an initial matter, the trial court did not apply the proximate cause standard as required by section 2-402 in determining plaintiff had failed to establish the standard of care applicable to Bakir. C924. Rather, the court treated such determination as an issue of law, instead of an issue of fact, and substituted its own, flawed, interpretation of Dr. Minore's opinion as to the standard of care. C924-926. The trial court alleged that Dr. Minore opined that the standard of care applicable to Bakir was set forth in the Medtronic emergency procedures. C925. However, as set forth above, Dr. Minore opined the standard of care required Bakir to recognize the differential diagnosis of baclofen withdrawal syndrome and provide treatment to Donald for baclofen withdrawal syndrome in a timely manner. C112. In rendering its decision as to standard of care the trial court both utilized the incorrect standard and narrowly applied the evidence to deny the plaintiff's motion to convert Bakir from a respondent in discovery to a defendant.

With regards to the issues of breach of the standard of care and proximate cause of Donald's injury, the trial court described its position, essentially, as the trier of fact. The court stated:

> "Before determining probable cause exists, the Court must make evidentiary findings to support the conclusion that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir was negligent and his negligence as a proximate cause of Mr. Cleeton's injuries and death. This requires the Corut to base its findings on its consideration of the evidence before the Court and where the evidence is conflicting, the Court can and must resolve the conflict in reaching its determination. *McGee v. Heimberger,* 287 Ill. App. 3d 242, 248." C929 (citation in original).

The trial court went on to balance and weigh the evidence presented by both the plaintiff and Bakir, to find that Bakir had breached no standard of care and caused no harm

to Donald. Specifically, the court held "[Bakir] considered Mr. Cleeton's presentation of symptoms. Those symptoms did not indicate Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome. Dr. Bakir considered the tests that had been performed. Those tests did not indicate…Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome." C931. Whether Donald's presentation of symptoms and test results were indicative of baclofen withdrawal syndrome is an issue of fact, which has been contested based upon the opinion of Dr. Minore and the testimony of various physicians, including Bakir. Further, the issue of whether Bakir reasonably believed Donald's symptoms generated from a urinary tract infection, in the face of evidence indicating improvement of the infectious process, is also a disputed issue of fact.

The trial court interpreted *McGee v. Heimberger* (222 Ill. Dec. 752 (1997)), to stand for the premise that, for purposes of section 2-402, the court steps into the shoes of the jury and becomes the finder of fact. However, the court relied upon an incomplete recitation of law set forth in *McGee v. Heimberger.* The particular portion cited addresses only the standard of review. Specifically, the court in that case stated:

> "A trial court's ruling on a motion to add a respondent in discovery as a defendant is entitled to deference in circumstances in which the court has heard testimony and resolved conflicting evidence, and the reviewing court will not overturn the trial court's ruling unless it is against the manifest weight of the evidence. [Citation]
>
> However, where (1) the facts are undisputed, (2) the credibility of witnesses is not an issue, and (3) in-court testimony has not been presented, a question of law is presented and a reviewing court may consider the question *de novo." McGee*, 222 Ill. Dec. at 756.

When read in its entirety, *McGee v. Heimberger* does not stand for the premise that the trial court *must* resolve conflicting evidence. *Id.* In fact, the court set forth very specific matters in which the court could resolve conflicts in evidence: namely, disputed facts,

issues of credibility, and in-court testimony. None of these three factors is present in this matter. The facts of the case themselves are not in dispute. The care Donald received is set forth in the medical records and has been attested to by various physicians. The dispute is not with regards to the facts of the case, but whether the facts presented indicate a reasonable pulmonology critical care physician should have reasonably recognized that Donald was suffering from baclofen withdrawal syndrome and provided appropriate and timely treatment for such condition, or more generally, duty, breach, and proximate cause. These ultimate issues in the case, which are supported by contested expert opinions and must be determined by the trier of the fact. In fact, the court in *McGee v. Heimberger* agreed, stating where the parties present conflicting facts supporting two different conclusions, it is a matter of fact that the jury must decide and is not within the purview of the court. *McGee,* 222 Ill. Dec. at 757. By weighing conflicting evidence and rendering opinions as to issues of fact, abrogating the position of a jury, the trial court exceeded its authority and, essentially, required the plaintiff to prove more than she would be required to survive summary judgement to convert Bakir from a respondent in discovery to a defendant.

In affirming the lower court's decision, the Court of Appeals, Fourth Circuit reasoned that the plaintiff failed to meet the probable cause burden pursuant to section 2-402 because although Dr. Minore's certificate of merit "sets forth the ways in which Dr. Bakir allegedly deviated from the standard of care" it did not set forth the actual standard of care applicable to Bakir. A-13. However, a direct statement of the applicable standard of care is not required; rather, a statement in a section 2-622 certificate of merit setting forth the was a physician deviated from the standard of care has been found sufficient

evidence of the standard of care to grant a motion to convert a respondent in discovery to a defendant. See *Long v. Mathew*, 270 Ill. Dec.776, 778 (2003) (statement by section 2-622 physician that radiologist failed to interpret and report x-ray studies sufficient to establish proximate cause), *Williams v. Medenica*, 211 Ill. Dec. 619, 622 (1995) (section 2-622 physician's claim that charting deficiencies in the medical records were indicative of similar deficiencies in care was sufficient to establish proximate cause). The court of appeals cited no authority for its contention that Dr. Minore's statement regarding Bakir's breach of the standard of care was insufficient to establish the applicable standard of care.

Neither of the lower courts applied the proper evidentiary standard to determine proximate cause. Rather, both the trial court and court of appeals utilized elevated standards, more similar to the requirements to survive summary judgement than to establish a meritorious claim under section 2-622, in ruling on plaintiff's motion to convert Bakir from a respondent in discovery to a defendant. Applying such elevated standard was in error and an abuse of discretion.

When the proper burden of proof to establish probable cause is applied to the evidence presented in this matter, it is clear that a man of ordinary caution and prudence would have an honest and strong suspicion that Bakir owed a duty of care to Donald which required him to diagnose baclofen withdrawal syndrome and provide timely treatment to Donald for baclofen withdrawal, including ordering an intrathecal injection of baclofen. Further, a man of ordinary caution and prudence would have an honest and strong suspicion that Bakir's breach of his duty of care caused or contributed to Donald's death.

II. The Rulings of the Lower Courts are Against Public Policy and the Legislative Intent of Section 2-402

The court's ruling in this matter is not limited to the rights of the parties of this case. Rather, how this court interprets the proximate cause requirement for conversion under section 2-402 will have broad applications to medical malpractice cases across the state and will affect plaintiffs use of respondents in discovery in future cases.

Section 2-402 was initially created to benefit a very specific demographic: doctors. "The legislative history of section 2-402 indicates that its purpose was to provide plaintiff's attorneys with a means of filing medical malpractice suits without naming everyone in sight as a defendant." *Moscardini v. Neurosurg, S.C.*, 206 Ill. Dec. 855, 859 (1994), citing *Clark v. Brokaw Hospital,* 81 Ill. Dec. 781 (1984). The legislature, however, was not concerned with provided benefit to plaintiffs. The legislature was concerned with the affect being named a defendant had on physicians, particularly as "It was believed that the label of 'defendant' in a medical malpractice suit contributed to the spiraling costs of medical malpractice insurance." *Id.* While section 2-402 may now be utilized to name respondents in discovery in any civil action, it was initially enacted to ensure medical malpractice litigation did not become "overly burdensome" to potential defendants, while still allowing plaintiffs to obtain necessary information from potentially liable treaters. *Id.* at 859.

In enacting section 2-402, the legislature recognized that being named as a defendant had a negative effect on doctors. Prior to the advent of section 2-402, the only means a plaintiff had to obtain necessary discovery from a physician, who may or may not have been negligent in his care of his patient, was to name said physician as a defendant, proceed through the discovery process, and, if discovery disclosed no liability on behalf of the physician, dismiss him from the case, but only after he had incurred substantial

litigation costs, born by his malpractice insurance carrier. As a result, malpractice insurance costs rose, and in turn caused an increase in the cost of healthcare.

Historically, the burden to convert a respondent in discovery to a defendant has been a low threshold. In every appellate court case where the plaintiff met the procedural requirements set forth in section 2-402, conversion has been allowed or the matter was reversed and remanded with instruction the lower court consider excluded evidence. See *Moscardini,* 206 Ill. Dec. 866 (1994), *Ingle v. Hospital Sisters Health System*, 96 Ill. Dec. 325 (1986), *Jackson-Baker v. Immesoete*, 272 Ill. Dec. 688 (2003), *McGee v. Heimberger,* 222 Ill. Dec. 752 (1997), *Long v. Mathew*, 270 Ill. Dec. 776 (2003), *Williams v. Medenica*, 211 Ill. Dec. 619 (1995). The courts reasoned "the purpose of encouraging plaintiffs to name medical providers as respondents-in-discovery rather than defendants will not be served if a high degree of likelihood of success is necessary to be shown before such respondents can be named as defendants." *Ingle*, 96 Ill. Dec. at 328. The courts believed, correctly, that plaintiffs would continue to name physicians as defendants, rather than utilizing the respondent in discovery option, if such high burden was required to convert respondents in discovery to defendants. *Id.* Because of the benefit doctors receive by being named a respondent in discovery rather than a defendant, the courts did not wish to discourage plaintiffs from utilizing section 2-402. *Long*, 270 Ill. Dec. at 783.

If the ruling of the Court of Appeals, Fourth District in this matter is upheld, this court will set a precedent that the evidence necessary to convert a respondent in discovery to a defendant pursuant to section 2-402 is substantially higher than compliance with the Healing Arts Malpractice Act (735 ILCS 5/2-622 (West 2013)) requires to file a medical malpractice case against a physician at the outset. This would present a quandary for

plaintiffs: either name potentially innocent physicians as defendants at the outset of the case, or take the risk of being unable to convert the physician within the statutory period by naming him as a respondent in discovery. It is unlikely plaintiffs or their attorneys will be willing to take the risk of continuing to name physicians as respondents in discovery, particularly as naming potential defendants as respondents in discovery confers no benefit to the plaintiff.

The negative effects of this court affirming the appellate court decision will be broad in scope. More physicians will be named as defendants. Costs of defending medical malpractice cases will rise, followed by the cost of medical malpractice insurance and the cost of healthcare in general. Furthermore, the joinder of additional defendants in medical malpractice cases will lead to delays in litigation due to scheduling conflicts among multiple attorneys, and cases are more likely to required significant involvement of the court due to increased motion practice involved with numerous defendants.

The result of upholding the court's ruling in this case will be, in essence, to gut section 2-402, rendering it useless. It is a fundamental principle of statutory construction that courts are to give effect to the intent of the legislature. *Long*, 270 Ill. Dec. at 782. It was certainly not the legislature's intent to enact an impractical and unused statute which imparts benefit to no one.

CONCLUSION

For the reasons set forth herein, the Supreme Court of Illinois should reverse the judgment of the Court of Appeals, Fourth District and remand this matter to the Circuit Court for the Seventh Judicial Circuit, Sangamon County, with direction to allow plaintiff to convert Mouhamad Bakir, M.D. from a respondent in discovery to a defendant.

Respectfully Submitted,

/s/ Katherine E. Perry
Katherine E. Perry
Timothy M. Shay
SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, Illinois 62704
(217) 523-5900
kperry@shayandassociates.com
timothyshay@shayandassociates.com
Attorneys for Plaintiff-Appellant

CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rules 341(a) and (b). The length of this brief, excluding the pages contained in the Rule 341(d) cover, the Rule 341(h)(1) table of contents and statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is 33 pages.

/s/ Katherine E. Perry
Katherine E. Perry

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OF ILLINOIS

FOURTH DISTRICT

CAROL CLEETON, as Independent Administrator of the Estate of Donald Cleeton, Deceased, Plaintiff-Appellant, v. SIU HEALTHCARE, INC.; CHARLENE YOUNG; ABDULLAH AL SAWAF; SIU PHYSICIANS & SURGEONS, INC., d/b/a SIU MEDICINE, an Illinois Corporation; STEPHANIE WHOOLEY; SUE FERRILL; ASHLEY KOCHMAN; and MEDTRONIC, INC., Defendants, and MEMORIAL MEDICAL CENTER; MOUHAMAD BAKIR; JESSICA FARLEY; NAUMAN JAHANGIR; HANNAH PURSEGLOVE; NATALIE MAHONEY; JONATHAN RODERICK DUTT; AND SHILPA CHAKU, Respondents in Discovery (Mouhamad Bakir, Appellee).	)	Appeal from the Circuit Court of Sangamon County No. 19L32 Honorable Raylene Grischow, Judge Presiding.

JUSTICE TURNER delivered the judgment of the court.
Justices DeArmond and Holder White concurred in the judgment.

ORDER

¶ 1 *Held*: The circuit court properly denied plaintiff's motion to convert respondent in discovery, Dr. Mouhamed Bakir, to a defendant.

¶ 2 Plaintiff, Carol Cleeton, as the independent administrator of the estate of Donald Cleeton, deceased, appeals the Sangamon County circuit court's May 3, 2021, order denying her motion to convert Dr. Mouhamad Bakir from a respondent in discovery to a defendant under section 2-402 of the Code of Civil Procedure (Procedure Code) (735 ILCS 5/2-402 (West 2018)).

The order also terminated Dr. Bakir's status as a respondent in discovery. On appeal, plaintiff contends the circuit court erred by denying her motion to convert Dr. Bakir to a defendant because (1) it failed to apply the proper standard of probable cause; (2) it erred in finding plaintiff failed to establish the standard of care applicable to Dr. Bakir; (3) it exceeded its authority by determining decedent's signs and symptoms were inconsistent with baclofen withdrawal syndrome; (4) it exceeded its authority by determining Dr. Bakir complied with the standard of care; and (5) the evidence supports the opinion of Dr. William Minore, plaintiff's expert witness, decedent died from baclofen withdrawal syndrome. We affirm.

¶ 3 I. BACKGROUND

¶ 4 When he was 17 years old, decedent sustained a cervical cord injury that left him a quadriplegic. In December 2014, Dr. Jose Espinosa implanted a Medtronic SynchroMed II programmable pump in decedent to reduce the extent of involuntary muscle spasms decedent experienced. The pump delivered baclofen, which is also known as Lioresal Intrathecal, for spasticity control. After the implantation, decedent's pump was managed by the Southern Illinois University (SIU) Department of Neurology, specifically defendant Charlene Young, a family nurse practitioner, and her clinic nurse, Ashley Kochman. Young and Kochman were employees of defendant SIU Healthcare, Inc.

¶ 5 On October 25, 2017, decedent, then 25 years old, presented with plaintiff, his mother, at the SIU Neurology clinic for a routine pump refill. Kochman and Young unsuccessfully attempted to refill decedent's pump multiple times. Young was eventually able to refill decedent's pump.

¶ 6 On October 29, 2017, around 8:15 p.m., decedent was brought by ambulance to the Memorial Medical Center emergency room because decedent was complaining of abdominal

pain and a headache following his pump refill. Decedent also noted increased spasms since the refill. He also recently had a urinary tract infection. Decedent was seen in the emergency room by Dr. Richard Austin. At 8:30 p.m., Dr. Austin consulted Dr. Nauman Jahangir, a neurology resident. The emergency room notes stated Dr. Jahangir recommended having a Medtronic representative interrogate the device. A Medtronic representative came to the emergency room and interrogated decedent's pump. The interrogation showed no functional error with the pump. The emergency room notes for decedent contain diagnoses of sepsis and acute urinary tract infection. Dr. Austin admitted decedent to the hospital and transferred decedent's care shortly before midnight. In transferring care of decedent, Dr. Austin spoke with Dr. Nichole Mirocha.

¶ 7 On October 30, 2017, Dr. Mirocha telephoned Dr. Bakir, a pulmonary critical care specialist, to have decedent transferred to the intensive care unit (ICU) to address tachycardia, altered mentation, and possible seizures. Dr. Mirocha provided Dr. Bakir with decedent's history, including the interrogation of decedent's baclofen pump in the emergency room. Decedent was transferred to the ICU around 10 a.m., and Dr. Bakir became decedent's managing physician. Dr. Keivan Shalileh, a pulmonary medicine fellow, and Dr. Hannah Purseglove, a resident, were also working in the ICU that day. As a pulmonary critical care specialist, Dr. Bakir was aware of baclofen, but the baclofen pump was not part of his intensive care and pulmonology practice. Prior to October 30, 2017, Dr. Bakir had never had a patient who potentially was experiencing baclofen withdrawal syndrome. Dr. Bakir did a review of decedent's chart, examined decedent, and spoke with plaintiff, who informed him of decedent's difficult pump refill on October 25, 2017. Due to decedent's heart rate, Dr. Bakir immediately consulted cardiology. Dr. Momin Siddique, a cardiologist, responded and ordered tests investigating a possible pulmonary embolism and decedent's elevated troponin level. Dr. Bakir

also consulted neurology, neurosurgery, and the baclofen pump team.

¶ 8 At 10:44 a.m., a Medtronic employee faxed the emergency procedures for baclofen withdrawal to Memorial Medical Center (Medtronic emergency procedure documents), after receiving a request for troubleshooting assistance with decedent's pump. The Medtronic emergency procedure documents were incorporated into Memorial Medical Center's electronic medical records for decedent at 6:44 p.m. on October 30, 2017. In his deposition, Dr. Bakir testified the Medtronic emergency procedure documents were never provided to him while he was caring for decedent.

¶ 9 Around 11:15 a.m., Dr. Abdullah Al Sawaf, a neurologist, and Dr. Shilpa Chaku, a neurology resident, examined decedent. Dr. Al Sawaf's differential diagnosis for decedent was "mild-moderate baclofen withdrawal vs sepsis (?urine source)." He noted decedent's "[n]ormal tone argues against baclofen withdrawal, but the timeline of events and dysautonomia supports that possibility." Dr. Al Sawaf further found sepsis could present similarly. He asked Young to interrogate decedent's pump to rule out failure. Young did so and reported the pump was working as expected. Dr. Al Sawaf found decedent's episodes in which his eyes would roll back and flutter were likely a dysautonomia phenomenon and not seizures. After Dr. Al Sawaf examined decedent, he and his team spoke with Dr. Bakir and the ICU team about decedent's case. During the discussion, both Dr. Bakir and Dr. Al Sawaf indicated their lack of familiarity with baclofen withdrawal syndrome. Dr. Al Sawaf stated he did not think it was baclofen withdrawal syndrome because decedent's tone was normal. No discussion took place about a possible pump catheter malfunction.

¶ 10 A code blue was called for decedent around 12:07 p.m. due to a lack of pulse. During the code, Dr. Espinosa recommended intrathecal administration of baclofen, which was

given by Dr. Todd Knox at 2:05 p.m. After three hours of resuscitation efforts, decedent was declared dead at 3:06 p.m. Later tests revealed the catheter for decedent's pump had holes in it.

¶ 11 In February 2019, plaintiff filed her wrongful death action against SIU Healthcare, Inc.; Young; and Dr. Al Sawaf. The following were named as respondents in discovery: Memorial Medical Center, Dr. Austin, Dr. Knox, Dr. Bakir, Medtronic, Inc., Dr. Mirocha, Jessica Farley, Sue Ferrill, and Stephanie Whooley. Farley was an emergency room nurse who cared for decedent when he was in the emergency room, and Ferrill and Whooley were employees of Medtronic. As the case progressed, additional defendants were added, as well as respondents in discovery. In September 2019, plaintiff filed a motion to extend Dr. Bakir's status as a respondent in discovery. Dr. Bakir filed a response to plaintiff's motion and a motion to terminate his status as a respondent in discovery. The circuit court granted plaintiff's motion and imposed a deadline of November 13, 2019, to convert Dr. Bakir as a defendant. Plaintiff sought another extension of Dr. Bakir's status as a respondent in discovery, and Dr. Bakir objected.

¶ 12 In November 2019, plaintiff filed a motion to convert Dr. Bakir from a respondent in discovery to a defendant pursuant to section 2-402 of the Procedure Code (735 ILCS 5/2-402 (West 2018)). With the motion, plaintiff filed a certificate of merit by Dr. Minore and proposed counts XXII (wrongful death) and XXIII (survival action) against Dr. Bakir. In his certificate, Dr. Minore opined, within a reasonable degree of medical certainty and based upon a review of the medical records provided by Memorial Medical Center, Dr. Bakir deviated from the standard of care by his failure to timely recognize the differential diagnosis of baclofen withdrawal syndrome, order treatment consistent with the Medtronic emergency procedures, and order the administration of intrathecal baclofen in a timely manner.

¶ 13 Proposed counts XXII and XXIII alleged decedent was transferred to Memorial Medical Center's intensive care unit at 12:01 p.m. on October 30, 2017, and came under Dr. Bakir's care. (The aforementioned time was not supported by the evidence). That same day, Memorial Medical Center received the emergency procedure documents for baclofen withdrawal syndrome from Medtronic at 10:44 a.m. At 11:14 a.m., Bakir had been notified decedent's troponin levels were elevated, an indication for baclofen withdrawal syndrome. Based upon the tests performed and the emergency procedures from Medtronic, it was clear decedent was suffering from baclofen withdrawal syndrome. Dr. Bakir did not order intrathecal baclofen until 1:38 p.m., which was not administered until 2:17 p.m. By that time, it was too late, and decedent died as a result of baclofen withdrawal syndrome. The counts alleged Dr. Bakir had a duty to provide adequate medical care, diagnosis, and treatment to his patients, including decedent, within the standard of care of a reasonably careful critical care physician. According to the counts, Dr. Bakir, contrary to his duty, committed one or more of the following negligent acts or omissions: (1) failed to timely recognize the differential diagnosis of baclofen withdrawal syndrome, (2) failed to order treatment consistent with the Medtronic emergency procedure documents, and (3) and failed to order the administration of intrathecal baclofen in a timely manner. As a direct and proximate result of one or more of Dr. Bakir's aforementioned acts or omissions, decedent sustained a lethal baclofen withdrawal that ultimately caused his death.

¶ 14 Dr. Bakir filed an objection to plaintiff's motion to convert and a memorandum of law supporting his objection. Dr. Bakir asserted the discovery refuted the assumptions and conclusions Dr. Minore reached in his certificate of merit, and thus plaintiff failed to establish probable cause for converting Dr. Bakir to a defendant. In support of his objection, Dr. Bakir referred to his deposition, Dr. Al Sawaf's deposition, and the answers to interrogatories by

Memorial Medical Center, Young, and Dr. Al Sawaf.

¶ 15 Plaintiff filed a reply to Dr. Bakir's objection, asserting, *inter alia*, the standard of care set forth by Dr. Minore was broader than the Medtronic emergency procedure documents and required Dr. Bakir to timely recognize baclofen withdrawal syndrome and timely order the administration of intrathecal baclofen to treat baclofen withdrawal syndrome. To the reply, plaintiff attached decedent's medical records, some materials from Medtronic, Dr. Bakir's deposition, and Dr. Shalileh's deposition.

¶ 16 On April 12, 2021, the circuit court heard arguments on plaintiff's motion to convert. The court took the matter under advisement and gave the parties 14 days to submit proposed orders. On May 3, 2021, the court entered its written order, denying plaintiff's motion to convert and terminating Dr. Bakir's status as a respondent in discovery. The court found (1) the Medtronic emergency procedure documents did not set forth the standard of care by which Dr. Bakir's conduct must be measured and, (2) even if the Medtronic emergency procedure documents did set forth the standard of care for Dr. Bakir, the evidence negates the basis upon which Dr. Minore relied upon in reaching his opinion a reasonable and meritorious cause existed for filing a medical malpractice action against Dr. Bakir. Included in the circuit court's order was a finding pursuant to Illinois Supreme Court Rule 304(a) (eff. Mar. 8, 2016) no just reason exists for delaying the enforcement or appeal from this order.

¶ 17 On May 18, 2021, plaintiff filed a timely notice of appeal in sufficient compliance with Illinois Supreme Court Rule 303 (eff. July 1, 2017). Accordingly, this court has jurisdiction under Rule 304(a).

¶ 18 II. ANALYSIS

¶ 19 On appeal, plaintiff challenges the circuit court's denial of her request to convert

Dr. Bakir from a respondent in discovery to a defendant under section 2-402 of the Procedure Code (735 ILCS 5/2-402 (West 2018)).

¶ 20 A. Standard of Review

¶ 21 Reviewing courts have applied different standards of review for a circuit court's determination of whether to convert a respondent in discovery to a defendant under section 2-402. Illinois courts have reviewed the issue *de novo* under the following circumstances: "(1) the facts are undisputed, (2) the credibility of the witnesses is not an issue, and (3) in-court testimony has not been presented." *Jackson-Baker v. Immesoete*, 337 Ill. App. 3d 1090, 1093, 787 N.E.2d 874, 877 (2003). When the circuit court has made factual determinations regarding conflicting evidence, some cases have applied an abuse of discretion standard (*Long v. Mathew*, 336 Ill. App. 3d 595, 600, 783 N.E.2d 1076, 1080 (2003) (citing *Froehlich v. Sheehan*, 240 Ill. App. 3d 93, 103, 608 N.E.2d 889, 896 (1992)); *Ingle v. Hospital Sisters Health System*, 141 Ill. App. 3d 1057, 1065, 491 N.E.2d 139, 144 (1986)) while others have applied the manifest weight of the evidence standard (*McGee v. Heimburger*, 287 Ill. App. 3d 242, 248, 678 N.E.2d 364, 368 (1997) (citing *People v. Enis*, 163 Ill. 2d 367, 393, 645 N.E.2d 856, 867 (1994)). In this case, the circuit court did not hold an evidentiary hearing and the parties presented documentary evidence, but the circuit court noted in its written order it resolved conflicting evidence in making its determination. However, we can address the merits of this appeal on the uncontested evidence, and thus we apply the *de novo* standard of review.

¶ 22 B. Probable Cause Under Section 2-402

¶ 23 Plaintiff contends the circuit court erred in its application of the probable cause standard contained in section 2-402. Since we are applying the *de novo* standard of review, we need not specifically address whether the circuit court properly applied the probable cause

standard. Instead, we will set forth the probable cause standard.

¶ 24 Section 2-402 allows plaintiffs to add respondents in discovery as defendants in a lawsuit where "the evidence discloses the existence of probable cause for such action." 735 ILCS 5/2-402 (West 2018). Illinois courts have explained the quantum of evidence necessary to establish probable cause under the statute as follows. "[T]he evidence necessary to establish the requisite probable cause need only be such as would lead a person of ordinary caution and prudence to believe or entertain an honest and strong suspicion that his injury was the proximate result of the tortious conduct of the respondent in discovery." *Williams v. Medenica*, 275 Ill. App. 3d 269, 272, 655 N.E.2d 1002, 1004 (1995) (citing *Froehlich*, 240 Ill. App. 3d at 100, 608 N.E.2d at 894; *Ingle*, 141 Ill. App. 3d at 1062, 491 N.E.2d at 142). However, the evidence "need not rise to the level of a high degree of likelihood of success on the merits or the evidence necessary to defeat a motion for summary judgment in favor of the respondents in discovery, nor is the plaintiff required to establish a *prima facie* case against the respondent in discovery." *Williams*, 275 Ill. App. 3d at 272, 655 N.E.2d at 1004 (citing *Ingle*, 141 Ill. App. 3d at 1062-65, 491 N.E.2d at 142-44). This court has described probable cause as a "low threshold." *McGee*, 287 Ill. App. 3d at 249, 678 N.E.2d at 368. However, we also have stated the circuit court's role was "gatekeeper—to simply assess whether it is fair to let the plaintiff proceed further against the respondents in discovery and subject them to the fact-finding process." *McGee*, 287 Ill. App. 3d at 247-48, 678 N.E.2d at 368. Further, before granting a motion to convert a respondent in discovery to a defendant, the court must hold an evidentiary hearing to review the discovery materials showing the plaintiff now has probable cause to name the respondent as a defendant. *Froehlich*, 240 Ill. App. 3d at 103, 608 N.E.2d at 896. Thus, the court considers the plaintiff's assertion of probable cause in light of the existing discovery to determine whether a person of

ordinary caution and prudence would believe or entertain an honest and strong suspicion the injury was the proximate result of the tortious conduct of the respondent in discovery.

¶ 25 Additionally, "[w]hat is sufficient to establish probable cause depends on the nature and complexity of the case." *Medjesky v. Cole*, 276 Ill. App. 3d 1061, 1064, 659 N.E.2d 47, 49 (1995). This court has recognized a medical malpractice case may require "a significantly greater amount of 'evidence' " than a negligence action based on a motor vehicle collision. *Medjesky*, 276 Ill. App. 3d at 1065, 659 N.E.2d at 49.

> " 'In a negligence medical malpractice case, the burden is on the plaintiff to prove the following elements of a cause of action: the proper standard of care against which the defendant physician's conduct is measured; an unskilled or negligent failure to comply with the applicable standard; and a resulting injury proximately caused by the physician's want of skill or care. [Citations.] Unless the physician's negligence is so grossly apparent or the treatment so common as to be within the everyday knowledge of a layperson, expert medical testimony is required to establish the standard of care and the defendant physician's deviation from that standard.' " *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 112, 806 N.E.2d 645, 653 (2004) (quoting *Purtill v. Hess*, 111 Ill. 2d 229, 241-42, 489 N.E.2d 867, 872 (1986).

¶ 26 C. Proper Standard of Care

¶ 27 As stated, the plaintiff must first establish the proper standard of care against which the defendant physician's conduct is to be measured. *Sullivan*, 209 Ill. 2d at 112, 806 N.E.2d at 653. Plaintiff asserts the circuit court erred by finding she failed to establish the proper standard of care against which Dr. Bakir's conduct was to be measured. Specifically, plaintiff

contends the circuit court misinterpreted Dr. Minore's certificate of merit, and she did present evidence of the standard of care. Dr. Bakir contends the circuit court was correct in finding plaintiff relied upon the Medtronic Emergency procedures to establish a standard of care. We agree with Dr. Bakir.

¶ 28 "In a medical malpractice action, the plaintiff must establish the standards of care against which the physician's conduct is measured by the use of expert testimony." *Iaccino v. Anderson*, 406 Ill. App. 3d 397, 402, 940 N.E.2d 742, 747 (2010). "The standard of care requires the defendant to act with 'the same degree of knowledge, skill and ability as an ordinarily careful professional would exercise under similar circumstances.' " *Sekerez v. Rush University Medical Center*, 2011 IL App (1st) 090889, ¶ 58, 954 N.E.2d 383 (quoting *Longnecker v. Loyola University Medical Center*, 383 Ill. App. 3d 874, 885, 891 N.E.2d 954, 963 (2008)). For example, in *Sekerez*, 2011 IL App (1st) 090889, ¶ 59, the reviewing court noted the standard of care was established by the plaintiff's expert witness, who testified the standard of care for the administration of Lovenox was set by guidelines in the hospital's dosing card and the Physician's Desk Reference. The plaintiff's expert further testified a patient's creatine clearance must be calculated to determine if the patient's kidneys are functioning properly prior to administering Lovenox. *Sekerez*, 2011 IL App (1st) 090889, ¶ 59.

¶ 29 In his certificate of merit, Dr. Minore did not expressly set forth the standard of care for a pulmonary critical care specialist treating a critically ill patient with a baclofen pump in the intensive care unit and where the physician had consulted multiple specialists regarding that patient's care.

¶ 30 Here, we agree with the circuit court Dr. Minore attempted to establish the standard of care in his following statement: "Based upon a review of the tests performed, the

presentation of symptoms and the Emergency Procedures faxed by Medtronic representatives, it was clear that [decedent] was suffering from Baclofen Withdrawal Syndrome." (A similar statement is set forth in paragraph 16 of the proposed count XXII). The aforementioned statement can be read to provide the Medtronic emergency procedure documents are the standard of care for treating a critically ill patient with a baclofen pump and decedent's symptoms. Plaintiff's reliance on Medtronic's emergency procedure documents in establishing the standard of care is further evidenced by paragraph 14 of proposed count XXII, which contains an overview of the information in the documents. We further agree with the circuit court the Medtronic emergency procedure documents do not establish the standard of care for measuring Dr. Bakir's conduct. While Memorial Medical Center received the emergency procedure documents from Medtronic at 10:44 a.m. on October 30, 2017, Dr. Bakir testified in his deposition he never received those documents before decedent's death. No other evidence suggests Dr. Bakir did receive the documents prior to decedent's death.

¶ 31 On appeal, plaintiff attempts to avoid reliance on the Medtronic emergency procedure documents for the standard of care and contends Dr. Minore set forth the standard of care in the following paragraph:

> "It is my opinion within a reasonable degree of medical certainty based upon a review of the medical records provided by Memorial Medical Center, that Mouhamad Bakir, M.D., deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner."

While the aforementioned opinion sets forth the ways in which Dr. Bakir allegedly deviated from the standard of care, it does not set forth the *actual* standard of care to which Dr. Bakir's conduct is to be measured. Plaintiff's arguments in her brief regarding the standard of care primarily focus on the alleged deviations from the standard of care as opposed to establishing the actual standard of care for a pulmonary critical care specialist. In fact, in her reply brief, plaintiff asserts she "clearly presented substantial 'evidence' including Dr. Minore's Certificate of Merit and the Plaintiff's medical records to establish probable cause that Bakir *breached the applicable standard of care*." (Emphasis added.)

¶ 32 Moreover, while decedent's medical records may show a deviation from the standard of care, plaintiff does not explain how those records establish the standard of care, which generally requires expert witness testimony (*Sullivan*, 209 Ill. 2d at 112, 806 N.E.2d at 653) and must be established first before addressing any possible deviation. Plaintiff further notes Dr. Bakir testified in his deposition he did have knowledge about baclofen and the symptoms of baclofen withdrawal syndrome. However, we agree with Dr. Bakir, knowledge about a syndrome and its symptoms does not establish the standard of care for a pulmonary critical care specialist. In his deposition, Dr. Bakir testified he was the managing physician for decedent in the ICU, and he had four teams working on decedent. Dr. Bakir worked on supporting decedent's heart rate, managing his blood pressure, and decedent's diagnosis of sepsis. He had other teams working on ruling out baclofen withdrawal syndrome from the differential diagnosis. Dr. Al Sawaf, the neurologist who was addressing the differential diagnosis of baclofen withdrawal syndrome, informed Dr. Bakir he did not think decedent was suffering from the syndrome based on decedent's normal tone. Moreover, Young had reported decedent's baclofen pump was working as expected. Expert testimony about the standard of care

was clearly needed to address this type of complex medical treatment. Thus, plaintiff's attempts to avoid reliance on the Medtronic emergency procedure documents fail because plaintiff did not set forth any expert testimony addressing Dr. Bakir's role as a managing physician with multiple teams of specialists working on decedent's complex medical case in the ICU. None of the cases plaintiff cites in support of her argument addressed a situation where the alleged deviation from the standard of care was being addressed by a consulting physician, who was supposed to have more expertise on the differential diagnosis at issue. Given Dr. Bakir's consultation of other medical professionals and no evidence on the standard of care in such a situation, the supporting evidence did not lead a person of ordinary caution and prudence to believe or entertain an honest and strong suspicion decedent's death was the proximate result of Dr. Bakir's conduct.

¶ 33 Accordingly, we find the circuit court properly found plaintiff failed to establish probable cause Dr. Bakir committed medical malpractice. Thus, we do not address plaintiff's other arguments.

¶ 34 III. CONCLUSION

¶ 35 For the reasons stated, we affirm the Sangamon County circuit court's judgment.

¶ 36 Affirmed.

IN THE CIRCUIT COURT FOR THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, deceased,

Plaintiff,

v.

SIU HEALTHARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., SIU PHYSICIANS & SURGEONS, INC., d/b/a SIU MEDICINE, an Illinois Corporation, STEPHANIE WHOOLEY, SUE FERRIL, ASHLEY KOCHMAN, And MEDTRONIC, INC.,

Defendants

and

MEMORIAL MEDICAL CENTER, MOUHAMAD BAKIR, M.D., JESSICA FARLEY, NAUMAN JAHANGIR, M.D, HANNAH PURSEGLOVE, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHILPA CHAKU,

Respondents in Discovery.

Case No: 2019-L-32

ORDER ON PLAINTIFF'S MOTION TO CONVERT RESPONDENT IN DISCOVERY DR. BAKIR TO A DEFENDANT

This matter comes before the Court on plaintiff's Motion to Convert Respondent in Discovery Mouhamad Bakir, M.D. from a respondent in discovery to a defendant. The Court having considered the plaintiff's motion, the pleadings and documents filed in support and in opposition to the motion, and the arguments of the attorneys and the applicable case law, the Court finds as follows:

FACTS

Plaintiff filed this medical malpractice lawsuit on February 13, 2019, seeking damages for injuries and the death of her son, Donald Cleeton, which she alleges were the result of the medical care and treatment he received at Memorial Medical Center on October 29-30, 2017. Attached to her Complaint is the affidavit of her attorney and a Certificate of Merit from Dr. William Stephen Minore. In his affidavit, plaintiff's attorney states he reviewed the facts of the case with Dr. Minore and Dr. Minore determined in a written

report that there exists a reasonable and meritorious cause for the filing of the action against Charlene Young, R.N., Abdullah Al Sawaf, M. D., and SIU Healthcare, Inc. Dr. Minore's Certificate of Merit was dated February 11, 2019. In the Certificate of Merit, Dr. Minore, stated he had reviewed the medical records from SIU Medicine Department of Neurology, Memorial Medical Center, the autopsy report and toxicology screens of Donald Cleeton, two sets of records obtained from Medtronic regarding the Baclofen pump and catheter, and the studies and testing done of the catheter which revealed operator-related puncture holes. Dr. Minore further stated:

> *My opinions may be modified based upon additional evidence, including the discovery deposition of Dr. Mouhamad Bakir and review of further evidence and testimony of the witnesses.*

Plaintiff did not name Dr. Bakir as a Defendant; instead, plaintiff designated Dr. Bakir as a Respondent in Discovery pursuant to the provisions of 735 ILCS 5/2-402.

On November 13, 2019, plaintiff timely filed the instant Motion to Convert Dr. Bakir to a Defendant. In support of this motion, plaintiff followed the provisions of 735 ILCS 5/2-622 and filed the affidavit of her attorney and another Certificate of Merit from Dr. Minore dated November 12, 2019. In his November 12, 2019, Certificate of Merit, Dr. Minore stated he had reviewed the same materials that he reviewed prior to authoring his February 11, 2019, Certificate of Merit. Dr. Minore did not review Dr. Bakir's deposition before issuing his November 12, 2019 Certificate of Merit. Dr. Bakir's deposition was taken on September 24, 2020, more than 10 months after Dr. Minore authored his Certificate of Merit. Notwithstanding this fact, Dr. Minore concluded Dr. Bakir deviated from the standard of care and stated there was a reasonable and meritorious cause for filing a lawsuit against him.

In his November 12, 2019 Certificate of Merit, Dr. Minore set forth the reasons for his determination that Dr. Bakir deviated from the standard of care. He stated:

> *After a review of the Memorial Medical Center records, the following timeline applies as to the care and treatment rendered by Dr. Mouhamad Bakir, M.D. Dr. Bakir is a critical care specialist and was in charge of the diagnosis and treatment of Donald Cleeton when he was transferred to the Intensive Care Unit at 12:01 p.m. on October 30, 2017. From Dr. Bakir's records, Medtronic's representatives and SIU Neurology clinic staff were contacted. At approximately 10:44 a.m., Memorial Medical Center received the faxed Emergency Procedures documents for Baclofen Withdrawal Syndrome. Inside those*

documents is language of the Emergency Procedures for Intrathecal Baclofen being administered. The records reflect that Dr. Bakir was notified of the elevated Troponin levels at 1:14 a.m. Based upon a review of the tests performed, the presentation of symptoms and the Emergency Procedures faxed by Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome. Intrathecal Baclofen was not ordered until 13:39 and not administered until 14:17. By the time the Intrathecal Baclofen had been administered, it was too late and Donald Cleeton died as a result of Baclofen Withdrawal Syndrome.

It is my opinion within a reasonable degree of medical certainty based upon a review of the medical records provided by Memorial Medical Center, that Mouhamad Bakir, M.D. deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner.

On February 22, 2021, Dr. Bakir filed an Objection to Plaintiff's Motion to Convert. In support of his objection, Dr. Bakir filed the medical records from the October 29-30 Memorial Medical Center admission, his discovery deposition, and the discovery deposition of Dr. Al Sawaf. These documents establish the following facts:

- Dr. Bakir is an internist and pulmonary medicine specialist and practices intensive care pulmonology.

- On the morning of October 30, 2017, Dr. Bakir received a phone call from Dr. Nichole Mirocha, Mr. Cleeton's managing physician. Dr. Mirocha provided Dr. Bakir Mr. Cleeton's history from October 29, 2017. She advised him Mr. Cleeton had been seen in the emergency department for complaints of abdominal pain, headache and leukocytosis (elevated white blood cell count). While in the emergency department he had been seen by a "pump specialist" from Medtronic because of a concern that his Baclofen pump was not functioning properly. At that time the pump was interrogated and it was found to be functioning properly. Mr. Cleeton was admitted to the hospital and started on antibiotics to treat sepsis that originated from a urinary tract infection. Dr. Mirocha advised Dr. Bakir Mr. Cleeton was experiencing tachycardia and losing consciousness and was being seen by the neurology and cardiology services. They called a rapid response and were transferring Mr. Cleeton to the intensive care unit for tachycardia, altered mental status and possible seizures.

- Mr. Cleeton arrived at the intensive care unit at Memorial Medical Center around 10:00 a.m. on October 30, 2017. Dr. Hannah Purseglove, a resident working with Dr. Bakir, obtained a history that Mr. Cleeton was a 25-year-old male with quadriplegia since 2009 after a pool accident. Mr. Cleeton presented to the emergency department on October 29, 2017 with complaints of muscle spasms in his abdomen. Mr. Cleeton had a Baclofen pump that was managed by SIU Neurology. The pump had been refilled on October 25, 2017. Mr. Cleeton was usually stable at that dose of medication. Mr. Cleeton's mother reported the refill was more difficult than normal and possibly complicated. In the emergency department, a Medtronic representative interrogated the Baclofen pump and concluded it

was working properly at the correct dose. Mr. Cleeton was found to have an elevated white blood cell count of 24.5, a lactic acid level of 2.5 and a urinalysis specimen that was positive for a urinary tract infection. Dr. Purseglove noted Mr. Cleeton had a history of recurrent urinary tract infections and had been followed by the SIU Infectious Disease Department for this problem. Dr. Purseglove noted Mr. Cleeton had a decreased level of consciousness and heart rate in the 190's on the medical floor. A rapid response was called around 10:00 a.m., and Mr. Cleeton was subsequently transferred to the intensive care unit.

- Dr. Bakir's differential diagnoses included septic shock secondary to urosepsis, possible Baclofen withdrawal/pump malfunction, elevated troponin possibly secondary to severe tachycardia versus sepsis versus myocarditis versus pulmonary embolus, and decubitus ulcers with questionable osteomyelitis.

- Based on Mr. Cleeton's presentation, Dr. Bakir requested consultations from specialists in cardiology and neurology. In addition, he requested assistance from Medtronic, the pump manufacturer, and the neurology staff who managed the pump.

- Dr. Momin Siddique, a cardiologist, responded to Dr. Bakir's request for a cardiology consultation. Dr. Siddique ordered a stat CT of the chest to investigate a possible pulmonary embolism, and an echocardiogram to investigate an elevated troponin level.

- Dr. Bakir consulted with Dr. Abdullah Al Sawaf, a neurologist, regarding the Baclofen pump and seizure work up.

- Dr. Al Sawaf and Dr. Shilpa Chaku, a resident, evaluated Mr. Cleeton at 11:15 a.m. on October 30, 2017. They obtained a history that Mr. Cleeton presented to the Emergency Department with leukocytosis and lactic acidosis. His urinalysis was positive for a urinary tract infection. His Baclofen pump had been checked in the emergency department and was found to be functioning properly. He had increasing muscle spasms. On the morning of October 30, 2017, he experienced an episode of eyes fluttering but he remained responsive during the episode. He had significant autonomic instability and had been transferred to the intensive care unit. Mr. Cleeton did not have a fever.

  On physical examination, it was noted Mr. Cleeton was awake and alert and able to answer questions appropriately. He followed commands and had spastic contractures in his upper extremities bilaterally. The tone in his lower extremities was "okay" and he was hyporeflexic. He appeared to be having abdominal spasms. During the examination he had an episode of eyes rolling back and fluttering but he was able to respond to verbal coaching from his mother.

  Dr. Al Sawaf's differential diagnosis was mild-moderate Baclofen withdrawal versus sepsis, normal tone argues against Baclofen withdrawal, but the timeline of events and dysautonomia supports that possibility. He noted sepsis could present similarly. The episodes of eyes roving were not seizures but likely a dysautonomia phenomenon.

  After he evaluated Mr. Cleeton, Dr. Al Sawaf spoke to Dr. Bakir. Dr. Bakir asked Dr. Al Sawaf whether he believed Mr. Cleeton was experiencing Baclofen withdrawal. Dr. Al Sawaf informed Dr. Bakir he did not believe Mr. Cleeton was experiencing Baclofen withdrawal because he had normal tone.

- Dr. Bakir is not an expert on Baclofen pumps. He has never been trained in the use of a Baclofen pump. His training in intensive care and pulmonology does not include training on the use of the Baclofen pump. Dr. Bakir requested assistance from Charlene Young and the neurology staff who had been involved in its management. He also requested assistance from Medtronic, the pump manufacturer. At 11:05 the Medtronic intrathecal Lioresal pump representative was paged for interrogations of the pump.

- After Dr. Bakir had requested consultations from the cardiology and neurology services, and ordered an investigation into the pump function, Mr. Cleeton started being less responsive and had labile blood pressures. At that point Dr. Bakir focused on a diagnosis of sepsis because that is the most likely condition that explained Mr. Cleeton's presentation. Mr. Cleeton had multiple sources of infection that supported a diagnoses of sepsis including a urinary tract infection with a very high white count in the urine and blood, decubitus ulcers that were stage IV with bone showing through the ulcer. The diagnosis of sepsis was confirmed by a high lactic acid level that was rising.

- Dr. Bakir consulted with other team members about what to do if Mr. Cleeton was in Baclofen withdrawal. This needed to be confirmed before administering Baclofen because if Mr. Cleeton was not in Baclofen withdrawal, administration of Baclofen could cause a Baclofen overdose.

- Dr. Bakir was also consulting with the cardiology service to determine if Mr. Cleeton had a pulmonary embolus or heart problems including a myocardial infarction, myocarditis, or ischemic heart disease.

- At 12:07 Mr. Cleeton went into cardiac arrest and a Code was called.

- During the Code, Dr. Bakir relied on the four teams involved in Mr. Cleeton's care for their respective areas of expertise. Dr. Bakir provided supportive care to address the tachycardia, hypotension, and administering CPR. Charlene Young interrogated the pump, aspirating the Baclofen and re-introducing it and determined the pump was functioning properly. A neurology and neurosurgery team was consulted regarding the Baclofen management.

- During the Code, the decision was made to administer intrathecal Baclofen because they had done everything for Mr. Cleeton and he was still coding. Even if it was a remote possibility, Baclofen was administered to give him every chance to recover from the Code.

- The Code was terminated at 15:06 at which time Mr. Cleeton was pronounced dead.

- After Mr. Cleeton's death an autopsy was performed. The pathologist, Dr. Nathaniel Patterson, concluded Mr. Cleeton's death was the result of the sequelae of quadriplegia due to remote cervical spine fracture.

On March 15, 2021, plaintiff filed a Reply to Dr. Bakir's Objection. In her Reply, plaintiff argued Dr. Bakir deviated from the standard of care by relying on a diagnosis of sepsis as an explanation for Donald Cleeton's presentation on October 30, 2017. According to plaintiff, there was "clear evidence his infectious process had improved, if not entirely resolved, prior to his transfer to the ICU" at 10:00 a.m. Thus, in the

absence of a reasonable basis to conclude sepsis was the cause of Mr. Cleeton's presentation, plaintiff argued that Dr. Bakir deviated from the standard of care by failing to diagnose and treat Baclofen withdrawal.

Plaintiff did not file expert opinion testimony in support of her position that her son's infection had improved or entirely resolved by the time he was admitted to the intensive care unit. Instead, she relied solely upon her own interpretation of the medical records in advancing the argument Donald Cleeton was cured of his sepsis. Plaintiff cited the following in support of her argument.

- A urinalysis obtained on October 29, 2017, at 10:10 p.m. showed amber cloudy infected urine; a urine culture obtained around the same time showed moderate probable contaminants and growth of 100,000 cfu/ml Klebsiella pneumoniae,
- Urine collected by a catheter at 10:05 p.m. on October 29, 2017 and on October 30, 2017 at 04:45 a.m. was observed by a nurse to be purulent, dark yellow, and foul smelling,
- Mr. Cleeton received two doses of antibiotics (Cefepime at 10:50 p.m. on October 29, 2017; Vancomycin at 11:21 p.m. on October 29, 2017),
- Urine collected by a catheter on October 30, 2017 at 10:00 a.m. was clear yellow and without foul odor,
- A blood culture was collected on October 30, 2017 at 00:06 a.m., which subsequently found to show growth of Coagulase negative Staphylococcus,
- A "follow up" blood culture collected on October 30, 2017 at 01:20 showed no growth of bacteria or yeast after five days of incubation, and
- Dr. Bakir was aware the blood culture performed on October 30, 2017 at 01:20 showed no signs of growth as of 11:51 a.m. that day.

In addition, plaintiff argued Mr. Cleeton presented with signs and symptoms of autonomic dysreflexia and that this condition can "resemble" Baclofen Withdrawal Syndrome. Based on these facts, plaintiff argues Dr. Bakir should have diagnosed Baclofen Withdrawal Syndrome.

On April 5, 2021, Dr. Bakir filed a Response to Plaintiff's Reply. In that response, Dr. Bakir offered the following evidence.

- Mr. Cleeton's urinary tract infection was due to a Klebsiella pneumoniae bacteria. This diagnosis was confirmed by a urine culture collected on October 29, 2017 at 21:23. A urine culture was not repeated prior to Mr. Cleeton's death. Because the urine culture was not repeated, there is no evidence the urinary tract infection had resolved by the time Mr. Cleeton was admitted to the intensive care unit.

- Mr. Cleeton also had blood cultures. The first blood culture was collected on October 30, 2017 at 00:06 a.m. The preliminary report of this culture was first reported at 22:42 on October 30, 2017 after Mr. Cleeton's death and showed Gram positive cocci in clusters, probably Staphylococcus species based on gram stain morphology. On October 31, 2017 at 13:24, the final report identified growth of Coagulase negative Staphylococcus species.

- The second blood culture was obtained on October 30, 2017 at 01:20 a.m. This culture was first reported at 24 hours on October 31, 2017 at 02:00 a.m. It was reported as showing no growth after 24 hours. The same result was reported at 48 hours, 72 hours, four days and the final report was on November 4, 2017 after five days of incubation.

- Mr. Cleeton's urinary tract infection was due to a Klebsiella pneumoniae bacteria. The bacteria identified on the blood culture was a Coagulase negative Staphylococcus species bacteria. These are two entirely separate and distinct pathogens. Therefore, the fact that the blood culture obtained on October 30, 2017 at 01:20 showed no growth does not prove the urinary tract infection, which was the result of a Klebsiella pneumoniae, a different pathogen, had resolved. Plaintiff compared two unrelated results and concluded the negative blood culture demonstrates the urinary tract infection was resolved.

- The initial blood culture collected on October 30, 2017 at 00:06 a.m. demonstrated Coagulase negative Staphylococcus species. The Coagulase negative Staphylococcus could have been from Mr. Cleeton's decubitus ulcers rather than the urinary tract.

- The second blood culture collected on October 30, 2017 at 01:20 was collected after Cefepime and Vancomycin had been given. Cefepime was administered on October 29, 2017 at 22:50 and October 30, 2017 at 12:01. Vancomycin was administered at 23:21.

- Administering an antibiotic before blood is collected for a blood culture results in a significant loss of pathogen detection. This fact is demonstrated by the fact Nurse Jessica Farley, the Emergency Room nurse, had to obtain permission from Dr. Austin, the Emergency Room physician, to start antibiotics before the blood cultures were complete. At 22:37 she noted "MD stated ok to start antibiotics before blood cultures complete; lab unable to get cultures will send another lab tech".

- The fact a blood culture obtained after antibiotics were administered is negative does not mean or imply that the patient does not have sepsis. Rather, it may mean the pathogen's growth has been suppressed by the antibiotic and the culture is incapable of identifying it.

- The fact that the 00:06 culture ultimately showed a Staphylococcus bacteria and the 01:20 culture ultimately showed no growth does not mean an antibiotic was effective in resolving the sepsis. No antibiotic would resolve an infection within an hour.

- Dr. Bakir did not conclude Mr. Cleeton's sepsis had resolved by 11:51 a.m. on October 30, 2017. At that time a nurse, Monica Gould, R.N. performed a vascular access visit and discussed the risk of infection when placing a central line. Dr. Bakir advised her the blood cultures were negative at that time.

- The fact the cultures were negative at that time does not establish Dr. Bakir had ruled out sepsis. At that time the cultures had not yet established the existence of a bacteria on the culture. Based on the reports from the 01:20 culture, the earliest a culture is reported is 24

hours. The 00:06 and the 01:20 cultures were not reported by 10:00 a.m. on October 30, 2017. The 00:06 culture was reported on October 30, 2017 at 22:42 and the 01:20 culture was reported the following day, October 31, 2017, at 02:01. Both of these reports were issued after Mr. Cleeton's death. Dr. Bakir could not have known the cultures would be negative by the time Mr. Cleeton was admitted to the ICU. The fact the cultures were later reported as showing no growth could not form the basis for Dr. Bakir to rule out sepsis at that time. Even if Dr. Bakir was aware of these reports, a negative culture does not rule out sepsis.

- The diagnosis of sepsis is demonstrated by Mr. Cleeton's elevated white blood cell count that was clearly elevated at all times during Mr. Cleeton's admission. A normal white blood cell count is 3.4-9.4. Mr. Cleeton's white blood cell counts were consistently abnormally high from the time of his admission (24.5 at 20:30), through the morning of October 30, 2017 (27.5 at 07:00, 26.3 at 12:28).

- The diagnosis of sepsis is also demonstrated by Mr. Cleeton's abnormally elevated lactic acid levels. A normal lactic acid level is 0.5 to 2.0. At 09:46 on the morning of October 30, 2017, Mr. Cleeton's lactic acid level was 2.8. This level increased to 10.7 by 12:28.

- Baclofen withdrawal would not cause elevations in Mr. Cleeton's white blood cell count and lactic acid levels.

- Autonomic dysreflexia (also known as dysautonomia) is a condition known to occur in patients with upper spinal cord injuries. Mr. Cleeton's spinal cord injury was located at the 5th and 6th cervical vertebrae. Patients with injuries at the C5-C6 level can experience dysautonomia. Dysautonomia occurs when the autonomic nervous system is not working properly. Because the autonomic nervous system regulates things like blood pressure and heart rate, patients with dysautonomia can experience fluctuations in blood pressure and heart rate. Dysautonomia can be triggered by stimulation. Frequent triggers for dysautonomia include infections. Mr. Cleeton had dysautonomia at baseline and as a result it was not unusual that his heart rate and blood pressure would fluctuate. On October 30, 2017 Mr. Cleeton had a urinary tract infection. The circumstances Mr. Cleeton presented on October 30, 2017, including baseline dysautonomia, a urinary tract infection, elevations in his white blood cell count, and elevations in his lactic acid level, were all consistent with a urinary tract infection that resulted in a sepsis that triggered an autonomic dysreflexia. The fact Mr. Cleeton had an exacerbation of his baseline dysautonomia on October 30, 2017 is consistent with the fact he had a urinary tract infection. And the fact Mr. Cleeton had dysautonomia in the context of a urinary tract infection would not lead to the conclusion that the dysautonomia is due to Baclofen withdrawal.

ANALYSIS

Section 2-402 of the Illinois Code of Civil Procedures sets forth the purpose of the respondent in discovery statute and the requirements for converting a person designated a respondent in discovery to a defendant. It states, in pertinent part, the following:

> The plaintiff in any civil action may designate as respondents in discovery in his or her pleading those individuals or other entities, other than the named defendants, believed by the plaintiff to have information essential to the determination of who should properly be named as additional defendants in the action.
>
> Persons or entities so named as respondents in discovery shall be required to respond to discovery by the plaintiff in the same manner as are defendants and may, on motion of the plaintiff, be added as defendants if the evidence discloses the existence of probable cause for such action.

To establish probable cause, a plaintiff must establish that the case against the respondent-in-discovery is such that a man of ordinary caution and prudence would entertain an honest and strong suspicion that the purported negligence of the respondent-in-discovery was a proximate cause of plaintiff's injury. *Ingle v Hospital Sisters Health System*, 151 Ill. App. 3d 1057, 1062 (4th Dist. 1986). What is sufficient to establish probable cause depends upon the nature and complexity of the case. In a medical malpractice case, a significantly greater amount of "evidence" may be necessary as compared to an automobile accident, for example. *Medjesky v Cole,* 276 Ill. App. 3d 1061, 1064-1065 (4th Dist. 1995).

From a procedural standpoint, Section 2-402 requires the plaintiff to introduce "evidence," the Court must hold a hearing, and the Court must make findings based on the evidence that plaintiff has met the burden of establishing probable cause. Only then can a respondent-in-discovery be converted to a defendant. *Torley v Foster G. McGaw Hospital* 116 Ill. App. 3d 19, 22-23 (1st Dist. 1983); *Froehlich v Sheehan* 240 Ill. App. 3d 93, 101-103 (1st Dist. 1992).

In a medical malpractice case, a plaintiff must plead and prove the proper standard of care against which the defendant physician's conduct is measured; an unskilled or negligent failure to comply with the applicable standard; and a resulting injury proximately caused by the physician's want of skill or care. *Mayer v Baisier* 147 Ill. App. 3d 150, 155 (4th Dist. 1986)(*citing Purtill v Hess* 111 Ill. 2d 229, 242-243 (Ill. 1986)). Therefore, in the context of a motion to convert pursuant to Section 2-402, the Court must examine the evidence and determine (1) the proper standard of care against which Dr. Bakir's conduct is to be measured and (2) whether a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard; and (3) a resulting injury proximately caused by his want of skill or care.

This Court finds the evidence is not sufficient enough upon which the Court can agree with Dr. Minore's conclusions pertaining to (1) the standard of care against which Dr. Bakir's conduct is to be measured, and (2) a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard. With respect to the former, the evidence before the Court establishes that the Medtronic Emergency Procedures do not set the standard of care by which Dr. Bakir's conduct must be measured. With respect to the latter, even if the Medtronic Emergency Procedures did set the standard of care for Dr. Bakir, the evidence negates the basis upon which Dr. Minore relies upon in reaching his opinion there exists a reasonable and meritorious cause for filing a medical malpractice cause of action against Dr. Bakir.

A. <u>The Medtronic Emergency Procedures Do Not Establish the Standard of Care Upon Which Dr. Bakir's Conduct is to be Measured</u>

Plaintiff relies upon the Certificate of Merit of Dr. William Stephen Minore, M.D. to establish the standard of care applicable to Dr. Bakir. In his Certificate of Merit, Dr. Minore states:

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

Therefore, according to Dr. Minore, the standard of care required Dr. Bakir to "timely recognize the differential diagnosis of Baclofen withdrawal" based on "the tests performed," "the presentation of symptoms," pursuant to the Medtronic Emergency Procedures documents. The question before the Court, therefore, is whether plaintiff has established the "Emergency Procedures faxed by Medtronic representatives" sets the standard of care against which Dr. Bakir's conduct is to be measured. For the reasons set forth below, the Court finds that the Emergency Procedures faxed by Medtronic representatives do not set the standard of care by which Dr. Bakir's conduct is to be measured.

The evidence establishes that Dr. Bakir was not provided and did not see the FAX while he was attending to Mr. Cleeton. This document was sent to Memorial Medical Center on the morning of October 30, 2017, and incorporated into the Memorial Medical Center electronic medical record at 6:44 p.m. that day. Thus, the FAX was first viewable as part of Mr. Cleeton's medical record three hours and 38 minutes

after his death and could not, therefore, set the standard of care by which Dr. Bakir's conduct must be measured. Alternatively, plaintiff argues a copy of the Medtronic Emergency Procedures instructions were included in a card that plaintiff provided to Dr. Keivan Shalileh, a fellow working with Dr. Bakir. Like the FAX, however, this card was never provided to Dr. Bakir and, could not, therefore, set the standard of care by which Dr. Bakir's conduct must be measured.

B. Even if the Medtronic Emergency Procedures Established the Standard of Care, Plaintiff Has Failed to Establish that a Man of Ordinary Caution and Prudence Would Entertain an Honest and Strong Suspicion that Dr. Bakir is Guilty of an Unskilled or Negligent Failure to Comply with the Applicable Standard of Care

Assuming the Emergency Procedures documents were provided to Dr. Bakir, the Court must consider whether a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir was guilty of an unskilled or negligent failure to comply with the applicable standard of care. In other words, the Court must determine whether "the tests performed" and Mr. Cleeton's "presentation of symptoms" warranted a diagnosis of Baclofen Withdrawal Syndrome. This question requires an analysis of the signs and symptoms Mr. Cleeton presented and the tests performed while under Dr. Bakir's care.

The Emergency Procedures documents identify the signs and symptoms of abrupt or advanced withdrawal as follows:

> Symptoms may progress to include high fever, altered mental status, exaggerated rebound spasticity, and muscle rigidity, in rare cases rhabdomyolysis, and multiple organ-system failure, and death.

Based on the evidence before the Court, Mr. Cleeton did not have a high fever. Baclofen withdrawal causes a fever in excess of 102 Fahrenheit. Based on the Memorial Medical Center records, Mr. Cleeton's temperatures were never that high. Plaintiff presents no evidence to contradict this fact.

Plaintiff argues Mr. Cleeton experienced altered mental status when he had short periods when his eyes would roll back and his eyelids would flutter in an unusual manner resembling seizure activity. Dr. Al Sawaf and Dr. Shilpa Chaku, his neurology resident, investigated these findings on the morning of October 31, 2017. During their evaluation, Mr. Cleeton was awake and alert, able to answer questions appropriately,

and followed commands. According to Dr. Al Sawaf and Dr. Chaku, these findings did not constitute "altered mental status" upon which a diagnosis of Baclofen Withdrawal Syndrome could be made.

Plaintiff contends Mr. Cleeton had increased spasticity, particularly in the abdomen and this finding meets the criteria for Baclofen Withdrawal Syndrome. While it is correct Mr. Cleeton had abdominal spasms, based on the evidence before the Court, this finding was not diagnostic of Baclofen Withdrawal Syndrome. In her discovery deposition, Dr. Chaku, a neurologist, explained the mechanism for spasms in a patient who is experiencing Baclofen withdrawal. According to Dr. Chaku, Baclofen is prescribed for a patient who has a spinal cord injury to reduce muscle tone and spasticity. When a spinal cord injury occurs, the normal signals from the brain to the spinal cord are interrupted. As a result, the muscles activate and become spastic. Baclofen functions to reduce the muscle activation. When a patient who has previously undergone Baclofen therapy experiences withdrawal, the Baclofen is no longer present to prevent the muscle spasms resulting in a return of pain due to the spasms, particularly in the back. During Dr. Chaku's examination on the morning of October 30, 2017, Mr. Cleeton did not complain of back pain or spasms. Rather, his spasms were isolated to his abdomen. With respect to abdominal spasms, Dr. Chaku noted Mr. Cleeton had a known urinary tract infection. Urinary tract infections are a frequent cause of abdominal spasms. During her examination, Dr. Chaku also examined Mr. Cleeton's upper and lower extremities. Mr. Cleeton had spastic contractures of both of his upper extremities. Spastic contractures are known to occur in a patient who has quadriplegia as a result of the spinal cord injury. Mr. Cleeton had been a quadriplegic since 2009. The fact he had spastic contractures of his upper extremities does not indicate he was experiencing rebound spasticity that is diagnostic of Baclofen withdrawal. Spastic contractures and rebound spasticity as a result of Baclofen Withdrawal are two entirely separate and unrelated things. During her neurologic examination, Dr. Chaku also examined Mr. Cleeton's lower extremities and found he had no spasticity or muscle rigidity. To the contrary, Mr. Cleeton was hyporeflexic, the opposite of muscle spasticity and rigidity.

Plaintiff does not argue Mr. Cleeton developed rhabdomyolysis. According to the evidence before the Court, rhabdomyolysis is a serious syndrome due to muscle injury. When Baclofen is withdrawn, the

muscles return to their pre-Baclofen state and develop spasticity. Muscle spasticity then squeezes myoglobin and CPK enzymes out of the muscle cells. The myoglobin and CPK enzymes are then released into the bloodstream. A diagnosis of rhabdomyolysis is made based on the CPK levels in the blood. To warrant a diagnosis of rhabdomyolysis, the CPK levels must be in excess of 5,000 to 10,000. Mr. Cleeton's CPK level was 583 on October 30, 2017 at 09:46 and 484 on October 30, 2017 at 12:28. These levels are a fraction of the levels necessary to make a diagnosis of rhabdomyolysis.

Similarly plaintiff does not argue Mr. Cleeton had multi-system organ failure. According to the evidence before the Court, multi-system organ failure is based upon a diagnosis of renal failure and liver failure. Baclofen withdrawal causes multi-system organ failure as result of the release of CPK enzymes and myoglobin into the bloodstream. When these reach high levels, they are toxic to the liver and kidneys. Mr. Cleeton's laboratory tests never demonstrated he was in renal or liver failure.

Finally, plaintiff argues Mr. Cleeton presented with autonomic dysfunction, autonomic dysfunction can resemble Baclofen Withdrawal Syndrome, and therefore, Dr. Bakir should have diagnosed Baclofen Withdrawal Syndrome. But autonomic dysreflexia also occurs in patients like Mr. Cleeton who have upper spinal cord injuries and urinary tract infections. In fact, Mr. Cleeton's baseline function included repeated episodes of autonomic dysfunction. Therefore, the fact Mr. Cleeton had autonomic dysreflexia does not lead to the conclusion that he had Baclofen Withdrawal Syndrome and is consistent with his baseline in the context of a urinary tract infection.

Based on the foregoing, there is no evidence upon which the Court can agree with Dr. Minore's conclusion that '*...a review of the tests performed, the presentation of symptoms, and the Emergency Procedures faxed by Medtronic representatives*, make it "*clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome.*" The evidence establishes the Emergency Procedures documents were never made available to Dr. Bakir prior to Mr. Cleeton's death and, even if Dr. Bakir had received these documents, none of the conditions set forth in the Emergency Procedures documents as indications of Baclofen Withdrawal Syndrome were present. Thus, not only is there a failure of evidence to support Dr.

Minore's position, the evidence refutes the basis upon which Dr. Minore relies in reaching his opinion there is a reasonable and meritorious cause for filing a medical malpractice cause of action against Dr. Bakir.

Plaintiff's motion to convert was timely filed after an agreed upon extension and before a substantial amount of discovery was undertaken so that plaintiff could comply with the filing deadlines of Section 2-402. This Court is not binding plaintiff to those filings. However, the certificate of merit by Dr. Minore and dated November 13, 2019 states,

> My opinions may be modified based upon additional evidence, including the discovery deposition of Dr. Mouhamad Bakir and review of further evidence and testimony of the witnesses… I reserve the right to amend, modify, or supplement my opinions upon further review of evidence and testimony of witnesses.

The doctor did not supplement or amend his opinions despite additional discovery having been conducted and depositions of several treating physicians having been obtained. Counsel for plaintiff could have provided this additional information to Dr. Minore to determine if his opinions changed in any way, but this was not done.

Accordingly, the Court finds that plaintiff has failed to satisfy her burden of establishing that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard. The Court is mindful of the cases which hold the plaintiff's burden under Section 2-402 is a "low threshold", *McGee v Heimburger* 287 Ill. App. 3d 242, 248-249 (4th Dist. 1997) and does not require a high degree of likelihood of success. *See Ingle v Hospital Sisters Health System*, 141 Ill. App. 3d 1057, 106. The Court is also mindful, however, that in its role as gatekeeper under Section 2-402, the Court must determine if there exists probable cause to convert Dr. Bakir from a respondent in discovery to a defendant. Before determining probable cause exists, the Court must make evidentiary findings to support the conclusion that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir was negligent and his negligence was a proximate cause of Mr. Cleeton's injuries and death. This requires the Court to base its findings on its consideration of the evidence before the Court and where the evidence is conflicting, the Court can and must resolve the conflict in reaching its determination. *McGee v Heimburger* 287 Ill. App. 3d 242, 248 In

McGee, the Court noted: "A trial court's ruling on a motion to add a respondent in discovery as a defendant is entitled to deference in circumstances in which *the court has heard testimony and resolved conflicting evidence,* and a reviewing court will not overturn the trial court's ruling unless it is against the manifest weight of the evidence. *Id.* at 248 (emphasis added). Here, the evidence is conflicting. Thus, the Court must consider and resolve conflicting evidence in makings its determination whether plaintiff has established probable cause. Although the threshold to convert a respondent in discovery has been deemed a "low threshold" that does not require a "high degree of likelihood of success", it is not "no threshold." If it were, the determination of probable cause would constitute mere "hoop jumping" or "empty formalism" and render the probable cause requirement of Section 2-402 meaningless. *Froehlich v Sheehan* 240 Ill. App. 3d 93, 103 (1st Dist. 1992).

Thus, the Court must examine the evidence in the context of the elements of a medical malpractice case. Plaintiff must plead and prove the proper standard of care against which the defendant physician's conduct is measured; an unskilled or negligent failure to comply with the applicable standard; and a resulting injury proximately caused by the physician's want of skill or care. *Mayer v Baisier* 147 Ill. App. 3d 150, 155 (4th Dist. 1986)(*citing Purtill v Hess* 111 Ill. 2d 229, 242-243 (Ill. 1986)). In plaintiff's proposed Complaint against Dr. Bakir, she relies on the Emergency Procedures documents to set the standard of care and alleges deviated from the standard of care by failing to timely diagnose and treat Baclofen Withdrawal Syndrome.

The Court finds plaintiff has failed to establish an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the standard of care. In reaching this conclusion, the Court has considered Dr. Minore's opinions as set forth in his Certificate of Merit as well as the evidence submitted by the parties, and concludes there is no support for Dr. Minore's conclusion that Dr. Bakir deviated from the standard of care.

Dr. Bakir considered the diagnosis of Baclofen Withdrawal Syndrome when he evaluated Mr. Cleeton. He considered Mr. Cleeton's presentation of symptoms. Those symptoms did not indicate Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome. Dr. Bakir considered the tests that had been

performed. Those tests did not indicate the Baclofen pump was malfunctioning or that Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome. Dr. Bakir consulted with specialists who also considered the diagnosis of Baclofen Withdrawal. Those specialists included the neurology and neurosurgery services to determine if Mr. Cleeton was in Baclofen withdrawal and, if he was, what to do. This diagnosis needed to be confirmed before Baclofen could be administered because if he was not in Baclofen withdrawal, administering Baclofen could cause a Baclofen overdose. Based on their evaluations, the specialists advised Dr. Bakir they did not believe Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome.

Dr. Bakir's working diagnosis was Mr. Cleeton was suffering from sepsis resulting from a confirmed urinary tract infection. Dr. Bakir's focus was treating Mr. Cleeton for sepsis because that was the most likely cause of his illness. Simultaneously, teams of specialists and clinicians were working on other possible explanations for his illness. Those teams included the cardiology service who evaluated Mr. Cleeton to determine if he had a pulmonary embolus, a myocardial infarction, myocarditis, or ischemic heart disease. While these evaluations were in progress and before they could be completed, Mr. Cleeton went into cardiac arrest, a Code was called, and Mr. Cleeton died despite efforts to resuscitate him.

Under these circumstances, the Court cannot conclude that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard of care. Nor can the Court conclude Mr. Cleeton died as a result any act or omission on Dr. Bakir's part.

THEREFORE, IT IS HEREBY ORDERED plaintiff's Motion to Convert is DENIED and Dr. Bakir's status as a Respondent in Discovery is TERMINATED.

There is no just reason for delaying the enforcement or appeal from this Order pursuant to Supreme Court Rule 304(a).

DATE: May 3, 2021

Raylene D. Grischow, *Circuit Court Judge*

performed. Those tests did not indicate the Baclofen pump was malfunctioning or that Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome. Dr. Bakir consulted with specialists who also considered the diagnosis of Baclofen Withdrawal. Those specialists included the neurology and neurosurgery services to determine if Mr. Cleeton was in Baclofen withdrawal and, if he was, what to do. This diagnosis needed to be confirmed before Baclofen could be administered because if he was not in Baclofen withdrawal, administering Baclofen could cause a Baclofen overdose. Based on their evaluations, the specialists advised Dr. Bakir they did not believe Mr. Cleeton was suffering from Baclofen Withdrawal Syndrome.

Dr. Bakir's working diagnosis was Mr. Cleeton was suffering from sepsis resulting from a confirmed urinary tract infection. Dr. Bakir's focus was treating Mr. Cleeton for sepsis because that was the most likely cause of his illness. Simultaneously, teams of specialists and clinicians were working on other possible explanations for his illness. Those teams included the cardiology service who evaluated Mr. Cleeton to determine if he had a pulmonary embolus, a myocardial infarction, myocarditis, or ischemic heart disease. While these evaluations were in progress and before they could be completed, Mr. Cleeton went into cardiac arrest, a Code was called, and Mr. Cleeton died despite efforts to resuscitate him.

Under these circumstances, the Court cannot conclude that a man of ordinary caution and prudence would entertain an honest and strong suspicion that Dr. Bakir is guilty of an unskilled or negligent failure to comply with the applicable standard of care. Nor can the Court conclude Mr. Cleeton died as a result any act or omission on Dr. Bakir's part.

THEREFORE, IT IS HEREBY ORDERED plaintiff's Motion to Convert is DENIED and Dr. Bakir's status as a Respondent in Discovery is TERMINATED.

There is no just reason for delaying the enforcement or appeal from this Order pursuant to Supreme Court Rule 304(a).

DATE: May 3, 2021

Raylene D. Grischow

Raylene D. Grischow, *Circuit Court Judge*

EFILED
11/13/2019 8:26 AM
Paul Palazzolo
7th Judicial Circuit
Sangamon County, IL
2019L 000032

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, Plaintiff v. SIU HEALTHCARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., STEPHANIE WHOOLEY, SUE FARRILL, and MEDTRONIC, INC., Defendants and MEMORIAL MEDICAL CENTER, ASHLEY KOCHMAN., MOUHAMAD BAKIR, M.D., NICOLE J. MIROCHA, D.O., M.S., JESSICA FARLEY, JOSE ESPINOSA, M.D., NAUMAN JAHANGIR, M.D., MOMIN SIDDIQUE, M.D., HANNAH PURSEGLOVE, M.D., JAN RAKINIC, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHILPA CHAKU, M.D., Respondents in Discovery.	)	Cause No. 2019-L-32

MOTION TO CONVERT MOUHAMAD BAKIR, M.D. FROM A RESPONDENT IN DISCOVERY TO A DEFENDANT

NOW COMES the Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, by and through her attorneys, Shay & Associates, and for her Motion to Convert MOUHAMAD BAKIR, M.D. from a Respondent in Discovery to a Defendant, states as follows:

1. 735 ILCS 5/2-402 states "the Plaintiff in any civil action may designate as Respondents in Discovery, in his or her pleading, those individuals or other entities, other than the

named defendants, believed by the Plaintiff to have information essential to the determination of who should properly be named as additional defendants in the action."

2. Further, 735 ILCS 5/2-402 states "[p]ersons or entitles so named as respondents in discovery…may, on motion of the plaintiff, be added as defendants if the evidence discloses the existence of probable cause for such action."

3. "A person or entity named as a respondent in discovery in any civil action may be made a defendant in the same action at any time within 6 months after being named as a respondent in discovery, even thought he time during which an action may otherwise be initiated against him or her may have expired during such 6 month period. An extension from the original 6-month period for good cause may be granted only once for up to 90 days for (1) withdrawal of plaintiff's counsel or (ii) good cause." 735 ILCS 5/2-402.

4. On February 13, 2019, the Plaintiff filed her Complaint at Law in the present matter. Count X of the Complaint at Law names MOUHAMAD BAKIR, M.D. as a Respondent in Discovery, pursuant to 735 ILCS 5/2-402.

5. On October 4, 2019, upon agreement of the parties, the Court extended the Respondent in Discovery Status of MOUHAMAD BAKIR, M.D. until November 13, 2019.

6. Pursuant to 735 ILCS 5/2-402, the Plaintiff may convert MOUHAMAD BAKIR, M.D. from a respondent in discovery to a defendant until November 13, 2019.

7. Attached hereto as Exhibit A are Counts XXII and XXIII against MOUHAMAD BAKIR, M.D. arising from the care and treatment of Donald Cleeton on October 29, 2017 and October 30, 2017 while Donald Cleeton was a patient at Memorial Medical Center, including an attorney affidavit and report of William Stephen Minore, M.D. as required by Section 2-622(a)(1) of the Illinois Code of Civil Procedure.

WHEREFORE, Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased prays that this Honorable Court:

I. Allow Plaintiff's Motion to Covert MOUHAMAD BAKIR, M.D. from a Respondent in Discovery to a Defendant;

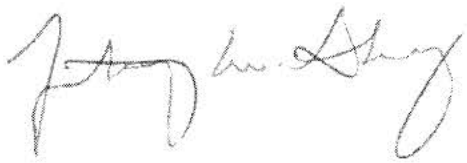
II. Allow Plaintiff to file her Amended Complaint including Counts XXII and XXIII, as attached hereto;

III. For such other relief that this Court deems just and equitable.

Respectfully submitted,

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, Plaintiff

BY: SHAY & ASSOCIATES



BY: _____
Timothy M. Shay

Timothy M. Shay
SHAY & ASSOCIATES
Attorney for Plaintiff
1030 Durkin Drive
Springfield, IL 62704
Phone: (217) 523-5900
Fax: (217) 523-5903
Email: timothyshay@shayandassociates.com

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing document was served upon the attorneys of record of all parties via Email in Springfield, Illinois on 11/13/14.

Sangamon County Circuit Clerk (Via E-File)
Sangamon County Complex
200 South Ninth Street
Springfield, IL 62701

Mr. Rami N. Fakhouri
Goldman, Ismail, Tomaselli, Brennan & Baum, L.L.P. (Via Email)
564 West Randolph Street
Suite 400
Chicago, IL 60661

Mr. William Davis (Via Email)
Brown Hay & Stephens, LLP
205 South 5th Street, #700
PO Box 2459
Springfield, IL 62705-2459

Mr. Adrian Harless (Via Email)
Heyl Royster
3731 West Wabash Avenue
Springfield, IL 62711

Mr. James E. Neville (Via Email)
Neville, Richards & Wuller, LLC
Professional Centre
5 Park Place
Belleville, IL 62226

Mr. John D. Hoelzer (Via Email)
Assistant United States Attorney
318 South Sixth Street
Springfield, IL 62701-1806

By:_____
Timothy M. Shay

SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, IL 62704
(217) 523-5900

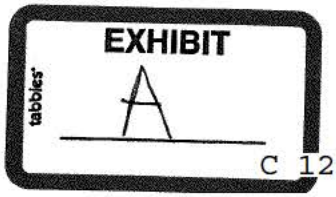
IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, Plaintiff v. SIU HEALTHCARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., STEPHANIE WHOOLEY, SUE FERRILL, MEDTRONIC, INC., and MOUHAMAD BAKIR, M.D., Defendants and MEMORIAL MEDICAL CENTER, ASHLEY KOCHMAN., NICOLE J. MIROCHA, D.O., M.S., JESSICA FARLEY, JOSE ESPINOSA, M.D., NAUMAN JAHANGIR, M.D., MOMIN SIDDIQUE, M.D., HANNAH PURSEGLOVE, M.D., JAN RAKINIC, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHILPA CHAKU, M.D., Respondents in Discovery.	)	Cause No. 2019-L-32

COUNT XXII
MOUHAMAD BAKIR, M.D.
WRONGFUL DEATH

NOW COMES the Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, by and through her attorneys, Shay & Associates, and for her Complaint at Law against the Defendant, MOUHAMAD BAKIR, M.D., states as follows:

1. On March 21, 2018, Plaintiff, CAROL CLEETON, was appointed as the Independent Administrator of the Estate of Donald Cleeton, Deceased, in the Seventh Judicial Circuit Court of Sangamon County, in cause no. 18-P-157.



2. At all times relevant hereto, Defendant MOUHAMAD BAKIR, M.D. (hereinafter referred to as "BAKIR") was a Critical Care Physician licensed to practice medicine in the State of Illinois.

3. On October 30, 2017, BAKIR was an agent, servant, and/or employee, whether actual or apparent of Defendant, SIU HEALTHCARE, INC. (hereinafter referred to as "SIU").

4. DONALD CLEETON (hereinafter referred to as "DONALD"), was born on April 13, 1992 and died on October 30, 2017.

5. DONALD was a patient of BAKIR who had sustained a cervical cord injury on July 24, 2009 at the C5-6 vertebral column that left him a quadriplegic.

6. On December 10, 2014, Dr. Jose Espinosa inserted a MEDTRONIC Synchro Med II programmable pump model 8637-40 with Serial Number NGV495951H at Memorial Medical Center into DONALD to reduce the extent of involuntary muscle spasms DONALD experienced.

7. On December 22, 2014, DONALD became a patient of SIU Department of Neurology and fell under the care of defendant AL SAWAF for management of the aforementioned intrathecal baclofen pump.

8. On October 25, 2017, DONALD, along with the Plaintiff, presented to SIU Department of Neurology for a refill of the intrathecal baclofen pump with 40 ML of Lioresol at a concentration of 2,000 mcgm/ml.

9. That during the October 25, 2017 office visit, multiple attempts were made by defendant YOUNG to refill the intrathecal baclofen pump, ultimately resulting in a puncture of the catheter.

10. On October 29, 2017, DONALD presented to the Memorial Medical Center Emergency Room via ambulance with a chief complaint of abdominal pain and headache, and a

history of having increased pain and spasm since the attempted refill of the intrathecal baclofen pump on October 25, 2017.

11. On October 30, 2017 at 12:01 p.m., DONALD was transferred to the Intensive Care Unit at Memorial Medical Center and came under the care of BAKIR.

12. Medtronic representatives and SIU Neurology clinic staff were contacted.

13. At approximately 10:44 a.m. on October 30, 2017, Memorial Medical Center received the faxed Emergency Procedure documents for Baclofen Withdrawal Syndrome from Medtronic.

14. The Emergency Procedure documents include Medtronics recommended emergency procedure for the Intrathecal Baclofen being administered. Specifically, the Emergency Procedure documents indicate the following:

a. Symptoms of Baclofen underdose;

b. Symptoms of intrathecal Baclofen withdrawal; and

c. Suggested treatment for intrathecal Baclofen underdose or withdrawal, specifically:

i. Administration of high-dose oral or enteral Baclofen;

ii. Restoration of intrathecal baclofen infusion; and/or

iii. intravenous benzodiazepines by continuous or intermittent infusion, titrating the dosage until the desired therapeutic effect is achieved.

15. At 11:14 a.m. on October 30, 2017, BAKIR was notified by a nurse that DONALD's Troponin levels were elevated, an indication for Baclofen Withdrawal Syndrome.

16. Based upon the tests performed and the Emergency Procedures faxed by Medtronic

representatives, it was clear that DONALD was suffering from Baclofen Withdrawal Syndrome.

17. BAKIR did not order Intrathecal Baclofen, as indicated, until 1:38 p.m. on October 30, 2017 and Intrathecal Baclofen was not administered until 2:17 p.m. that day.

18. By the time the Intrathecal Baclofen had been administered, it was too late and DONALD died as a result of Baclofen Withdrawal Syndrome.

19. DONALD was declared dead at 3:06 p.m. on October 30, 2017.

20. At all times relevant hereto, there existed a duty on the part of the Defendant, BAKIR, to provide adequate medical care, diagnosis, and treatment to his patients, including DONALD, within the standard of care of a reasonably careful Critical Care Physician.

21. Contrary to his duty, BAKIR was guilty of one or more of the following negligent acts or omissions:

a. Failed to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome;

b. Failed to order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017; and

c. Failed to order the administration of Intrathecal Baclofen in a timely manner.

22. As a direct and proximately result of one or more of the aforementioned negligent acts or omissions on the part of BAKIR, DONALD sustained a lethal baclofen withdrawal which ultimately caused his death on October 30, 2017.

23. DONALD left as his surviving hers at law his mother, CAROL CLEETON, and sister, Heather Cleeton, who suffered pecuniary loss and damage as a result of the death of

DONALD, have been deprived of, and will in the future be deprived of his affection, society and companionship and have suffered and will continue to suffer grief as a result of the death of DONALD.

WHEREFORE, Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, prays that this Honorable Court enter a judgement against the Defendant MOUHAMAD BAKIR, M.D., in such an amount in excess of this Court's jurisdictional requisite of $50,000.00 that will fairly and adequately compensate for the losses alleged herein, and for costs of suit.

PLAINTIFF DEMANDS A TRIAL BY A JURY OF TWELVE

COUNT XXIII
MOUHAMAD BAKIR, M.D.
SURVIVAL ACTION

NOW COMES the Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, by and through her attorneys, Shay & Associates, and for her Complaint at Law against the Defendant, MOUHAMAD BAKIR, M.D.., states as follows:

1.-22. Plaintiff repeats and realleges paragraphs 1-22 of Count XXII as paragraphs of 1-22 of this Count XXIII as though fully set forth herein.

23. That as a direct and proximate result of one or more of the aforementioned negligent acts or omissions of BAKIR, DONALD was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, loss of enjoyment of a normal life and medical expenses prior to his death for which, had he survived, he would have been entitled to maintain an action for such damages; that such action has survived him and accrued to the benefit of his heirs at law: his mother CAROL CLEETON, and his sister Heather Cleeton, who have suffered pecuniary loss and damages as a result of the death of DONALD.

WHEREFORE, Plaintiff, CAROL CLEETON, as Independent Administrator of the Estate

of DONALD CLEETON, Deceased, prays for judgment against the Defendant, MOUHAMAD BAKIR, M.D., in such an amount in excess of this Court's jurisdictional requisite of $50,000.00 that will fairly and adequately compensate for the losses alleged herein, and for costs of suit.

PLAINTIFF DEMANDS A TRIAL BY A JURY OF TWELVE

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased,

Plaintiff,

BY: SHAY & ASSOCIATES

BY: _____
Timothy M. Shay

Timothy M. Shay
SHAY & ASSOCIATES
Attorney for Plaintiff
1030 S. Durkin Drive
Springfield, IL 62704
Phone: (217) 523-5900
Fax: (217) 523-5903
E-mail: timothyshay@shayandassociates.com

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased, Plaintiff v. SIU HEALTHCARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., STEPHANIE WHOOLEY, SUE FERRILL, MEDTRONIC, INC., and MOUHAMAD BAKIR, M.D., Defendants and MEMORIAL MEDICAL CENTER, ASHLEY KOCHMAN., NICOLE J. MIROCHA, D.O., M.S., JESSICA FARLEY, JOSE ESPINOSA, M.D., NAUMAN JAHANGIR, M.D., MOMIN SIDDIQUE, M.D., HANNAH PURSEGLOVE, M.D., JAN RAKINIC, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHILPA CHAKU, M.D., Respondents in Discovery.	)	Cause No. 2019-L-32

AFFIDAVIT

TIMOTHY M. SHAY, being duly sworn on oath states:

1. That he is one of the attorneys for the Plaintiff, licensed to practice law in the State of Illinois.

2. That he has reviewed the Plaintiff's claim against the Defendants for damages arising in the cause arising on October 25, 2017, and all other relevant aspects of said claim.

3. That he reasonably believes that the Plaintiff's claim for damages in this cause exceeds $50,000.00.

FURTHER, Affiant Sayeth Naught.

Timothy M. Shay

Subscribed and sworn to before me this 13th day of November, 2019.

Notary Public

OFFICIAL SEAL
COREY A. TAYLOR
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Oct. 25, 2021

Timothy M. Shay
SHAY & ASSOCIATES
Attorney for Plaintiff
1030 Durkin Drive
Springfield, IL 62704
Phone: (217) 523-5900
Fax: (217) 523-5903
Email: timothyshay@shayandassociates.com

EFILED
11/13/2019 8:26 AM
Paul Palazzolo
7th Judicial Circuit
Sangamon County, IL
2019L 000032

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, Deceased,

Plaintiff

v.

SIU HEALTHCARE, INC., CHARLENE YOUNG, F.N.P., ABDULLAH AL SAWAF, M.D., STEPHANIE WHOOLEY, SUE FERRILL, MEDTRONIC, INC., and MOUHAMAD BAKIR, M.D.,

Defendants

and

MEMORIAL MEDICAL CENTER, ASHLEY KOCHMAN., NICOLE J. MIROCHA, D.O., M.S., JESSICA FARLEY, JOSE ESPINOSA, M.D., NAUMAN JAHANGIR, M.D., MOMIN SIDDIQUE, M.D., HANNAH PURSEGLOVE, M.D., JAN RAKINIC, M.D., NATALIE MAHONEY, M.D., JONATHAN RODERICK DUTT, M.D., and SHILPA CHAKU, M.D.,

Respondents in Discovery.

Cause No. 2019-L-32

AFFIDAVIT

TIMOTHY M. SHAY, being duly sworn on oath states:

1. That I am one of the attorneys for the Plaintiff, CAROL CLEETON, in the above-captioned matter.

2. That I swear out this Affidavit in compliance with Section 2-622(a)(1) of the Illinois Code of Civil Procedure to file contemporaneously with, and in support of the Complaint at Law filed in this instant action.

3. That I have consulted and reviewed the facts of this case with William Stephen Minore, M.D.

4. That William Stephen Minore, M.D., is a physician licensed to practice medicine in all of its branches, who specializes his practice in the fields of anesthesiology and pain management. (A copy of his Curriculum Vitae is attached hereto and marked as Exhibit A).

5. That I believe that William Stephen Minore, M.D., by his extensive training, practice and scholarly studies and research, and by review of the relevant medical records attached in his report of November 12, 2019, and attached to this Affidavit as Exhibit B, is knowledgeable in the relevant issues involved in this particular action.

6. That I reasonably believe that William Stephen Minore, M.D., practices, and has practiced, within the last five years in the same area of healthcare or medicine that are issues in this particular action.

7. That I reasonable believe that William Stephen Minore, M.D., is qualified by experience and demonstrated competence to address the issues of this case.

8. That William Stephen Minore, M.D., has determined in a report, attached hereto as Exhibit B, after his review of the medical records and other relevant materials involved in this particular action, that there is a reasonable and meritorious case for the filing of the instant action against Mouhamad Bakir, M.D.

9. That I have concluded, on the basis of Dr. William Stephen Minore's review and consultation, that there is a reasonable and meritorious cause for filing an action against Mouhamad Bakir, M.D.

FURTHER, Affiant Sayeth Naught.

Timothy M. Shay

Subscribed and sworn to before me this 13th day of November, 2019.

Notary Public

OFFICIAL SEAL
COREY A. TAYLOR
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Oct. 25, 2021

Timothy M. Shay
SHAY & ASSOCIATES
Attorney for Plaintiff
1030 Durkin Drive
Springfield, IL 62704
Phone: (217) 523-5900
Fax: (217) 523-5903
Email: timothyshay@shayandassociates.com

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing document was served upon the attorneys of record of all parties via Email in Springfield, Illinois on 11/13/19.

Sangamon County Circuit Clerk (Via E-File)
Sangamon County Complex
200 South Ninth Street
Springfield, IL 62701

Mr. Rami N. Fakhouri
Goldman, Ismail, Tomaselli, Brennan & Baum, L.L.P. (Via Email)
564 West Randolph Street
Suite 400
Chicago, IL 60661

Mr. William Davis (Via Email)
Brown Hay & Stephens, LLP
205 South 5th Street, #700
PO Box 2459
Springfield, IL 62705-2459

Mr. Adrian Harless (Via Email)
Heyl Royster
3731 West Wabash Avenue
Springfield, IL 62711

Mr. James E. Neville (Via Email)
Neville, Richards & Wuller, LLC
Professional Centre
5 Park Place
Belleville, IL 62226

Mr. John D. Hoelzer (Via Email)
Assistant United States Attorney
318 South Sixth Street
Springfield, IL 62701-1806

By:_____
Timothy M. Shay

SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, IL 62704
(217) 523-5900

CURRICULUM VITAE
WILLIAM STEPHEN MINORE, M.D., F.C.C.P., FASA, F.I.C.S., C.P.E.

MAILING ADDRESS: Rockford Anesthesiologists Associated
2202 Harlem Road, P.O. Box 2905
Loves Park, IL 61132-2905

DATE OF BIRTH: March 16, 1958
BIRTHPLACE: Detroit, Michigan

EDUCATION:

Lee M. Thurston High School
Livonia, Michigan
1976 (Valedictorian)

University of Michigan
Inteflex Program Biomedical Sciences
Ann Arbor, Michigan B.S. 1980

University of Michigan Medical School
Ann Arbor, Michigan M.D. 1982

POST-DEGREE TRAINING:

Fellowship, Anesthesiology
Cardiac and Transplantation Anesthesia
Pediatric and Adult
University of Nebraska Medical Center
Omaha, Nebraska August 1986 - June 1987

Fellowship, Anesthesiology
Cardiovascular and Vascular Anesthesia
University of Michigan Hospitals
Ann Arbor, Michigan July 1986 - August 1986

Residency, Anesthesiology
University of Michigan Hospitals
Ann Arbor, Michigan July 1984 - June 1986

Residency, General Surgery
University of Michigan Hospitals
Ann Arbor, Michigan July 1983 - June 1984

Internship, General Surgery
University of Michigan Hospitals
Ann Arbor, Michigan July 1982 - June 1983

ACADEMIC APPOINTMENTS:

Fellow
American Society of Anesthesiologists
November 2018

ACADEMIC APPOINTMENTS: (continued)

Fellow
International College of Surgeons
United States Section, Executive Committee
March 2007 – Permanent Appointment

Clinical Assistant Professor
University of Illinois
College of Medicine
Rockford, Illinois August 1987 - Present

Assistant Professor
Department of Anesthesiology
University of Nebraska Medical Center
Omaha, Nebraska July 1987 - August 1987

Instructor
Department of Anesthesiology
University of Nebraska Medical Center
Omaha, Nebraska August 1986 - June 1987

PROFESSIONAL APPOINTMENTS:

Illinois Society of Anesthesiologists:
President 2004 - 2005
President Elect 2002 - 2003
Vice President 2002 - 2003
Chairman, Nominating Committee 2005 - 2006
Chairman, Economics Committee 2001 - 2004
Assistant Treasurer 2001 – 2002
Ad Hoc Committee for Mini-Internship 2001 - 2002
Legislative Review Subcommittee 2001 - 2002
Committee on Economics 2000 - 2001
Nominating Committee 2000 - 2001
Committee on Practice Management 2000 - 2001
Committee for McQuistion Award 2000 - 2001
District IV Director 1999 – 2001
District IV Alternate Delegate 1996 - 2001

Illinois State Medical Society:
Council on Economics 2016 - 2019
Council on Economics 2015 - 2016
Council on Economics 2012 - 2015
Council on Membership & Advocacy 2006 - 2011

Illinois Society of Interventional Pain Physicians
Director at Large 2015
Vice President 2015 - 2016
Chief Executive Officer 2007 - 2011
Executive Director 2002 – 2007
Lifetime Director

American Society of Interventional Pain Physicians
Lifetime Director
Director, Emeritus 2011
Vice President, Financial Affairs

PROFESSIONAL APPOINTMENTS: (continued)

Illinois Society of Anesthesiologists (continued)
Chairman, Economics & Membership Committee
Political Action Committee (ASIPP-PAC)
Medicare B Carrier Advisory Committee (CAC)
2008 – 2011
2005 – 2008
2002 – 2005
Midwest Anesthesia Conference (MAC/PAC)
Moderator, April 19, 2002
Moderator, May 19, 2001
Rosalind Franklin University of Medicine and Science
Nurse Anesthesia Advisory Board 2013

DIRECTORSHIPS:

President & CEO
Rockford Anesthesiologists Associated, L.L.C.
Rockford, Illinois, January 2009 - Present
Medical Pain Management Services, Ltd.
Rockford, Illinois, January 2009 - Present
Rockford Ambulatory Surgical Treatment Center, Ltd.
Rockford, Illinois, January 2009 - Present

President
Rockford Anesthesiologists Associated, L.L.C.
Rockford, Illinois, March 1995 – January 2009
Medical Pain Management Services, Ltd.
Rockford, Illinois, January 1999 – January 2009
Rockford Ambulatory Surgical Treatment Center, Ltd.
Rockford, Illinois, September 1996 – January 2009

Chairman
Cardiovascular/Vascular Anesthesia Group
Rockford Anesthesiologists Associated
Rockford, Illinois, November 1991 - Present

Vice President
Rockford Anesthesiologists Associated, L.L.C.
Rockford, Illinois, November 1991 - March 1995
Rockford Ambulatory Surgical Treatment Center, Ltd.
Rockford, Illinois, February 1994 - September 1996
Medical Pain Management Services, Ltd.
Rockford, Illinois, November 1991 - January 1999

COMMUNITY APPOINTMENTS:

Rock River Valley Blood Center (RRVBC)
Representing the Winnebago County Medical Society
January 2019 – February 2022

COMMUNITY APPOINTMENTS: (continued)

OSF Saint Anthony Northern Region Emergency Medical Services-Belvidere, Princeton, Whiteside Counties Tactical Emergency Medical Services (TEMS)
Medical Director, September 21, 2015 – December 2018

Rockford Area Economic Development Council
Director, January 2009 – May 2016
Chairman, Nominating Committee

Health Care Advisory Committee
State Representative, State of Illinois

Rockford Health Council
Treasurer, January 2010 – April 2011
Director, January 2005 – December 2007

Rockford Area Chamber of Commerce
Board of Directors, May 2002 – June 2009

Rosecrance Foundation Board
Board of Directors, July 2007 – June 2008

COURSE DIRECTOR:

Advanced Transesophageal Echocardiography; Rockford Memorial Hospital, April 1993, October 1993, February 1994, September 1994

Transesophageal Echocardiography: An Introduction; Rockford Memorial Hospital, April 1993, October 1993, January 1994, June 1994

CLINICAL TRAINER:

Transesophageal Echocardiography in ICU/OR
June 1991 - Present

Medtronics Clinical Preceptor for dorsal column stimulators and intrathecal catheters, January 1993 - Present

GRANT/CONTRACT SUPPORT:

Principal Investigator "Labetalol in Post Coronary Bypass Hypertension",
1986 - 1987

Principal Investigator "Use of Implantable Pumps with Spinal Opioids for Malignant and Non-Malignant Pain Syndromes",
1989 - Present

Principal Investigator "Use of a New Intrathecal Spinal Catheter for Synchromed Pumps",
1994 - Present

CERTIFICATIONS:

Diplomate, National Board of Medical Examiners, 1983
BCLS and ACLS, 1982, 1983, 1984, 1986, 1988,1990
ACLS Instructor, 1985, 1989
Certified, American Board of Anesthesiology 1988
Diplomate, American Academy of Pain Management, 1989

Recertification, Subspecialty of Pain Medicine
American Board of Anesthesiology, 10/4/2014 – 12/31/2024

Recertification, Subspecialty of Pain Medicine
American Board of Anesthesiology, 1/1/2004 – 12/31/2013

Diplomate, American Board of Anesthesiology
Pain Management, 1993

Physician's Recognition Award
American Medical Association, 4/1/2000 – 4/1/2003

Certified Physician Executive, American College of Physician Executives, 1999

LICENSURE:

State of Michigan, 1983 #46091
State of Nebraska, 1986 #17290
State of Illinois, 1987 #036-075603
State of Wisconsin, 1998 #40470

SPECIAL INTERESTS/AREAS OF RESEARCH:

Pain Management - Neurolysis - peripheral/intrathecal
Cardiac Anesthesia – adult and pediatrics
Vascular Anesthesia
Dorsal Column Stimulation
Reflex Sympathetic Dystrophy
Implantable Morphine pumps/intrathecal catheters
High Risk OB Anesthesia
Staff Member - Pediatric Intensive Care (PICU) and Adult Intensive Care

MEMBERSHIPS IN PROFESSIONAL SOCIETIES:

American Society of Interventional Pain Physicians
Illinois Society of Interventional Pain Physicians
American Medical Association
American Society of Anesthesiologists
International Anesthesia Research Society
Society of Cardiovascular Anesthesiologists
Illinois Society of Anesthesiologists
Winnebago County Medical Society
Association of Pain Management Anesthesiologists

HOSPITAL AFFILIATIONS AND COMMITTEES:

University of Illinois College of Medicine at Rockford
Dean's Action Council

HOSPITAL AFFILIATIONS AND COMMITTEES: (continued)

University of Illinois College of Medicine at Rockford
Executive Committee
Committee on Student Affairs, Promotions, Awards & Scholarships
OSF Saint Anthony Medical Center – Active Staff
Tactical Emergency Medical Services, Medical Director
Anesthesia Section, Steering Committee
Trauma QI Committee, Trauma/Burn Committee
Trauma Program Operational Process Performance
Operating Room Committee, Chair
Credentials Committee
Rockford Ambulatory Surgery Center
Credentials Committee
SwedishAmerican Hospital – Active Staff
Anesthesia Committee, Perioperative Committee
Freeport Memorial Hospital – Courtesy Staff
Van Matre Health South Rehab Hospital – Active Staff
Katherine Shaw Bethea – Associate Staff
Anesthesia Department, Chair
Medical Staff Committee
Rochelle Community Hospital – Courtesy Staff

BIBLIOGRAPHY

PUBLICATIONS:

Improving Satisfaction Among Established Patients in a Midwestern Pain Clinic; Applied Nursing Research 33 (2016) 54-60, October 15, 2016

Abstracts, Labetalol in Post Coronary Bypass Hypertension – Society of Cardiovascular Anesthesia 1988

Opioid Guidelines in the Management of Chronic Non-Cancer Pain – Pain Physician. 2006; 9:1-40, ISSN 1533-3159

AWARDS:

Distinguished Service Award – 2018
American Society of Interventional Pain Physicians
Outstanding Patient Access to Care & Patient Safety

Outstanding Service Award – 2017
American Society of Interventional Pain Physicians
Outstanding Education, Policies & Procedures

Distinguished Service Award – 2016
Illinois Society of Anesthesiologists
Outstanding Education, Patient Safety & Outcomes

AWARDS: (continued)

Citizen Service above Excellence and
Entity Service above Excellence – 2016
Rockford Police Department & The City of Rockford

PRESENTATIONS:

I. "Complex Regional Pain Syndrome"
II. "Narcotic Analgesics, Use, Misuse and Alternatives"
University of Illinois College of Medicine Rockford., Medical Education & Evaluation (invited lecturer) April 2018

International Conference Clinical Case Reports 2017: "Exploration of Advancements in the Field of Medicine" (invited, Organizing Committee Member, Panelist & Session Chair) Dubai, United Arab Emirates, April 2017

"Chronic Pain & RSD" University of Illinois College of Medicine at Rockford (invited lecturer) March 2017

"SWAT Narcan Training" TAC MED Program in conjunction with Saint Anthony Medical Center and the Rockford Police Department, (TAC MED Medical Director) April 2016

"Pain Management 2015" Grand Rounds, SwedishAmerican Hospital, (invited lecturer) April 2014

"Narcotics and Prescriptive Guidelines" OSF Saint Anthony Medical Center's May Day Conference, Giovanni's Conference Center, Rockford, Illinois (invited lecturer) May 2013

"Strategies in Negotiating Managed Care Contracts" Caesar's Palace, Las Vegas, Nevada, University of Chicago, Division of the Biological Sciences and the Pritzker School of Medicine, (invited lecturer) May 2012

"New Treatment Modalities for CRPS— Neuropathic Pain" Christchurch, New Zealand, Burwood Hospital, Pain Management Centre (invited lecturer) May 2011

"Pain Management in Ambulatory Surgery Centers" (invited moderator) — FASA 2009 National Meeting, Nashville, Tennessee April 2009

"New Treatment Modalities for CRPS — Neuropathic Pain" New Horizons in Medicine, Midwest Educational Institute, Golfito, Costa Rica (invited lecturer) February 2009

"Radiofrequency Ablation" Rock River Valley Chapter, National Association of Orthopedic Nurses, Giovanni's Conference Center, Rockford, Illinois (invited lecturer) December 2008

"What is New in Pain Management" Seminar on Changing Medicine, Kenai Peninsula, Soldotna, Alaska (featured lecturer) July 2008

PRESENTATIONS:
(continued)

"Reflex Sympathetic Dystrophy" Nelspruit MediClinic, Nelspruit, South Africa (invited lecturer) June 2007

"Treatment of Neuropathic Pain" Queen Elizabeth Hospital, Kowloon Side of Jordan, Kowloon, Hong Kong, (invited lecturer) April 2006

"Neuropathic Pain" Grand Rounds, OSF Saint Anthony Medical Center, (invited lecturer) Rockford, Illinois March 2006

"Reflex Sympathetic Dystrophy" Lower Extremity Medicine, Midwest Educational Institute, Hospital CIMA, (invited lecturer) San José, Costa Rica, January 2006

"Anesthesia in the Out-Patient Setting, Pitfalls & Emergencies" ASPSN 31st Annual Convention, (invited lecturer) Chicago, Illinois, September 2005

"Pain Management Update, What's New in 2005" Illinois Valley Community Hospital, (invited lecturer) Peru, Illinois, September 2005

"Toxemia" SwedishAmerican Hospital, Birth Place, (invited lecturer) Rockford, Illinois, May 2005

"Narcotics and The Federal Government" Aim Immediate Care (invited lecturer) Sycamore, Illinois, March 2005

"Narcotics and The Federal Government" OSF Saint Anthony Medical Group, (invited lecturer) Rockford; Illinois, March 2005

"Drugs Utilized in OB Anesthesia" SwedishAmerican Hospital, Birth Place, (invited lecturer) Rockford, Illinois, December 2004

"Narcotics and The Federal Government" Grand Rounds, OSF Saint Anthony Medical Center, Rockford, Illinois, October 2004

"Hypovolemic Shock" SwedishAmerican Hospital, Birth Place, (invited lecturer) Rockford, Illinois, August 2004

"Physical and Psychological Aspects of Drug Addiction" The Nurses Expo, (invited lecturer) Clock Tower Resort, Rockford, Illinois, March 2004

"A Physician's Perspective of the Pain Management Community" The NHCAA Institute for Health Care Fraud Prevention, Fraud in Pain Management, (invited lecturer) Newport Beach, California, March 2004

"Psychological Components of Pain Management" The NHCAA Institute for Health Care Fraud Prevention, Fraud in Pain Management, (invited lecturer) Newport Beach, California, March 2004

PRESENTATIONS:
(continued)

"Liability Crisis" American Society of Interventional Pain Physicians, 5th Annual Meeting, (invited lecturer) Alexandria, Virginia, September 2003

"Plaintiff's Expert Witness" American Society of Interventional Pain Physicians, 5th Annual Meeting, (invited lecturer) Alexandria, Virginia, September 2003

"Expert Witness: Fact or Fiction?" American Society of Interventional Pain Physicians, Interventional Pain Management Symposium, (invited lecturer) San Diego, California, March 2003

"Handling a Difficult Patient" American Society of Interventional Pain Physicians, 2nd Semiannual Interventional Pain Medicine/Practice Symposium (invited lecturer) March 2002

"Workplace Violence" American Society of Interventional Pain Physicians, 2nd Semiannual Interventional Pain Medicine Practice Symposium (invited lecturer) March 2002

"Reflex Sympathetic Dystrophy" Midwest Educational Institute, Kenai Peninsula, Alaska (invited lecturer) June 2001

"Pain Management OPIOIDS, RSD'S and New Techniques" Grand Rounds, OSF Saint Anthony Medical Center, Rockford, Illinois September 1999

"Reflex Sympathetic Dystrophy Diagnosis, Treatment and Prognosis" Bowman Gray School of Medicine Conference, Cabo San José, Mexico (invited lecturer) September 1999

"RSD's - Dorsal Column Stimulation for RSD's, Pain Syndromes, an Overview" American Society Pain Management R.N. National Meeting, Dallas, Texas (invited lecturer) May 1995

"RSD's - Diagnosis, Prognosis and Treatment" Anesthesia Annual Meeting, Rockford, Illinois (invited lecturer) March 1995

"Handling the Difficult Patient, Violence in the Workplace" Changing Medicine Seminar, (invited lecturer) Baja, Mexico, August 2003

"Treatment of Back Pain and Its Sequelae" Pain Management Grand Rounds, Rockford, Illinois, February 1995

"Intraoperative Transesophageal Echocardiography for Cardiac Anesthesiology" Rockford Memorial Hospital, (course director) January 1995

"Chronic Pain Syndromes in Workmen's Compensation" Winnebago County Bar Association Workmen's Compensation Seminar, Rockford, Illinois (guest speaker) January 1995

PRESENTATIONS:
(continued)

"IV Conscious Sedation in Pediatrics and Neonates" Regional Pediatric Conference, Clock Tower Resort, Rockford, Illinois, Sponsored by Rockford Memorial Hospital, (guest lecturer), November 1994

"Advanced Techniques in Transesophageal Echocardiography for Diagnosticians" 13 Category I CME Credits, Kenora, Ontario, (course director) October 1994

"Use of Spinal Opioids in Pregnant Women at Term" Kenora, Ontario, October 1994

"Use of Antiemetics in the Postoperative Setting" Anesthesia Grand Rounds, Chicago Society of Anesthesiologists, (invited lecturer) April 1994

"Use of Muscle Relaxants for Intrauterine Procedures" Regional Perinatal Conference, Rockford Memorial Hospital, Rockford, Illinois, May 1993

"Advanced Techniques in Transesophageal Echocardiography for Diagnosticians" 13 Category I CME Credits, Rocky Mountain Lodge, British Columbia, (course director) April 1993

"Use of Implantable Morphine Pumps for Chronic Benign and Malignant Pain Syndromes" C.G.H. Hospital Medical Staff Grand Rounds, Sterling, Illinois, (invited lecturer) April 1993

"Conscious Sedation" Regional Care Symposium, Swedish American Hospital, Rockford, Illinois (invited lecturer) September 1997

"Pain Management Roundtable Discussion: What's New in Pain Management" ASPMN National Meeting, Dallas, Texas (invited discussant) May 1995

"Use of Intraoperative Transesophageal Echocardiography for Cardiac and Non-Cardiac Surgery" St. Joseph Academy of Anesthesiology Meeting, Memorial Hospital, South Bend, Indiana, (invited lecturer) April 1993

"Use of Spinal and Epidural Opioids in Chronic and Malignant Pain Syndromes" Woodstock Hospital Grand Rounds (invited lecturer) April 1992

"Prophylaxis of Aspiration Perioperatively" University of Kentucky (Grand Rounds)(invited lecturer) May 1990

"Cardiac Anesthesia and Critical Care: An Update on What's New" Symposium Director Kentucky Society of Anesthesia (invited lecturer) April 1990

"Perioperative Risk Factors and Operative Risk Reduction for Anesthesia and Surgery" Chicago Society of Anesthesia (invited lecturer) March 1990

PRESENTATIONS:
(continued)

"Use of Non-Invasive and Invasive Monitors for Reduction of Myocardial Ischemia" Annual Meeting of Dayton Society of Anesthesia (invited lecturer) March 1990 (Transesophageal Echo)

"Use of Transesophageal Echocardiography in Diagnosis of Myocardia Ischemia" Society of Cardiovascular Anesthesiology Meeting University Missouri, January 1990, Symposium Director - Cardiovascular Section

"Thromboelastography: Its Use to Reduce Operative Transfusions" University of Lexington Cardiac Surgery Society (invited lecturer) Lexington, Kentucky, May 1989

"Control of Preoperative Hypertension in Out Patients" Columbus Society Anesthesia Annual Meeting (invited lecturer) Columbus, Ohio, May 1989

"Thromboelastography: Its Use and Applications in Anesthesia" Indiana University Department of Anesthesia Grand Rounds (invited lecturer) Indianapolis, Indiana, April 1989

"Preop Evaluation of Patients for Major Vascular Surgery" University of Louisville, Anesthesia Grand Rounds (invited lecturer) Louisville, Kentucky, April 1989

"Aspiration and Outpatient Surgery" Evansville Society of Anesthesia Grand Rounds (invited lecturer) Evansville, Indiana, March 1989

"Role of Epidural Narcotics for Post OP Pain Control" Grand Rounds (invited lecturer) Topeka, Kansas, February 1989

"Use of Parenteral Antihypertensives" SwedishAmerican Hospital (E.R. Grand Rounds) Rockford, Illinois, January 1989

"Use of Parenteral Antihypertensives Perioperatively, An Intensive Overview" Green Bay Anesthesia Society, (invited lecturer) Green Bay, Wisconsin, December 1988

"Use of Antihypertensives in Anesthesia International Symposium" (invited discussant) Naples, Florida, November 1988

"Use of Inotropes in Separation From Cardiopulmonary Bypass" Baltimore Society of Anesthesiologists (invited lecturer) Baltimore, Maryland, November 1988

"Treatment and Prophylaxis for Acid Aspiration Syndrome: A New Look at an Old Problem" Greater Baltimore Medical Center (Grand Rounds) Baltimore, Maryland, November 1988

"The New Muscle Relaxants, Use and Implications" New York Anesthesia Symposium (invited lecturer) New York, New York, October 1988
I. "Thromboelastography and Its Clinical Implications to Reduce Transfusions"

PRESENTATIONS:
(continued)

"The New Muscle Relaxants, Use and Implications" New York Anesthesia Symposium (invited lecturer) New York, New York, October 1988 (continued)
II. "Anesthesia for Cardiac and Hepatic Transplantation" New York Hospital Grand Rounds (invited lecturer) New York, New York, August 1988

"Use of Antihypertensives in Pregnancy Induced Hypertension" (invited lecturer) Elgin, Illinois, July 1988
I. "Thromboelastography: Its Use in Obtaining Hemostasis"
II. "Review of Coagulation and Its Abnormalities" Anesthesia Seminars, Lake Lawn Lodge, (invited lecturer) Lake Geneva, Wisconsin, June 1988

"Treatment and Theories of Perioperative Hypertension and Its Implications" Milwaukee Society of Anesthesiologists (invited lecturer) June 1988

I. "Preop Preparation for Cardiac Surgery"
II. "Emergence from Cardiopulmonary Bypass" Kansas State Society of Anesthesia (invited lecturer) Topeka, Kansas, February 1988

"Anesthesia for Vascular and Cardiovascular Surgery: What, When and Why" Wichita Society of Anesthesiologists (invited lecturer) Wichita, Kansas, February 1988

"Cardiac Anesthesia 1989" Kentucky Society of Anesthesia Annual State Meeting (invited lecturer) Lexington, Kentucky, April 1989

"Cardiac Anesthesia 1989, An Update" Pittsburgh Anesthesiology Society (invited lecturer) Pittsburgh, Pennsylvania, March 1989

"Preop Cardiac Evaluation of Patients for Surgery" Memphis Society of Anesthesiologists (invited lecturer) Memphis, Tennessee, January 1988

"Use of Inotropes in Cardiac Anesthesia" Missouri State Anesthesia Society Meeting (review course) Columbia, Missouri, January 1988

"Use of H_2 in the Perioperative Period" State Anesthesia Society Meeting, South Dakota (invited lecturer) Rapid City, South Dakota, Fall 1987

"Review of Inotropic Drugs and Their Mechanism of Action" Denver Anesthesiology Society (invited lecturer) Denver, Colorado, July 1987

"Labetalol and Its Cardiovascular Functions" Tarrant County Anesthesia Society Meeting (invited lecturer) Fort Worth, Texas, July 1987

"Control of Malignant Hypertension and a Review of Antihypertensives" Denver General Hospital (invited lecturer) Denver, Colorado, July 1987

PRESENTATIONS:
(continued)

"Anesthesia for Vascular Surgery" Presbyterian Hospital (invited lecturer) Dallas, Texas, July 1987

"Preop Evaluation and Preparation of the Patient for Cardiovascular Surgery" Monterey Bay Anesthesiology (invited lecturer) Monterey, California, July 1987

"Use of Antihypertensive in Anesthesia with Reference to Cardiac Anesthesia" (invited lecturer) Nashville, Tennessee, June 1987

"Control and Treatment of Malignant Hypertension" Tri Cities Regional Anesthesia Meeting (invited lecturer) Kingsport, Tennessee, June 1987

"H_2 Antagonists for Anesthesia" Rapid City Regional Hospital Anesthesia Grand Rounds (invited lecturer) Rapid City, South Dakota, June 1987

"Labetalol: Its Clinical Relevance and Use in Hypertension" Colorado Anesthesiologists Society (invited lecturer) Broadmoor Hotel, Colorado Springs, Colorado, June 1987

"Hypertensive Crises in Anesthesia" Rapid City Regional Hospital Grand Rounds (invited lecturer) Rapid City, South Dakota, June 1987

H_2 Antagonists in the Elderly" Hot Springs VA Medical Conference (invited lecturer) Hot Springs, South Dakota, June 1987

"Current Therapy of Preoperative Hypertension" Clarkson Hospital Grand Rounds (invited lecturer) Rapid City, South Dakota, June 1987

"Current Concepts in Control of Malignant Hypertension" (invited lecturer) Red Oak, Iowa, May 1987

"Use of H_2 Antagonist in the Preoperative Setting" Denver Medical Society (invited lecturer) Denver, Colorado, April 1987

"Preop Preparation and Evaluation of Patients for Cardiac/Vascular Surgery" Denver Society of Anesthesiologists (invited lecturer) Denver, Colorado, April 1987

"Cardiac Evaluation Prior to Anesthesia and Surgery" San Jose Hospital Grand Rounds (invited lecturer) San Jose, California, July 1987

"Current Treatment and Physiology of Hypertension" Denver General Hospital Medical Grand Rounds (invited lecturer) Denver, Colorado, April 1987

"Orthotopic Liver and Cardiac Transplantation" Kirksville Osteopathic Hospital Grand Rounds (invited lecturer) Kirksville, Missouri, April 1987

PRESENTATIONS:
(continued)

"Vascular Surgery and Hypertensive Management" Department of Surgery Grand Rounds, Grand Rounds, Topeka Medical Center (invited lecturer) Topeka, Kansas, April 1987

"Hypertensive Crisis and Its Management" Internal Medicine Grand Rounds (invited lecturer) Kirksville, Missouri, April 1987

"Preeclampsia and Peripartum Hypertension" St. Anthony Hospital (Anesthesia Grand Rounds) Denver, Colorado, March 1987

"Cardiac Anesthesia and Hypertension" Denver General Hospital (Anesthesia Grand Rounds) Denver, Colorado, March 1987

"Use of H_2 Antagonists in the Perioperative Period" State Anesthesia Society Meeting, South Dakota (invited lecturer) Rapid City, SD, Fall 1987

"Review of Inotropic Drugs and Their Mechanisms of Action" Denver Anesthesiology Society (invited lecturer) Denver, Colorado, July 1987

"Labetalol and Its Cardiovascular Functions" Tarrant County Anesthesia Society Meeting (invited lecturer) Fort Worth, Texas, July 1987

"Control of Malignant Hypertension and a Review of Antihypertensives" Denver General Hospital (invited lecturer) Denver, Colorado, July 1987

"Use of Inotropes in Cardiac and Non-Cardiac Surgical Procedures" University of Nebraska Medical Center (Anesthesia Grand Rounds) Omaha, Nebraska, January 1987

"Post Operative Control of Hypertension and A Review of Current Antihypertension Therapy Post Cardiac Surgery" Kansas City Society of Anesthesiology (invited lecturer) Marriott Plaza, Kansas City, Missouri, January 1987

"Perioperative Control of Hypertension" Research Medical Center (Anesthesia Grand Rounds) Kansas City, Missouri, January 1987

"Techniques of Anesthesia for Cardiac Transplantation" University of Nebraska Medical Center (Anesthesia Grand Rounds) Omaha, Nebraska, December 1986

"Invasive Hemodynamic Monitoring and Its Applications" University of Nebraska Medical Center (Anesthesia Grand Rounds) Omaha, Nebraska, October 1986

"Labetalol and Its Applications" Educational Seminars (teleconference), October 1986

"Anesthesia for Vascular Surgery" Regional Anesthesia Conference (invited lecturer) Ann Arbor, Michigan, June 1986

PRESENTATIONS:
(continued)

"Hypertensive Emergencies and Their Treatment" Heritage Hospital Medical Grand Rounds (invited lecturer) Trenton, Michigan, May 1986

12/2018jmw

Certificate of Merit of Dr. William Stephen Minore, M.D.

I, William Stephen Minore, MD, have been asked to review the medical records and subpoenaed records of Donald Cleeton, deceased, to determine what, if any, deviations from the standard of care occurred during the hospitalization of Donald Cleeton at Memorial Medical Center from October 29, 2017 through October 30, 2017, when he died. Specifically, I was asked to review the care and treatment by Dr. Mouhamad Bakir, M.D., a critical care specialist.

As my Curriculum Vitae attests, I am a Board-Certified anesthesiologist, certified by The American Board of Anesthesiology (ABA), as well as a Diplomat through The American Board of Anesthesiology. My sub-specialty is pain medicine. My practice is conducted through Rockford Anesthesiologists Associated and Medical Pain Management Services, LTD., where I hold the title of President and CEO. I am well-versed on the care and treatment of patients who have undergone Baclofen pump implantations similar to that of Donald Cleeton.

I have had the opportunity to review the medical records from SIU Medicine Department of Neurology, Memorial Medical Center, and the autopsy report and toxicology screens of Donald Cleeton. I have further reviewed two sets of records obtained from Medtronic pursuant to subpoena that address the products at issue, including the Baclofen pump and catheter. I have further had the opportunity to review the studies and testing done of the catheter that revealed several operator-related puncture holes.

After a review of the Memorial Medical Center records, the following timeline applies as to the care and treatment rendered by Dr. Mouhamad Bakir, M.D. Dr. Bakir is a critical care specialist and was in charge of the diagnosis and treatment of Donald Cleeton when he was transferred to the Intensive Care Unit at 12:01 p.m. on October 30, 2017. From Dr. Bakir's records,

Medtronic representatives and SIU Neurology clinic staff were contacted. At approximately 10:44 a.m., Memorial Medical Center received the faxed Emergency Procedure documents for Baclofen Withdrawal Syndrome. Inside those documents is language of the Emergency Procedure for Intrathecal Baclofen being administered. The records reflect that Dr. Bakir was notified of the elevated Troponin levels at 11:14 a.m. Based upon a review of the tests performed, the presentation of symptoms and the Emergency Procedures faxed by Medtronic representatives, it was clear that Donald Cleeton was suffering from Baclofen Withdrawal Syndrome. Intrathecal Baclofen was not ordered until 13:39 and not administered until 14:17. By the time the Intrathecal Baclofen had been administered, it was too late and Donald Cleeton died as a result of Baclofen Withdrawal Syndrome.

It is my opinion within a reasonable degree of medical certainty based upon a review of the medical records provided by Memorial Medical Center, that Mouhamad Bakir, M.D., deviated from the standard of care by his failure to timely recognize the differential diagnosis of Baclofen Withdrawal Syndrome, order treatment consistent with the Medtronic Emergency Procedures received at Memorial Medical Center at approximately 10:44 a.m. on October 30, 2017 and order the administration of Intrathecal Baclofen in a timely manner.

My opinions may be modified based upon additional evidence, including the discovery deposition of Dr. Mouhamad Bakir and review of further evidence and testimony of the witnesses. As such, there is a reasonable and meritorious cause for filing a medical malpractice cause of action against Mouhamad Bakir, M.D.

I reserve the right to amend, modify, or supplement my opinions upon further review of evidence and testimony of the witnesses.

Dated: 12 Nov 2019, 2019.

William Stephen Minore, M.D

OFFICIAL SEAL
PAMELA J. CARROLL
Notary Public, State of Illinois
My Commission Expires 06/25/22

Pamela J. Carroll
11/12/19

EFILED
5/10/2021 3:35 PM
Paul Palazzolo
7th Judicial Circuit
Sangamon County, IL
2019L 000032

APPEAL TO THE APPELLATE COURT OF ILLINOIS
FOURTH JUDICIAL DISTRICT

FROM THE CIRCUIT COURT FOR THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON, as Independent Administrator Of the Estate of DONALD CLEETON, Deceased,	)	
Plaintiff-Appellant,	)	
v.	)	Cause No. 2019 L 32
MOUHAMAD BAKIR, M.D.,	)	
Respondent in Discovery-Appellee.	)	

NOTICE OF APPEAL

Notice is hereby given that CAROL CLEETON, as Independent Administrator of the Estate of DONALD CLEETON, deceased, Plaintiff, no Appellant in the above entitled matter, by and through her attorneys, SHAY & ASSOCIATES, hereby appeals pursuant to Supreme Court Rule 304(a) to the Appellate Court of Illinois for the Fourth Judicial District from the Order of the Circuit of the Seventh Judicial Circuit, Sangamon County, denying the Plaintiff's Motion to Convert MOUHAMAD BAKIR, M.D. from a Respondent in Discovery to a Defendant and terminating MOUHAMAD BAKIR, M.D.'s status as a Respondent in Discovery. An express written finding pursuant to Supreme Court Rule 304(a) was issued by the Honorable Raylene Grishchow of the Circuit Court for the Seventh Judicial Circuit, Sangamon County, on May 3, 2021, rendering this matter ripe for appeal.

The Plaintiff-Appellant prays that this Appellate court reverse the aforesaid Order of the Circuit Court of Sangamon County, find said Order to be in no force and effect, find that the court erred in issuing the order, remand this matter to the Circuit Court with instructions accordingly to

reverse said Order and convert MOUHAMAD BAKIR, M.D. from a Respondent in Discovery to a Defendant, and for such other and further relief as this Court deems just and reasonable.

Respectfully submitted,

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

BY: SHAY & ASSOCIATES

BY: _____
Timothy M. Shay
(ARDC # 6193754)

SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, Illinois 62704
Telephone: (217) 523-5900
Facsimile: (217) 523-5903
Email: shayandassociates@comcast.net

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing document was served upon the attorneys of record of all parties via Email/E-file in Springfield, Illinois on **05/10/21**,

Judge Grischow (Via Email)
Sangamon County Complex
200 South Ninth Street
Springfield, IL 62701

Sangamon County Circuit Clerk (Via Efile)
Sangamon County Complex
200 South Ninth Street
Springfield, IL 62701

Mr. Rami N. Fakhouri
Goldman, Ismail, Tomaselli, Brennan & Baum, L.L.P. (Via Email)
564 West Randolph Street
Suite 400
Chicago, IL 60661

Mr. William Davis (Via Email)
Brown Hay & Stephens, LLP
205 South 5th Street, #700
PO Box 2459
Springfield, IL 62705-2459

Mr. Adrian Harless (Via Email)
Heyl Royster
3731 West Wabash Avenue
Springfield, IL 62711

Mr. James E. Neville (Via Email)
Neville, Richards & Wuller, LLC
Professional Centre
5 Park Place
Belleville, IL 62226

By:_____
Timothy M. Shay

SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, IL 62704
(217) 523-5900

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APPEAL TO THE APPELLATE COURT OF ILLINOIS
FOURTH JUDICIAL DISTRICT
FROM THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON

Plaintiff/Petitioner

Reviewing Court No: 4-21-0284
Circuit Court/Agency No: 2019L000032
Trial Judge/Hearing Officer: RAYLENE GRISCHOW

v.

SIU., ET AL

Defendant/Respondent

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09/27/2019	Motion to Terminate	C 63-C 66
09/27/2019	Response to Motion to extend respondent in discovery status	C 67-C 71
11/01/2019	Motion for Extension of Time	C 72-C 87
11/04/2019	Response to Motion to Extend Respondent in Discovery Status	C 88-C 92
11/13/2019	Affidavit of Attorney	C 93-C 114
11/13/2019	Affidavit	C 115-C 116
11/13/2019	Motion to Convert Mouhamad Bakir, M.D. from Respondent in Discovery	C 117-C 128
02/22/2021	Memorandum of Law Support Exhibit -- Dr. AlSawaf Deposition	C 129-C 292
02/22/2021	Memorandum of Law - Support of Objection to Motion to Convert Dr Bakir	C 293-C 314
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APPEAL TO THE APPELLATE COURT OF ILLINOIS
FOURTH JUDICIAL DISTRICT
FROM THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT
SANGAMON COUNTY, ILLINOIS

CAROL CLEETON
Plaintiff/Petitioner

Reviewing Court No: 4-21-0284
Circuit Court/Agency No: 2019L000032
Trial Judge/Hearing Officer: RAYLENE GRISCHOW

v.

SIU., ET AL
Defendant/Respondent

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Date Filed	Title/Description	Page No.
03/15/2021	Memorandum of Law in Support of Reply to Objection to Motion to	SUP C 4-SUP C 146

CERTIFICATE OF SERVICE

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. The undersigned certifies that the foregoing Brief of Appellant we electronically filed with the Illinois Supreme Court on **November 2, 2022**, and on that date a copy of the same was sent via electronic mail to the following counsel of record at the e-mail addresses below:

Counsel on Appeal for Appellee:
Ann C. Barron
Heyl, Royster, Voelker & Allen, P.C.
105 West Vandalia Street, STE 100
Edwardsville, IL 62025
Email: ABarron@heylroyster.com

/s/ Katherine E. Perry
Katherine E. Perry
Timothy M. Shay
SHAY & ASSOCIATES
1030 Durkin Drive
Springfield, Illinois 62704
Telephone: (217) 523-5900
Facsimile: (217) 523-5903
Email: kperry@shayandassociates.com
timothyshay@shayandassociates.com