2018 IL App (1st) 171078

No. 1-17-1078

Order filed December 7, 2018

Fifth Division

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

NARIMAN HATTAR, as Special Administrator of the Estate of Jiries Hattar,	)	
	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellant,	)	Cook County.
	)	
v.	)	No. 13 L 1265
	)	
GEORGE MESLEH, M.D., and MIDWEST SURGICAL GROUP, S.C.,	)	Honorable
	)	Patrick F. Lustig,
	)	Judge, presiding.
Defendants-Appellees.	)	

JUSTICE LAMPKIN delivered the judgment of the court.
Presiding Justice Rochford and Justice Hoffman concurred in the judgment.

O R D E R

¶ 1 *HELD*: The trial court did not abuse its discretion in barring testimony from plaintiff's expert that had not been disclosed properly. The trial court additionally did not abuse its discretion in barring plaintiff from cross-examining defendants' expert on the previously undisclosed theory of the case. The trial court's decision denying plaintiff's motion to amend was proper. The trial court did not abuse its discretion in refusing the jury's request to view medical records during deliberations.

¶ 2 Plaintiff, Nariman Hattar, as special administrator of the Estate of Jiries Hattar, appeals the jury's verdict in favor of defendants, Doctor George Mesleh and Midwest Surgical Group,[1] in the underlying medical negligence action. At trial, plaintiff alleged that, following Jiries' hernia repair surgery, Dr. Mesleh negligently failed to timely diagnose and treat an infection, which ultimately resulted in Jiries' death. On appeal, plaintiff contends the trial court erred in: (1) a number of evidentiary rulings barring the admission of expert testimony; (2) denying plaintiff leave to amend her complaint; and (3) refusing to allow the jury to review Jiries' medical records during deliberations. Based on the following, we affirm.[2]

¶ 3 BACKGROUND

¶ 4 On December 15, 2005, Dr. Mesleh performed Jiries' hernia repair surgery. Jiries was 61 years old at the time. Plaintiff, Jiries' wife, does not allege any negligence related to the surgery. However, sometime after the surgery, Jiries developed a clostridium difficile colitis (C-diff) infection. He died from complications related to the C-diff infection on December 21, 2005.

¶ 5 Plaintiff originally filed her complaint on November 16, 2007. The complaint was voluntarily dismissed on April 26, 2012.[3] Plaintiff then refiled the underlying complaint on February 5, 2013.[4] In relevant part, the refiled complaint alleged Dr. Mesleh committed medical malpractice, in that he failed to timely diagnose and treat Jiries' C-diff infection which resulted in Jiries developing pseudomembranous colitis and toxic megacolon. The refiled complaint

[1] Midwest Surgical Group was named only in its capacity as Dr. Mesleh's principle.

[2] In adherence with the requirements of Illinois Supreme Court Rule 352(a) (eff. July 1, 2018), this appeal has been resolved without oral argument upon the entry of a separate written order.

[3] An amended complaint was filed in the interim on April 8, 2008.

[4] Christ Hospital and Medical Center and Rebecca Hopkins, P.A., were also named defendants; however, they were dismissed from the case and are not parties to the instant appeal.

additionally provided that "this action is brought pursuant to the Illinois Wrongful Death Act" (740 ILCS 180/1 *et seq.* (West 2004)).

¶ 6 On September 13, 2016, which was over three years later, but just two days before the trial was scheduled to commence, plaintiff's new counsel filed a motion to amend the refiled complaint. In relevant part, plaintiff's counsel argued that an amended complaint was required where the refiled complaint included allegations for a medical malpractice survival claim in addition to the Wrongful Death Act claim, but Jiries' family members erroneously were not named as plaintiffs. Plaintiff's counsel requested leave to amend to add Jiries' family members as named plaintiffs and to add language to distinguish the two claims. The trial court denied the motion, finding the requested amendment would add previously undisclosed theories of damage on the eve of trial. Plaintiff then filed a motion to reconsider. In that motion, plaintiff requested, *inter alia*, that the trial court at least allow the jury to consider damages for Jiries' conscious pain and suffering prior to his death. The trial court ultimately granted plaintiff's motion to reconsider in part, thereby allowing her to seek recovery only for Jiries' conscious pain and suffering. The court, however, denied the remaining motion, thus, barring other grounds of survival damages, such as recovery for loss of earnings and medical expenses. The trial court reasoned that plaintiff had produced discovery from Jiries' family members regarding their observations of Jiries' pain and suffering prior to his death, and, therefore, allowing the jury to consider those survival claim damages would not prejudice defendants.

¶ 7 Then, before the trial began, the court ruled on a number of defendants' motions *in limine*. In relevant part, the trial court barred plaintiff from seeking damages for medical expenses and for lost earnings associated with a new business purchased by Jiries two months

before his death. The trial court additionally barred Jiries' family members from testifying to certain inflammatory hearsay statements allegedly made by Jiries prior to his death. The trial court further barred criticisms of Dr. Mesleh related to the administration of post-operative antibiotics by plaintiff's expert. More specifically, the trial court ruled that, because neither plaintiff's answers to requests for Illinois Supreme Court Rule 213 (Ill. S. Ct. R. 213 (eff. Jan. 1, 2007)) expert opinions nor her expert's discovery deposition disclosed an opinion that Dr. Mesleh deviated from the standard of care in his management of post-operative antibiotics, plaintiff was barred from engaging in that line of questioning.

¶ 8 At trial, Dr. Mesleh testified that he had been a general surgeon at Christ Hospital for over 36 years and had served as the chair of the department since 1996. Dr. Mesleh, an assistant professor of surgery at Rush University Medical Center and University of Illinois, had performed between 150 and 200 hernia repair surgeries per year over the course of his career. Dr. Mesleh added that he had extensive experience treating patients with C-diff infections.

¶ 9 Dr. Mesleh testified that, prior to surgery and for three days thereafter, Jiries received a prophylactic antibiotic called Cefazolin, which was more commonly known as Ancef. Dr. Mesleh explained that abdominal surgeries generally presented a high risk of infection, and Ancef worked to reduce the incidence of infection following surgeries such as that performed on Jiries. According to Dr. Mesleh, during surgery, he discovered extensive scar tissue adhesions in Jiries' small intestine that required him to separate the adhesions with scissors. The surgery lasted approximately two hours and was without complication. The surgery originally was scheduled on an outpatient basis, but Dr. Mesleh decided to admit Jiries to the hospital due to the extensive adhesions found during the surgery and because of Jiries' level of pain.

¶ 10 Following the surgery, Dr. Mesleh observed Jiries in the hospital on a daily basis. On December 16, 2005, the day after surgery, Dr. Mesleh noted that Jiries had no issues overnight. Jiries, however, had developed post-operative ileus, or paralysis of the bowels, which is also known as "lazy bowel." Dr. Mesleh testified that the condition was common following abdominal surgery. On December 17, 2005, Jiries reported that his pain was improving and he was tolerating his diet well. According to his notes, Dr. Mesleh hoped to discharge Jiries within the next day or two. On December 18, 2005, Jiries reported continued pain and continued lack of bowel function. Upon examination, Jiries' bowel was minimally tender and moderately distended, and demonstrated hyperactive sounds. In response, Dr. Mesleh ordered IV fluids, instructed Jiries to continue with his liquid diet, and gave Jiries a suppository to stimulate a bowel movement. According to Dr. Mesleh, Jiries did not show any signs or symptoms of C-diff infection on December 18, 2005. Dr. Mesleh explained that C-diff infection is caused by bacteria and is most commonly found in the hospital through cross-contamination from patient to patient.

¶ 11 On December 19, 2005, Jiries complained of bloating and minimal pain. Jiries had an overnight episode of feculent vomiting, which originates in the intestine as opposed to the stomach. According to Dr. Mesleh, feculent vomiting is common for patients with post-operative ileus. Jiries had no other vomiting episodes that day. Dr. Mesleh testified that, upon examination, Jiries' abdomen was non-tender and distended, with no bowel sounds. The surgical incision appeared to be healing well. Jiries' temperature was normal and his pulse was slightly elevated. Dr. Mesleh testified that he inserted an NG tube into Jiries in order to suction fluid from his bowel and to relieve some of the pressure caused by the ileus. Dr. Mesleh testified that Jiries had a history of cardiac issues, so he ordered an EKG, cardiac enzyme labs, and a cardiology

consultation due to Jiries' elevated pulse. Dr. Mesleh also placed a Foley catheter to monitor Jiries' urine output and to ensure he was receiving enough fluids. Jiries' EKG was performed just after 12:00 p.m. The results were abnormal and could not rule out the possibility of a cardiac event. Jiries also demonstrated a change in mental status, such that he was agitated.

¶ 12 Around 9:30 p.m. on the same day, Dr. Mesleh learned from a nurse that Jiries had a liquid bowel movement around 1:45 p.m. Dr. Mesleh testified that he ordered a stool toxin sample to check for C-diff infection as a precautionary measure. The sample was sent to the laboratory and typically required 24 hours for results. According to Dr. Mesleh, his suspicion for C-diff infection was extremely low because Jiries did not present with profuse, watery diarrhea, which is consistent with C-diff infection. Dr. Mesleh emphasized that the primary indicator of C-diff infection is profuse diarrhea. Dr. Mesleh added that nursing notes indicated Jiries became agitated and attempted to remove his NG tube on the evening of December 19, 2005. In addition, Jiries' temperature became elevated shortly after midnight. As a result, blood cultures, urine cultures, and urinalysis were ordered and aggressive fluid resuscitation was initiated.

¶ 13 Dr. Mesleh next observed Jiries at 6 a.m. on December 20, 2005. The results from the stool, blood, and urine cultures remained pending at the time. Upon examination, Jiries' blood pressure had dropped, his temperature remained elevated, and his breathing was accelerated. In light of the changes in Jiries' status, Dr. Mesleh transferred him to the medical intensive care unit at approximately 8:00 a.m. Once transferred, some of Jiries' lab results became available. Dr. Mesleh learned Jiries had elevated cardiac enzymes, which caused the surgeon to suspect an infection in Jiries' abdomen. In response, Dr. Mesleh ordered a broader-range antibiotic, Cipro. Jiries continued to remain on Ancef, which Dr. Mesleh acknowledged was not effective in

treating C-diff infections. Dr. Mesleh instituted the hospital's pulmonary embolism protocol due to Jiries' accelerated breathing. Jiries received a blood thinner and a central line to monitor his fluids and to prevent heart failure. Dr. Mesleh also ordered a nephrology consultation due to Jiries' low urine output. According to Dr. Mesleh, at the time, his suspicion that Jiries had a C-diff infection remained low. The stool toxin culture results were still pending. Both the cardiologist and the nephrologist examined Jiries around 11:00 a.m. Neither physician included C-diff infection as a differential diagnosis following their examinations.

¶ 14 Later on December 20, 2005, around 3:00 p.m. or 4:00 p.m., Jiries began experiencing continuous, profuse diarrhea. Dr. Mesleh testified that was the first meaningful indication Jiries could have developed a C-diff infection. In response, Dr. Mesleh ordered a chest x-ray, discontinued Ancef, and started Jiries on Flagyl, which was a more targeted antibiotic used to treat C-diff infections. The stool toxin results continued to remain pending; however, Dr. Mesleh testified that he chose to initiate the Flagyl treatment prophylactically. Dr. Mesleh also performed a protoscope procedure, which allowed him to visually examine Jiries' colon. According to Dr. Mesleh, the procedure revealed severe pseudomembranous colitis, or inflammation of the colon due to infection. Dr. Mesleh also observed signs of toxic megacolon, which is a very rare condition characterized by a distended colon and sepsis. Dr. Mesleh testified that pseudomembranous colitis and toxic megacolon are severe conditions that can be caused by C-diff infection. He estimated that he had treated patients with toxic megacolon approximately 20 times during his career. Dr. Mesleh added that toxic megacolon is a surgical emergency with a high mortality rate. Dr. Mesleh testified that he recommended Jiries receive a total colectomy, *i.e.*, total removal of his colon leaving only a part of the rectum. After discussing the risks and

benefits of the procedure with Jiries' family, the family elected to proceed with the surgery. Dr. Mesleh testified that, even with surgery, he believed Jiries only had a 50 percent chance of survival. Around 10 p.m. that evening, the results of the stool toxin culture confirmed the C-diff infection diagnosis.

¶ 15 Dr. Mesleh testified that he began surgery around 12:30 a.m. on December 21, 2005. The procedure lasted over three hours and concluded at approximately 3:40 a.m. Jiries ultimately died later on December 21 of septic shock and multiple organ failure. Jiries' death certificate, which was signed by Dr. Mesleh, listed his cause of death as "C. diff colitis."

¶ 16 Dr. Mesleh opined that, given the severity of Jiries' disease, he could not have done anything to save the patient. Dr. Mesleh explained that he could not have made the C-diff infection diagnosis until after Jiries developed profuse diarrhea during the afternoon or evening on December 20, 2005. Before then, Jiries did not exhibit any signs or symptoms of C-diff infection. According to Dr. Mesleh, Jiries' lack of a bowel movement through the morning of December 19, 2005, was inconsistent with C-diff infection. Dr. Mesleh testified that he had never seen a patient with C-diff infection who suffered from ileus or who did not have active diarrhea. Dr. Mesleh explained that the single episode of liquid stool on December 19 just after Jiries received a suppository was not indicative of C-diff infection. The single liquid stool did not constitute diarrhea. Instead, Jiries did not develop the classic, continuous diarrhea associated with C-diff infection until the afternoon of December 20. Dr. Mesleh testified that, once he suspected C-diff infection, he initiated Flagyl, which was within the standard of care. Dr. Mesleh added that he began the treatment protocol despite lacking confirmation of the diagnosis from the stool toxin sample that had been ordered on December 19. Dr. Mesleh stated that he timely

diagnosed Jiries with toxic megacolon. He opined that his decision to perform emergency surgery was appropriate and within the standard of care. According to Dr. Mesleh, there was nothing he could have done to prevent Jiries from developing toxic megacolon or to prevent Jiries' death on December 21, 2005.

¶ 17 Doctor Todd Campbell testified as plaintiff's expert via a videotaped evidence deposition. In the deposition, Dr. Campbell testified that his practice focused on breast surgery and breast care treatment for the prior three years. Dr. Campbell stated that he had just left the position; however, during those three years, he also covered emergency room calls. Dr. Campbell could not recall when he last performed a hernia repair surgery. Moreover, Dr. Campbell could not provide the number of patients that he had treated with C-diff infection and did not know if he had ever diagnosed a case of C-diff infection during his career.

¶ 18 Dr. Campbell explained that, when antibiotics are administered, the "bacteria flora in the colon" changes and an overgrowth of naturally-occurring bacteria can lead to a C-diff infection. According to Dr. Campbell, the "general protocol" once a doctor determines, or at least "strongly" suspects, that a patient has C-diff infection, is "to stop the antibiotic that the patient is taking, initiate therapy, which is Flagyl, and monitor the patient's clinical course and see how they respond to whatever that therapy is." Dr. Campbell opined that earlier initiation of treatment with Flagyl for C-diff infection would produce better results. Dr. Campbell added that "Flagyl *** is a well-tolerated medication. *** [M]ost patients don't have contradiction to Flagyl ***, and *** the side effects are relatively low." Dr. Campbell stated that one of the indications of C-diff infection is diarrhea; however, Dr. Campbell added that it is possible to have a C-diff infection without diarrhea.

¶ 19 Dr. Campbell opined that, based on his review of the medical records, Dr. Meslah should have recognized the C-diff infection in Jiries when Jiries' clinical condition began deteriorating on December 19, 2005. Dr. Campbell further opined that Dr. Mesleh's failure to timely diagnose and treat the C-diff infection violated the standard of care and caused Jiries' death. Dr. Campbell based his opinion on Jiries' overall clinical picture, including his abdominal exams, vital signs, and change in mental status.

¶ 20 Dr. Campbell, however, agreed that abdominal distention, which Jiries encountered, was common in parties with a post-operative ileus. Dr. Campbell additionally acknowledged that Jiries did not have an elevated temperature until 12:16 a.m. on December 20, 2005. Moreover, Dr. Campbell agreed that tachycardia, or an increased heart rate, could be caused by many things. Campbell acknowledged that the only reference to Jiries' having diarrhea prior to the initiation of Flagyl was on December 19 at 1:45 p.m. Dr. Campbell agreed that Dr. Mesleh ordered a stool toxin sample around 9 p.m. on December 19 and initiated Flagyl before receiving those results. Dr. Campbell also stated that the decision whether to initiate Flagyl depends on a doctor's "clinical suspicion." Dr. Campbell further acknowledged that Jiries could have developed toxic megacolon even if Dr. Meslah had begun administering Flagyl on the afternoon of December 19. Dr. Campbell could not say for certain whether earlier Flagyl treatment would have obviated the need for surgery.

¶ 21 Doctor Robert Citronberg testified that he was the director of the division of infectious diseases and the president of the medical staff at Advocate Lutheran General Hospital in Park Ridge, Illinois. Dr. Citronberg completed his fellowship training in infectious disease in 1994. Dr. Citronberg added that he had been published within the field and given numerous lectures,

including presentations on C-diff infections. Dr. Citronberg testified that he had treated over 2,000 patients, more than 100 per year, with C-diff infections during his career. Dr. Citronberg explained that "virtually all" patients with C-diff infections experienced fevers, substantially elevated white blood counts, and copious amounts of diarrhea. According to Dr. Citronberg, C-diff infection occurs across a spectrum ranging from a mild disease to a very severe disease wherein pseudomembranous colitis and toxic megacolon result. Dr. Citronberg had treated hundreds of cases of pseudomembranous colitis. Toxic megacolon, however, was considered a "pretty rare complication" that Dr. Citronberg had treated approximately 50 or 60 times.

¶ 22 Dr. Citronberg opined that Dr. Mesleh had no basis to suspect that Jiries had C-diff infection on December 19, 2005. Dr. Citronberg added that, until the afternoon of December 20, 2005, "there was a very low clinical suspicion that [Jiries] would have had [C-diff] infection." Jiries did not show signs of C-diff infection until the afternoon or evening of December 20, when he developed profuse diarrhea and a fever. Prior to that, Jiries had not had a bowel movement since surgery, his temperature was normal, and his white blood cell count was normal. Dr. Citronberg testified that increased heart rate and mental status changes, which Jiries experienced on December 19, were nonspecific findings, especially for a hospital patient receiving pain medication. Dr. Citronberg added that abdominal distention is a very common finding in patients such as Jiries, who were experiencing post-operative ileus.

¶ 23 Dr. Citronberg acknowledged that Jiries had a single episode of liquid stool in the afternoon on December 19. Dr. Citronberg highlighted that the nurse who charted the episode testified at her deposition that she observed only a small amount of liquid stool. Dr. Citronberg clarified that the medical definition of diarrhea is three or more watery stools within a 24-hour

period. One episode of liquid stool did not meet the criteria for diarrhea. Dr. Citronberg stated that the most likely explanation for Jiries' single episode of liquid stool was that he received laxatives due to the ileus. Dr. Citronberg noted that Jiries' medical record did not contain any additional references to liquid, watery stool until the afternoon of December 20 when Dr. Mesleh began to administer Flagyl.

¶ 24 According to Dr. Citronberg, when Dr. Mesleh sent in the stool sample for testing on December 19 around 9:30 p.m., there was a "very, very low clinical suspicion that C[-diff infection] was present." Dr. Citronberg opined, "based upon a reasonable degree of infectious disease certainty," that it was not necessary to start Flagyl at that time. Dr. Citronberg explained that one of two factors should be present before initiating Flagyl: (1) a positive stool sample result for C-diff infection; or (2) a high clinical suspicion for C-diff infection, meaning "somebody [with] diarrhea, fever, and a markedly elevated white blood count." Dr. Citronberg opined that, based on a reasonable degree of medical certainty and according to the standard of care, Dr. Mesleh was not required to administer Flagyl before 3:00 p.m. on December 20. Dr. Citronberg added that he believed Jiries' experienced "an extremely explosive and rapidly progressive case" of C-diff infection. Dr. Citronberg opined that initiating Flagyl on December 19 or earlier on December 20 would not have affected the outcome of Jiries' case. He explained, "[t]he presentation of [Jiries'] disease was so severe and so rapid, that even if he had gotten a couple of doses of Flagyl before that time, it wouldn't have had any impact whatsoever."

¶ 25 Doctor William Soper testified that he was the chairman of the division of general surgery for Northwest Community Hospital (Northwest Community) in Arlington Heights, Illinois. Dr. Soper also served on Northwest Community's infection control committee. Dr.

Soper approximated that he had performed thousands of hernia repairs over the course of his 28-year career. Dr. Soper testified that toxic megacolon is a very rare and severe complication of C-diff infection. Dr. Soper stated that he had only observed two other cases, and both of the patients died.

¶ 26 Dr. Soper opined that, based on his review of Jiries' medical records, Jiries did not show symptoms of C-diff infection on December 19, 2005. Dr. Soper testified that, as a reasonably careful surgeon, the level of suspicion for C-diff infection was very low on December 19, 2005 and into the late afternoon of December 20, 2005. According to Dr. Soper, the standard of care did not require Dr. Mesleh to diagnose or begin treatment for C-diff infection on December 19 or up until the late afternoon of December 20. Dr. Soper explained that none of the x-rays performed on Jiries' abdomen on December 19 or December 20 indicated that he was suffering from toxic megacolon. According to Dr. Soper, an x-ray of someone with toxic megacolon would show "changes in the wall of the intestines *** like air in the wall *** and basically the intestines becoming necrotic and dying."

¶ 27 Dr. Soper testified that Dr. Mesleh acted within the standard of care by transferring Jiries to the medical intensive care unit on the morning of December 20 based upon his changing symptoms. Dr. Soper clarified, however, that there was no suspicion of C-diff infection at that time. Dr. Soper opined that Jiries rapidly developed toxic megacolon and Dr. Mesleh timely diagnosed and treated the condition. Dr. Soper further opined that initiating Flagyl on December 19 or earlier in the day on December 20 would not have made any difference for Jiries. According to Dr. Soper, Flagyl requires 24 hours to become effective and, thus, administering the drug earlier would not have prevented Jiries from developing toxic megacolon.

¶ 28 On cross-examination, plaintiff's counsel repeatedly attempted to impeach Dr. Soper's testimony that there was nothing in the medical records prior to December 20 that would indicate Jiries had C-diff infection despite the fact that Jiries had been on Ancef for multiple days. The trial court repeatedly sustained defendants' counsel's objections to the attempted impeachment, including plaintiff's attempt to impeach Dr. Soper using the Illinois Adverse Health Care Events Reporting Law of 2005 (410 ILCS 522/10-1 (West 2004)). Notwithstanding, Dr. Soper ultimately testified that antibiotic exposure is one of the biggest risk factors for C-diff infection. Additionally, after overruling defendants' objection, Dr. Soper acknowledged his testimony that, despite knowing Jiries' had been exposed to antibiotics, he maintained there was no reason to suspect a C-diff infection before December 20. Plaintiff then attempted to admit an exhibit explicitly detailing Dr. Mesleh's continuation of Ancef, and the trial court advised plaintiff, outside the presence of the jury:

> "Here's the problem that we have, and we go back to the beginning, and cases are kind of molded around the discovery and disclosure.
>
> ***
>
> And your experts never expressed any criticism of the continuation of Ancef or said that it should have been discontinued
>
> Now, if they thought that that was the issue, then that should have been disclosed and then the defense respon[ds] to the issues as they're disclosed.
>
> The way the case has gone since 2007 is that that's never been an issue.
>
> And now you want to make it an issue, but you don't have any medical testimony from your experts to tie it up."

Dr. Soper maintained that a reasonably careful physician would not have suspected Jiries had developed a C-diff infection prior to December 20.

¶ 29 Jiries' family members testified regarding the impact on their lives of losing him as a husband, father, grandfather, business partner, and mentor.

¶ 30 Prior to deliberations, plaintiff requested that Jiries' medical records be sent to the jury room. The trial court denied the request, finding that providing them would risk having the jurors fail to independently assess the expert testimony offered during trial and would allow them to potentially improperly interpret information contained within those records. Once deliberations commenced, the jury sent a note requesting to view portions of Jiries' medical records. The trial court again denied the request, instructing the jury to decide the case based on the evidence heard during trial. Then, the jury sent a second note requesting to review Jiries' medical records to "verify Dr. visits, Nurse's visits, etc. as well as timeline." The trial court denied the request and instructed the jury to decide the case based on the evidence heard during trial. The record does not contain a transcript or acceptable substitute detailing any discussions the trial court had with the parties' counsels in connection with the jury's requests. Ill. S. Ct. R. 323 (eff. Dec. 13, 2005).

¶ 31 The jury ultimately returned a general verdict in favor of defendants. Judgment was entered on the verdict. In response, plaintiff filed a motion for a new trial, arguing: (1) the trial court erred in barring Dr. Campbell's testimony regarding Dr. Mesleh's prescribing of post-operative antibiotics; (2) the trial court erred in barring her from impeaching Dr. Soper regarding Jiries' antibiotic exposure; (3) the trial court erred in denying her request to amend the complaint to include a survival action and in barring her from introducing statements made by Jiries while in the hospital; and (4) the trial court erred in refusing to provide the jury with Jiries' medical

records during deliberations. With regard to the trial court's failure to allow admission of Dr. Campbell's testimony related to post-operative antibiotics, plaintiff stated that Dr. Campbell testified at his evidence deposition that "[d]efendant should have been aware of decedent's risk of acquiring C-diff because of decedent's prolonged exposure to the antibiotic Ancef while under [d]efendant's care." In further support, plaintiff averred Dr. Campbell testified during his discovery deposition that antibiotic exposure is the most significant factor for diagnosing C-diff. Plaintiff attached one page of Dr. Campbell's alleged discovery deposition,[5] in which the witness testified that, in order to diagnose a C-diff infection, a doctor must assess the patient's clinical scenario. The witness explained:

> "As surgeons we most often see [C-diff infections] in patients that have received antibiotics. I mean, usually when we see it, it is in an acute setting, either hospital or someone who presents to our office, so that's when we typically would think about it as a diagnosis in someone who has gotten antibiotics, number one, and two, has some type of abdominal complaint. I mean, typically it could be abdominal pain, diarrhea. Those are generally what we would sort of look for in the patient we thought might have the C-difficile colitis."

¶ 32 In denying the motion for a new trial, the trial court generally noted that plaintiff failed to attach a trial transcript, which prevented the court from reviewing "what discussions occurred, whether objections were raised. Because if you don't raise objections, you waive objections. But it's difficult to make that determination when you don't have a copy of the transcript." More specifically, in response to plaintiff's claim that Dr. Campbell's testimony was improperly

[5] There are no identifying marks on the page to confirm the name of the witness or when the testimony was given. The single page is merely a portion of the discovery deposition.

limited, the trial court emphasized that, prior to trial, plaintiff never disclosed as a theory of her case that Dr. Mesleh failed to appreciate a known risk associated with Ancef or breached the standard of care by failing to discontinue the prescription postoperatively. The trial court stated that the theory was not included in plaintiff's Rule 213 disclosures or in the portion of Dr. Campbell's discovery deposition, nor was it a natural or logical corollary of those disclosures. The trial court further noted that plaintiff failed to make an offer of proof for the purported testimony.

¶ 33 Next, in response to plaintiff's claim that she was improperly prevented from impeaching Dr. Soper, the trial court found that plaintiff was allowed to question Dr. Soper regarding Dr. Mesleh's clinical decisions prior to diagnosing Jiries with C-diff infection, including the medications Jiries was prescribed. The trial court provided that it only limited plaintiff's cross-examination of Dr. Soper consistent with its prior rulings that Dr. Soper could not testify whether Dr. Mesleh's failure to discontinue Ancef was a deviation from the standard of care because that opinion was not disclosed prior to trial. The trial court further explained that plaintiff's attempt to impeach Dr. Soper with an inapplicable statute would have been irrelevant, prejudicial, and confusing for the jury.

¶ 34 Then, in response to plaintiff's claim of error for denying her motion to amend the complaint to add a survival claim, the trial court reiterated that its basis for denying the motion was the lack of timeliness, in that the motion was brought 9 years after the original action was filed, and the lack of proper disclosure, in that there was no evidence or discovery regarding survival damages other than for Jiries' conscious pain and suffering. The trial court further noted that the issue was moot and any error was harmless because the jury did not consider damages

where it found in favor of defendants. Moreover, the trial court noted that plaintiff did not contest the trial court's decision to grant defendants' motions *in limine* barring evidence regarding medical expenses and loss of earning due to lack of disclosure. The trial court further found that allowing hearsay statements that Jiries allegedly made regarding what he was feeling while in the hospital was highly prejudicial and had no relevance for establishing whether defendant deviated from the standard of care.

¶ 35 Finally, in response to plaintiff's claim that the trial court improperly denied the jury's request to review Jiries' medical records during deliberations, the court explained "[b]ecause the medical records contained extensive medical information beyond the average juror's understanding as well as irrelevant information that may have confused or improperly influenced the jury," it was not appropriate to send the records to the jury.

¶ 36 This appeal followed.

¶ 37 ANALYSIS[6]

¶ 38 I. Evidentiary Errors

¶ 39 Plaintiff first contends the trial court erroneously restricted her ability to examine the expert witnesses regarding Dr. Mesleh's failure to appreciate that Jiries' antibiotic exposure placed him at an increased risk for developing a C-diff infection. Plaintiff maintains the line of questioning was a permissible elaboration on, or logical corollary to, Dr. Campbell's disclosed opinion.

[6] We caution plaintiff's counsel to abide by the dictates of Illinois Supreme Court Rule 23 and avoid citing as precedent unpublished written orders, which he did on multiple occasions in his appellant brief. Ill. S. Ct. R. 23 (eff. July 1, 2011).

¶ 40 We review a trial court's evidentiary rulings for an abuse of discretion. *Chapman v. Hubbard Woods Motors, Inc*., 351 Ill. App. 3d 99, 105 (2004). An abuse of discretion will be found where no reasonable person would take the view adopted by the court. *Foley v. Fletcher*, 361 Ill. App. 3d 39, 46 (2005).

¶ 41 In order to sustain a medical malpractice action, a plaintiff generally must present expert testimony demonstrating the defendant deviated from the standard of care and the deviation proximately caused the plaintiff's injuries. *Nedzvekas v. Fung*, 374 Ill. App. 3d 618, 623 (2007). Illinois Supreme Court Rule 213 is a discovery rule that dictates mandatory witness disclosures. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 109 (2004). Rule 213(f)(3) requires parties to furnish, among other things, the subject matter, conclusions, and opinions of controlled witnesses testifying at trial, *i.e.*, the party, the party's current employee, or the party's retained expert. Ill. S. Ct. 213(f)(3) (eff. Jan. 1, 2007). Moreover, Rule 213(g) limits the direct testimony of expert opinions to "[t]he information disclosed in answer to a Rule 213(f) interrogatory" or in a discovery deposition. Ill. S. Ct. 213(g) (eff. Jan. 1, 2007). The supreme court has found that a Rule 213 disclosure requires "specifics," and litigants must strictly comply with the rule. *Sullivan*, 209 Ill. 2d at 109. The purpose of the rule is "to avoid surprise and permit litigants to ascertain and rely upon the opinions of experts retained by the opposing party." *Scassifero v. Glaser*, 333 Ill. App. 3d 846, 860 (2002). "A witness may elaborate on a disclosed opinion as long as the testimony states logical corollaries to the opinion, rather than new reasons for it." *Foley*, 361 Ill. App. 3d at 47 (citing *Barton v. Chicago & North Western Transportation Co.*, 325 Ill. App. 3d 1005, 1039 (2001)). In other words, the trial testimony must be encompassed by the

original opinion. *Id*. The trial court may not allow previously undisclosed opinions that advance a new theory of negligence. *Id*.

¶ 42 Plaintiff's Rule 213 disclosure provided, in relevant part, that Dr. Campbell would testify:

> "that there was a delay in diagnosis in the postoperative period and this directly contributed to the death of the patient. Review of the records indicates the patient was not progressing in the expected time frame given the operation performed. On 12/19/05, the patient clearly exhibited signs of significant clinical decline with increasing oxygen requirement, tachycardia, chills, low urine output, hypotension and mental status changes. A c.diff toxin assay was sent on 12/19/0[5] at 2200 [hours]. This clearly shows that c.diff colitis was in the differential diagnosis of Dr. Mesleh and it is at this point empiric antibiotic therapy should have been initiated against c.diff colitis given the clinical deterioration of the patient. Instead, the order for the antibiotic (Flagyl) was not written until 12/20/05 after the c.diff toxin assay was resulted positive earlier that same day. This delay [in] diagnosis and appropriate intervention resulted in the patient returning to the operating room in near extremis with little chance of survival. ***. That in his professional medical opinion, the actions of Dr. George Mesleh in this case constituted medical malpractice."

According to plaintiff, in his discovery deposition, Dr. Campbell was asked, "In your opinion from your experience and knowledge of this disease, what is the appropriate clinical scenario that would lead you as a general surgeon to suspect C-difficile?" The deponent responded:

> "As surgeons we most often see it in patients that have received antibiotics. I mean, usually when we see it, it is in an acute setting, either hospital or someone who presents to our office, so that's when we typically would think about it as a diagnosis in someone who has gotten antibiotics, number one, and two, has some type of abdominal complaint. I mean, typically it could be abdominal pain, diarrhea. Those are generally what we would sort of look for in the patient we thought might have the C-difficile colitis."

The record does not contain Dr. Campbell's entire discovery deposition. The single page portion referenced by plaintiff lacks identifying marks, but it was attached to plaintiff's motion for a new trial and was considered by the trial court in denying the motion.

¶ 43 Dr. Campbell did not testify at trial. Instead, his videotaped evidence deposition was played for the jury in his absence. Prior to doing so, the trial court had granted, over plaintiff's objection, defendants' motion *in limine* that "Ancef can come in as [part of] the whole [clinical] picture and everything else. [Dr. Campbell] just can't say it was a deviation from the standard of care" to keep Jiries on Ancef after the operation. Then, the day before Dr. Campbell's evidence deposition was to be shown to the jury, the trial court held a hearing outside the jury's presence to consider defendants' objections to the evidence deposition testimony. During the hearing, the trial court struck various lines of Dr. Campbell's testimony, which seemingly the court and the parties had in transcript form. The trial transcript from the hearing reveals that the objectionable testimony related to Dr. Mesleh's failure to discontinue Ancef after the operation. The trial court reasoned that the testimony was not previously disclosed in the Rule 213 disclosures or in Dr. Campbell's discovery deposition. The record, however, does not contain the unredacted transcript of Dr. Campbell's evidence deposition.

¶ 44 It was plaintiff's burden to provide this court with a sufficiently complete record for our review. *Foutch v. O'Bryant*, 99 Ill. 2d 389, 391 (1984). In the absence of a sufficiently complete record, the reviewing court will presume "that the order entered by the trial court was in conformity with law and had a sufficient factual basis. Any doubts which may arise from the incompleteness of the record will be resolved against the appellant." *Id*. at 391-92. Our supreme court has instructed that "where the issue on appeal relates to the conduct of a hearing or proceeding, this issue is not subject to review absent a report or record of the proceedings." *Webster v. Hartman*, 195 Ill. 2d 426, 432 (2001).

¶ 45 Based on the record before us, our review is limited to the piecemeal context that we can gather through the hearing transcript. We cannot affirmatively establish what testimony was objected to and what testimony was eliminated. The transcript only demonstrates that the trial court struck various lines of Dr. Campbell's evidence deposition. The record, therefore, is void of Dr. Campbell's disputed testimony. Because we lack the ability to meaningfully review the trial court's rulings regarding Dr. Campbell's challenged testimony, we must presume the trial court did not err in its decision. See *id.*; *Foutch*, 99 Ill. 2d at 391-92. Moreover, plaintiff failed to provide an offer of proof in his posttrial motion or during the hearing on the motion. Accordingly, we have no means to assess the purported excluded testimony. Plaintiff's contention, therefore, is waived. See *Malanowski v. Jabamoni*, 332 Ill. App. 3d 8, 14 (2002) ("[t]he failure to make an offer of proof of excluded testimony waives that issue for purpose of review").

¶ 46 Despite the inadequacy of the record, we conclude the trial court did not abuse its discretion in prohibiting Dr. Campbell from opining at trial that Dr. Mesleh breached the

standard of care by failing to appreciate that Jiries' postoperative exposure to the antibiotic Ancef placed him at an increased risk for developing a C-diff infection. The record demonstrates that Dr. Campbell did not opine in his Rule 213 disclosure or his discovery deposition anything expressly related to Jiries' postoperative prescriptions. Dr. Campbell's disclosed opinion regarding the link between antibiotics and C-diff infections was a generalization across patients. More specifically, Dr. Campbell testified that antibiotics in a patient's system can cause the overgrowth of naturally-occurring bacteria and lead to a C-diff infection. There was no disclosed opinion by Dr. Campbell linking Jiries, Ancef, and his C-diff infection nor was that opinion a logical corollary to his stated opinion. The challenged opinion was a new, undisclosed theory of negligence. We, therefore, fail to find the trial court abused its discretion in barring plaintiff's attempts to admit the challenged opinion. See *id.*

¶ 47 Plaintiff similarly contends the trial court abused its discretion by preventing her from cross-examining Dr. Soper, one of defendants' experts, regarding Dr. Mesleh's failure to discontinue Ancef. Plaintiff argues she should have been allowed to elicit testimony from Dr. Soper regarding Jiries' postoperative exposure to antibiotics and to impeach Dr. Soper on his contradicting admissions that nothing in Jiries' medical records indicated a risk of C-diff infection while also admitting that antibiotic exposure is one of the most serious risks for developing C-diff. Plaintiff insists the "only way to prove the lie, was to discuss the decedent's antibiotic exposure, which the [Dr. Soper] had already acknowledged awareness of."

¶ 48 We find the trial court did not abuse its discretion. Dr. Soper did testify on cross-examination that antibiotic exposure was a risk factor for developing a C-diff infection. More critically, Dr. Soper acknowledged that, despite antibiotic exposure posing as a risk factor, he did

not believe there was a reason to suspect Jiries had a C-diff infection before December 20. Accordingly, although Dr. Soper maintained his opinion that Dr. Mesleh did not breach the standard of care, the jury was advised that Jiries' antibiotic exposure was a risk factor in developing a C-diff infection and that Dr. Soper's direct testimony provided that there was nothing in Jiries' medical records indicating a C-diff infection. Dr. Soper's contradicting testimony was provided to the jury. Plaintiff, therefore, was limited only in questioning Dr. Soper regarding the new, undisclosed theory that Dr. Mesleh breached the standard of care by failing to discontinue Ancef. We have already determined that the trial court did not abuse its discretion in limiting plaintiff from eliciting this opinion from her expert. We further find the trial court did not abuse its discretion in limiting plaintiff's cross-examination of Dr. Soper. *Cf. Jackson v. Reid,* 402 Ill. App. 3d 215, 234 (2010) (the disclosure requirements did not limit or restrict the plaintiff's cross examination of the defendant's expert opinion where the work-product doctrine did not apply and the attorney-client privilege had been waived).[7]

¶ 49 II. Motion to Amend

¶ 50 Plaintiff next contends the trial court erred in denying her motion to amend her complaint to clarify and clearly allege both a wrongful death and a survival claim.

¶ 51 Generally, a trial court should exercise its discretion liberally to allow a party to amend his or her pleading so long as doing so would further the ends of justice. *Alpha School Bus Co. v. Wagner*, 391 Ill. App. 3d 722, 748 (2009). That said, the privilege to amend a pleading is not absolute. *Id*. In determining whether to allow an amendment, a trial court should consider: (1)

[7] Plaintiff has abandoned her argument that the Illinois Adverse Health Care Events Reporting Law of 2005 applied to Dr. Soper's testimony. The argument, therefore, is waived. Ill. S. Ct. R. 341(h)(7) (eff. Nov. 1, 2017).

whether the proposed amendment would cure the defective pleading; (2) whether other parties would sustain prejudice or surprise because of the proposed amendment; (3) the timeliness of the proposed amendment; and (4) whether there were earlier opportunities to amend. *Loyola Academy v. S & S Roof Maintenance, Inc.*, 146 Ill. 2d 263, 273 (1992). A trial court's decision whether to allow an amendment is reviewed for an abuse of discretion. *Id*.

¶ 52 Here, plaintiff sought to amend her complaint two days before the jury trial was scheduled to begin, which was over three years after plaintiff had refiled the underlying complaint. Although the trial court initially denied the request to amend in total, upon reconsideration, the court granted plaintiff's motion in part, thereby allowing the jury to consider damages for Jiries' conscious pain and suffering while in the hospital. The trial court adopted the "hybrid approach" suggested by plaintiff, finding there would not be unfair surprise to defendants where testimony regarding Jiries' conscious pain and suffering had been disclosed. Jiries' family members testified at trial about their observations of his pain and suffering in the days before his death, and the jury was instructed that it could consider conscious pain and suffering when awarding damages. Based on the lack of diligence in proposing the amendment, the earlier opportunities to amend, and, most importantly, the surprise and prejudice that the full amendment would impose on defendants, we conclude the trial court did not err in denying plaintiff's motion to amend the refiled complaint. See *id.*

¶ 53 Moreover, we cannot ignore the fact that the jury never reached the matter of damages where it found in favor of defendants on the issue of liability. In general, errors concerning the extent of damages are not reversible where the jury finds the defendant was not liable, and the plaintiff fails to establish the error was so "pervasive and prejudicial" that there is a likelihood it

may have affected the jury's decision regarding liability. *Brax v. Kennedy*, 363 Ill. App. 3d 343-352 (2005). Plaintiff does not allege the trial court's refusal to amend to allow the jury to consider the entirety of survival damages was so "pervasive and prejudicial" that there was a likelihood it may have affected the jury's decision on liability. In fact, in an attempt to argue that defendants would not suffer unfair surprise or prejudice by the amendment, plaintiff conceded that there was no additional evidence necessary to support liability under a survival claim. Plaintiff, instead, argued that both her wrongful death and survival claims were based on the same set of facts. Because there was no set of additional facts to support the survival claim, plaintiff cannot establish that the trial court's decision affected the jury's decision on liability. Furthermore, plaintiff failed to challenge the trial court's motions *in limine* restricting damages to pain and suffering and barring Jiries' family members from testifying regarding Jiries' statements made before death. Any challenge, therefore, is waived. Ill. S. Ct. R. 341(h)(7) (eff. Nov. 1, 2017) ("[p]oints not argued are waived and shall not be raised in reply brief, in oral argument, or on petition for rehearing").

¶ 54 III. Exhibits During Jury Deliberations

¶ 55 Plaintiff finally contends the trial court erred in refusing to allow the jury to view Jiries' medical records during deliberations.

¶ 56 Pursuant to section 2-1107(d) of the Code of Civil Procedure (735 ILCS 5/2-1107(d) (West 2016)), documents read or received into evidence may be provided to the jury during deliberations. The decision whether to send exhibits to the jury during deliberations rests within the sound discretion of the trial court and will not be disturbed absent an abuse of that discretion.

Young v. Alden Gardens of Waterford, LLC, 2015 IL App (1st) 131887, ¶ 66; *Malanowski*, 332 Ill. App. 3d at 14.

¶ 57 Plaintiff does not challenge the trial court's initial decision not to provide the jury with the medical records when it began deliberations. Plaintiff additionally does not challenge the trial court's response to the jury's first note generally requesting the records. Plaintiff takes issue with the trial court's refusal to allow the jury to view specified records requested by the jury in its second note. The exhibits requested were those viewed by the jury during trial, namely, "boards" that included the doctor and nurse visits and a timeline of the events. Plaintiff argues the trial court's initial reasoning for refusing to provide the records no longer applied because there was no risk that the requested records would be misunderstood by the jurors where they already had been presented at trial. Instead, plaintiff argues the records were essential to assist the jury to establish the critical timeline related to Dr. Mesleh's delay in diagnosing Jiries with a C-diff infection.

¶ 58 We first note that the appellate record is devoid of a transcript or acceptable substitute detailing any conversations the parties had with the court regarding the trial court's responses to the jury's notes. See Ill. S. Ct. R. 323 (eff. Dec. 13, 2005). We, therefore, have no way to know whether plaintiff objected to the trial court's decision to deny the jury's requests for Jiries' medical record. In order to properly preserve an error for appellate review, a litigant must both simultaneously object and raise the challenged error in a posttrial motion. *People v. Enoch*, 122 Ill. 2d 176, 186 (1988). Without a sufficient record, we are unable to determine whether plaintiff satisfied her obligation to object at trial. Plaintiff, however, did include the purported error in her

posttrial motion. Waiver aside, we conclude the trial court did not abuse its discretion in denying the jury's records request.

¶ 59 Courts have found a trial court does not abuse its discretion in refusing to allow records during jury deliberations where "the records contained extensive medical information beyond the average juror's understanding as well as irrelevant information which might have improperly influenced the jury." *Id*. (citing *Fultz v. Peart*, 144 Ill. App. 3d 364, 380 (1986)); *Merlo v. Parisi*, 255 Ill. App. 3d 53, 62-63 (1993). *Malanowski*, *Fultz*, and *Merlo* all shared factual similarities to the case at bar. In all of those cases, where the trial courts refused the jury's requests to take hospital records into the jury room, the trial witnesses for both parties were allowed to refer to and read parts of the records, and counsels for both parties were allowed to refer to the records in closing arguments. *Malanowski*, 332 Ill. App. 3d at 14; *Fultz*, 144 Ill. App. 3d at 380; *Merlo*, 255 Ill. App. 3d at 63. Likewise, in this case, the jury observed the documents, heard the witnesses' testimony in connection with the records, and both plaintiff's and defendants' counsel were able to refer to the records in their closing arguments. More critically, the record on appeal does not contain the "board" that plaintiff argues should have been provided to the jury. Without a sufficient record to assess plaintiff's claim, we must presume the trial court's decision was in accordance with the facts and the law. *Foutch*, 99 Ill. 2d at 391-92. We, therefore, conclude the trial court did not abuse its discretion in refusing to allow the jury to view the requested medical records during its deliberations.

¶ 60 CONCLUSION

¶ 61 We affirm the trial court's judgment.

¶ 62 Affirmed.