2016 IL App (1st) 151012-U
No. 1-15-1012

THIRD DIVISION
December 7, 2016

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

CYNTHIA WILLIAMS and, KENNETH WILLIAMS, individually, and as Parents and Next Friends of KENNADI WILLIAMS, a minor,	)	Appeal from the Circuit Court of Cook County.
Plaintiffs-Appellants,	)	No. 10 L 12558
v.	)	The Honorable Donald Suriano, Judge Presiding.
BYRON ROSNER, M.D., and, REPRODUCTIVE HEALTH ASSOCIATES, S.C., a for-profit corporation,	)	
Defendants-Appellees.	)	

JUSTICE PUCINSKI delivered the judgment of the court.
Presiding Justice Fitzgerald Smith and Justice Cobbs concurred in the judgment.

ORDER

¶ 1 *Held:* jury verdict in favor of defendants in a wrongful pregnancy action affirmed where: the evidence did not so overwhelmingly favor the plaintiff parents to warrant a judgment notwithstanding the verdict; the verdict was not against the manifest weight of the evidence; the jury received a proper set of instructions; and the circuit court's evidentiary rulings did not amount to an abuse of discretion.

¶ 2 Plaintiffs Cynthia Williams and Kenneth Williams, individually, and as parents and next friends of Kennadi Williams, a minor born with sickle cell disease following an unsuccessful sterilization procedure, filed a complaint advancing claims of negligence and wrongful pregnancy against defendants Byron Rosner, M.D., and Reproductive Health Associates (Reproductive Health). The cause proceeded to trial where the jury returned with a verdict in favor of defendants. Plaintiffs have filed a *pro se* appeal challenging the verdict. For the reasons set forth herein, we affirm the judgment of the circuit court.

¶ 3 BACKGROUND

¶ 4 Cynthia and Kenneth Williams are both carriers of the sickle cell trait, and their first child, a son, was born with sickle cell disease. In January 2001, after the birth of the couple's son, Cynthia began receiving OB/GYN Services from various physicians employed by Reproductive Health and practiced various birth control options prescribed by the doctors. On November 28, 2005, Cynthia elected to undergo a tubal ligation in an effort to achieve permanent sterility. The procedure was subsequently canceled, however, when complications arose with respect to the anesthesia.

¶ 5 Thereafter, on December 8, 2008, Cynthia had a consultation with Doctor Rosner to further discuss birth control options. At the conclusion of the consultation, Cynthia elected to undergo a mini-laparotomy and tubal ligation procedure, to be performed by Doctor Rosner. Cynthia underwent the procedure on December 30, 2008.

¶ 6 Thereafter, on June 24, 2009, Cynthia learned that she was pregnant. Cynthia gave birth to a daughter, Kennadi, on February 1, 2010, via cesarean-section (C-section). At this time, Cynthia learned that only her right fallopian tube had been tied during the December 2008 sterilization procedure. Kennadi was subsequently diagnosed with sickle cell disease. Following

Kennadi's birth and diagnosis, plaintiffs filed a complaint and amendments thereto, against defendants advancing claims of medical negligence and wrongful pregnancy. In their amended filings, plaintiffs alleged that Cynthia had a consultation with Doctor Rosner, during which she communicated the following relevant information: that she and her husband were carriers of the sickle cell trait; that they had a son afflicted with sickle cell disease; and that they desired permanent sterility to avoid conceiving another child with sickle cell disease. Doctor Rosner scheduled a tubal ligation procedure following their discussion. Plaintiffs, however, alleged that Doctor Rosner negligently "failed to perform an adequate or appropriate tubal ligation" procedure and that, as a direct and proximate result of the Doctor Rosner's negligence, they "had an unplanned pregnancy and undesired fertility and gave birth to a child afflicted with [s]ickle [c]ell [d]isease." Plaintiffs further alleged that the birth of a child afflicted with sickle cell disease was "a foreseeable consequence of" Doctor Rosner's negligence due to the fact that he had "actual knowledge that [plaintiffs] were [both] carriers of the [s]ickle [c]ell [t]rait, and that the birth of a child afflicted with [s]ickle [c]ell [d]isease would be a likely consequence of a failed tubal ligation" procedure. As a result, plaintiffs sought to recover a variety of damages including the extraordinary expenses that they would incur in raising Kennadi to the age of majority.

¶ 7 Defendants, in turn, denied plaintiffs' allegations and then moved to dismiss their claim for wrongful pregnancy. In support of their motion, defendants argued that there was no Illinois authority expressly permitting parents who file wrongful pregnancy actions to recover extraordinary expenses associated with raising a child born with a genetic defect or abnormality following an unsuccessful sterilization procedure. Defendants further argued dismissal was proper because there was no way for plaintiffs to satisfy the element of proximate cause. That is,

defendants argued that while the arguably negligent tubal ligation procedure was indisputably the cause of Cynthia's pregnancy, it was not the cause of Kennadi's genetic defect.

¶ 8 The circuit court denied defendants' motion to dismiss plaintiffs' wrongful pregnancy claim. In a supplemental order entered *nunc pro tunc*, the circuit court certified the following question for interlocutory review:

> "Whether a plaintiff in an action for wrongful pregnancy may recover the extraordinary expenses of raising a child afflicted with sickle cell disease when the defendant physician knew (1) that the plaintiff and her husband were carriers of the sickle-cell trait, and (2) that the plaintiffs had previously conceived a child with sickle-cell disease, and (3) that the plaintiffs desired sterilization to avoid giving birth to another child afflicted with sickle-cell disease?"

¶ 9 This court accepted the certified question for review and on February 26, 2014, we filed an opinion answering the certified question in the affirmative. *Williams v. Rosner*, 2014 IL App (1st) 120378. In doing so, we concluded, in pertinent part:

> "We decline to impose a rigid arbitrary damage limitation on damages available to wrongful pregnancy plaintiffs. Rather, we conclude that where as here, the birth of a child with a genetic abnormality is a foreseeable consequence of a negligently performed sterilization procedure and where the parents' desire to avoid contraception precisely for that reason has been communicated to the doctor performing the procedure, parents may assert a claim for the extraordinary expenses that they will incur in raising their child to the age of majority." *Id.* ¶ 36.

¶ 10 Our disposition was solely limited to the potential availability of extraordinary damages and we rendered no opinion as to liability. After this court answered the certified question submitted for review, the cause subsequently proceeded to trial.

¶ 11 Trial

¶ 12 At trial, Doctor Lewis Hsu, a pediatric hematology physician and the Director of the Pediatric Sickle Cell Department at the University of Chicago, provided the jury with a detailed explanation of sickle cell disease. He testified that "sickle cell is an inherited blood condition that affects the red blood cells," which are the cells "that carry the oxygen" throughout the body. Individuals afflicted with sickle cell disease have "sickled" or irregular crescent-shaped red blood cells. Due to their irregular shape, the blood cells can break apart prematurely. In addition, when the sickled red blood cells travel through blood vessels they can get stuck, resulting in a blockage of blood flow. Doctor Hsu explained that sickle cell disease is an "inherited condition" that may occur when both of the child's parents are carriers of the sickle cell trait. Parents who are carriers of the sickle cell trait have one normal gene allele and one allele for sickle cell disease. Generally, carriers of the sickle cell trait are healthy and exhibit no symptoms of sickle cell disease. When two people with the sickle cell trait procreate, however, there is a 25% that their child will have sickle cell disease. Children born with sickle cell disease generally require careful medical monitoring. Doctor Hsu explained that babies with sickle cell disease are more susceptible to infection and death. Moreover, as the children get older, there are concerns about dehydration, strokes, blindness, and lung and kidney problems. In addition, because the crescent-shaped red blood cells characteristic of sickle cell disease may block blood flow, tissue death occurs more frequently in people with sickle cell disease resulting in organ

damage and infection. Given the complications that can result from sickle cell disease, children born with the condition often require more frequent medical care and monitoring.

¶ 13 Kenneth Williams testified he first learned that he was a carrier of the sickle cell trait in 1992, when his son Christopher was born and subsequently diagnosed with sickle cell disease. Following Christopher's birth, he and his wife practiced various forms of birth control in an effort to avoid having another child afflicted with sickle cell disease. Cynthia, however, experienced complications with different birth control methods. Ultimately, after an unplanned pregnancy of a healthy child, she decided to undergo a tubal ligation procedure in 2005. The procedure, however, was not performed because complications arose when doctors attempted to intubate and anesthetize Cynthia.[1] Thereafter, in 2008, Cynthia met with Doctor Rosner and decided to attempt another tubal ligation procedure. There were no complications during the procedure and Kenneth and Cynthia were under the impression that "the procedure went well." In 2009, however, they discovered that Cynthia was pregnant. They were both upset and scheduled a meeting with Doctor Rosner to get "answers;" however, Kenneth testified that they "never got answers about why [Cynthia] became pregnant" following her tubal ligation procedure. After Kennadi was born following a scheduled C-section procedure, Kenneth and Cynthia learned that her left fallopian tube had not been tied. Sometime thereafter, they learned that Kennadi was born with sickle cell disease.

¶ 14 Cynthia Williams testified that she knew that she carried the sickle cell trait before she married Kenneth, but that neither she nor her husband knew that he was also a carrier of the trait until she gave birth to their son who was subsequently diagnosed with sickle cell disease.

1 We note that the medical records contained in the record on appeal do not indicate whether a bilateral tubal ligation was scheduled in 2005. The records, however, reflect Doctor Goldstone's understanding that Cynthia had previously undergone a left salpingo oopherectomy, and thus had both her left fallopian tube and left ovary removed.

Cynthia further testified that she had an ovarian cyst that ruptured when she was younger and that she underwent an oopherectomy[2] when she was in the 7th Grade. Although she never knew which of her ovaries was removed, she was always aware that she only had one ovary and relayed that information to her doctors. Cynthia confirmed that she and her husband practiced various forms of birth control after their son was diagnosed with sickle cell disease because they were "adamant" that they did not want to have any more children who could potentially be afflicted with the same genetic condition. Eventually, she sought out reproductive counseling and services at Reproductive Health. She conferred with Doctor Goldstone, a physician at the practice, and relayed her prior medical history and her desire for permanent sterility. Cynthia testified that she told Doctor Goldstone that she only had one ovary and that Doctor Goldstone performed an ultrasound to verify her story. She did not know what the ultrasound showed.[3] Thereafter, a tubal ligation procedure was scheduled in 2005; however, the procedure could not be performed when the doctors encountered difficulties intubating and anesthetizing her.[4] Cynthia testified that she decided to undergo a second tubal ligation attempt in 2008. By that time, Doctor Goldstone had retired and she was referred to Doctor Rosner, another physician at the practice.

¶ 15 Cynthia testified that when she met with Doctor Rosner, she relayed that she had a son with sickle cell disease and that she wanted a tubal ligation to prevent giving birth to another child afflicted with the same condition. She also informed him that she only had one ovary. Doctor Rosner performed the procedure on December 30, 2008. Afterwards, he told her that

2 An oopherectomy is a surgical procedure in which one or both of a woman's ovaries are removed. http://www.mayoclinic.org/tests-procedures/oophorectomy/basics/definition/PRC-20012991 (last visited October 19, 2016).

3 The ultrasound itself is not included in the record on appeal.

4. There is a report contained in the record on appeal indicating that the procedure had been cancelled. The procedure identified in the report is a "TL." There is no mention of a bilateral tubal ligation.

"everything went well." He never mentioned adhesions and never informed her that he had only tied one of her tubes.

¶ 16 Cynthia recalled that sometime in June 2009, she began experiencing severe breast tenderness and felt "extremely, extremely tired." She thought she might have breast cancer and scheduled an appointment with her primary care physician. She was "shock[ed]" to discover that she was actually pregnant and sought an explanation from Doctor Rosner; however, he was not able to provide her with a reason as to why she became pregnant following the tubal ligation procedure. Cynthia ultimately gave birth to Kennadi via C-section. Doctor Van Woert, her surgeon, also performed a tubal ligation procedure after delivering Kennadi. He subsequently informed Cynthia that her left fallopian tube had never been tied and that she was "never sterile." Cynthia and her husband also later found out that Kennadi had been born with sickle cell disease. Thus far, Kennadi has not had any major complications caused by her disease; however, she is monitored regularly by a pediatric hematologist.

¶ 17 On cross-examination, Cynthia acknowledged that during an earlier deposition, she had testified that she told Doctors Goldstone and Rosner that her left ovary had been removed. She denied informing her doctors that one of her fallopian tubes had also been removed.

¶ 18 Doctor John Van Woert, a licensed OB/GYN, testified that he provided Cynthia with prenatal care after she became pregnant with Kennadi. Because Cynthia had two prior C-sections, he planned to deliver Kennadi via C-section as well. In addition, Cynthia wanted him to examine her pelvis and perform a tubal ligation procedure. Cynthia informed him that she had undergone a prior unsuccessful tubal ligation and that she "wanted to see what was found inside her pelvis." In addition, she "wanted to be re-sterilized." Cynthia also told Doctor Van Woert that one of her ovaries had been removed when she was younger.

¶ 19 Doctor Van Woert testified that he intended to "tie off both tubes" because that is "always" the way that such procedures are to be done. He explained that surgeons are required to assess both fallopian tubes during a tubal ligation procedure. Given the fact that Cynthia had undergone two prior C-sections, he assumed that he would find adhesions, or internal scar tissue, when he operated on her. He explained that the adhesions would need to be removed if they were located in the area where the incision would be made. The "filmy" thin adhesions could be "peeled away," whereas the thicker and denser adhesions would have to be cut away. He explained that surgeons have to be very careful with adhesions because damage to "vessels" and "a variety of structures" can occur if the adhesions are not handled properly.

¶ 20 Doctor Van Woert testified that the C-section was uneventful and that he turned his attention to the tubal ligation after successfully delivering Kennadi. He encountered "a lot of adhesions in various states of thickness" that obscured Cynthia's uterus and fallopian tubes. After breaking down the adhesions so that he could "visualize the left fallopian tube and ovary," he was able to tie off the left tube. He then "took down some more adhesions" before working on the right side. Once he did so, he encountered a right tube that was a "little bit shorter than the left tube" and was "kind of wrapped around itself." Doctor Van Woert then tied the right tube. Based on the observations he made while performing Cynthia's bilateral tubal ligation, her left fallopian tube had not been touched during her first tubal ligation procedure. Doctor Van Woert acknowledged, however, that even when a tubal ligation is performed reasonably carefully, a woman may nonetheless become pregnant. He testified that he apprised Cynthia of the recognized failure rate for tubal ligations prior to her procedure.

¶ 21 Doctor John DiOrio, plaintiffs' retained expert witness, reportedly provided standard of care and causation testimony; however, the record on appeal does not contain transcripts of his trial testimony.

¶ 22 Doctor Rosner testified that Cynthia became his patient sometime in 2006 or 2007 after one of the partners of the practice retired. When Cynthia became his patient, he spoke to her and familiarized himself with her medical history. As such, he was aware that a prior tubal ligation procedure had been cancelled when complications arose with respect to the anesthesia. Cynthia also reported that both her left ovary and her left fallopian tube had been removed when she was younger. Doctor Rosner also familiarized himself with a 2004 ultrasound, but explained that ultrasounds are "not *** good imaging tests for the presence or absence of fallopian tubes" or ovaries.

¶ 23 Doctor Rosner testified that he and Cynthia discussed a potential tubal ligation for the first time in 2008. At that time, Cynthia relayed that she no longer wanted to take birth control pills, that she had a son with sickle cell disease and that she did not want any more children. Doctor Rosner agreed to perform a tubal ligation and recommended that he complete the procedure utilizing a mini-laparatomy, "which is a small incision about two and a half inches at most in length in the lower part of the abdomen above the top of where the uterus should be." He explained that a mini-laparotomy can be performed using "spinal anesthesia" rather than general anesthesia and testified that he believed that this method would "be a much safer approach considering [Cynthia's] complication with general anesthesia in the past." Doctor Rosner testified that he discussed the potential risks of the procedure with Cynthia and also informed her that there was a known failure rate associated with tubal ligation surgeries.

¶ 24 Doctor Rosner testified that he never intended to perform a bilateral tubal ligation because Cynthia had informed him that her left fallopian tube and left ovary had been removed; rather, he intended to focus his attention on Cynthia's right tube.[5] He did not order any imaging studies to be performed prior to surgery because "it wasn't necessary" and because ultrasounds are unreliable. The surgery was scheduled for December 30, 2008. On that date, Doctor Rosner made a small incision "in the midline" area and entered the abdomen. Upon doing so, he found very thick adhesions; however, he was not surprised by that finding given that Cynthia had undergone prior C-sections and other surgeries. He testified that adhesions make surgeries more difficult because they often have "a lot of blood supply" and there can be "a lot of blood loss" when an adhesion is "lysed" or cut. In addition, adhesions "can take pelvic and abdominal organs and make them stick and be in places they're not naturally found." They also make it difficult for surgeons "to visualize wherever [they are] trying to go."

¶ 25 Doctor Rosner testified that he was able to see the "top of an ovary" on the right side and was able to tie Cynthia's right tube. He acknowledged that he was not able to visualize the left side of Cynthia's uterus due to the thick adhesions; however, he testified that the applicable standard of care did not require him to do so in light of the "history that [Cynthia] gave him personally and documented several times *** in [the] office chart that she previously had her left tube and ovary removed." Doctor Rosner testified that the presence of the thick adhesions that obscured the left side of Cynthia's uterus was consistent with her prior statements that her left fallopian tube and ovary had been removed. Given Cynthia's history, he made a "judgment call" and decided not to try to cut the adhesions to visualize the left side of her uterus because he believed the benefit in doing so did not outweigh the significant risks. He explained: "if I was to

5 Cynthia's medical records indicate that she was scheduled for a "mini[-] laparotomy and tubal ligation." The term "bilateral tubal ligation" is not mentioned

just cavalierly start cutting her, making a bigger abdominal incision, laparotomy to which she had not consented and going through even with the greatest of care dissecting those thick and all those other omental adhesions which were described earlier, there is always the great potential to do harm to her bowel, to her bladder, to have excessive blood lost and infection." He testified that he believed that Cynthia had one healthy tube and that he had properly tied that tube and effectively sterilized her. He decided not to "dissect all th[e] adhesions in the left adnexa because it was [his] belief that there was no tube and/or ovary in that area."

¶ 26 After the procedure, Doctor Rosner told Cynthia that the surgery went well and that she was permanently sterilized. He confirmed that he was informed approximately six months later that she was pregnant. Doctor Rosner then had a meeting with plaintiffs, who were both understandably upset that Cynthia was pregnant. He informed them that the tubal ligation had obviously failed; however, he had no explanation as to why it had failed at that time. Given that Cynthia had been his patient for several years, he wanted to "take care of her through her pregnancy;" however, she elected to receive prenatal care elsewhere and he did not have anymore contact with her.

¶ 27 Although Cynthia became pregnant, Doctor Rosner testified that he he complied with the requisite standard of care. The medical and gynecological history that Cynthia provided reasonably led him to believe that after he tied her right tube, she would be sterile. Any pre-surgical diagnostic imaging would not have provided any additional information. Moreover, the standard of care did not require him to visualize the left side of her uterus. He explained: "if something is not there, and to look and confirm that something is not there and put the patient at further risk of a larger operation with lysis of adhesions and all the risks that are inherent to that with damage to the bladder, to the bowel, to the ureter, *** was not in [Cynthia's] best interest."

This is especially true because the observations he made during the surgery, including the presence of thick adhesions, were consistent with Cynthia's reported history that her left fallopian tube and ovary had been removed.

¶ 28 On cross-examination, Doctor Rosner acknowledged that he "would have looked at the left side if [he] could" have easily and safely done so. At the time of the procedure, however, his "objective was to look at the right side first and then see what [he] could see on the left." He reiterated that Cynthia had told both him and Doctor Goldstone that she had her left fallopian tube and left ovary removed and that his focus on the right side was appropriate. Doctor Rosner testified that the ovary he encountered during the procedure was "in the midline" and admitted he "assumed" it was the right ovary.

¶ 29 Doctor Susan Warner, an OB/GYN, testified as defendants' retained expert witness. After reviewing all of the pertinent medical records and deposition testimony, Warner opined that Doctor Rosner complied with the requisite standard of care in connection with Cynthia's tubal ligation procedure. She testified that Doctor Rosner appropriately relied on Cynthia's account of her prior surgeries including her prior left salpingo oophorectomy (left fallopian tube and ovary removal) before he performed the procedure. She explained that patient's medical history is a very important source of information prior to a tubal ligation procedure because a woman's fallopian tubes and ovaries are not palpable and a physical examination will thus generally yield "very limited" information. That is, a surgeon will not really know much about the woman's reproductive structures until he is "inside the patient's abdomen." Ultrasounds are similarly not necessarily helpful prior to surgery because they can provide both false positives and false negatives. In particular, Doctor Warner noted that Cynthia underwent three different ultrasounds between 2001 and 2006 and that the results of those ultrasounds were "very

inconsistent and confusing." Cynthia's 2001 ultrasound purportedly showed a right ovary, but contained no image of a left ovary. Her 2004 ultrasound documented a "cystic area in the area of the left ovary," whereas no ovaries could be "visualized" from the 2006 ultrasound. Given that ultrasounds are considered to be unreliable for purposes of locating and identifying reproductive structures, Doctor Warner testified that the standard of care did not require Doctor Rosner to order additional ultrasounds prior to performing Cynthia's 2008 tubal ligation procedure. The standard of care simply required that Doctor Rosner take a history from Cynthia and review her chart prior to performing the procedure.

¶ 30 Doctor Warner agreed that the standard of care normally requires a doctor performing a tubal ligation procedure to tie both of his patient's fallopian tubes; however, she explained that Cynthia's procedure did not involve a "normal situation" because her medical records showed that she had relayed that her left fallopian tube and left ovary had been removed. Doctor Warner testified that based on her understanding of the procedure, Doctor Rosner was able to visualize Cynthia's right fallopian tube after he made an incision. Due to the presence of significant adhesions, however, he was not able to visualize the right ovary, but he "felt the presence of the right ovary." He then tied Cynthia's right fallopian tube. When Doctor Rosner turned to the "left side" he encountered thick adhesions, which he found to be consistent with Cynthia's report that she had undergone a left salpingo oophorectomy. Doctor Warner confirmed that the presence of adhesions necessarily makes surgery more risky and more complicated. The adhesions can stick to certain parts of the anatomy causing them to be "found [in places] where you wouldn't necessarily expect them to be." In addition, when a surgeon cuts through adhesions, patients can suffer substantial blood loss and require transfusions. Given the dangers posed by adhesions, a surgeon must perform a "risk-benefit analysis" and evaluate the risks

posed by taking down adhesions during a surgical procedure. Based on the information that Doctor Rosner had available to him at the time of the procedure, Doctor Warner testified that there were "no[]" benefits of taking down the adhesions on the left side of Cynthia's abdomen. Given the potential complications that could result if he took down the adhesions, Doctor Warner opined that he did not deviate from the standard of care when he failed to take down the adhesions and tie Cynthia's left fallopian tube. She further opined that he performed a competent ligation of Cynthia's right fallopian tube. She explained that the portion of the right tube that was cut was subsequently sent to pathology and was positively identified as a portion of the fallopian tube. Therefore, based on the information of which he was aware at the time he performed the surgery, Doctor Rosner reasonably believed that he had performed a fallopian tubal ligation that created sterilization.

¶ 31 On cross-examination, Doctor Warner acknowledged that Doctor Rosner never verified the status of Cynthia's ovaries prior to surgery. She further acknowledged that a surgeon performing a tubal ligation procedure has an obligation to identify intraoperatively the pelvic structures that are the focus of the procedure. Based on the fact that Doctor Van Woert found a left ovary situated off the left side of Cynthia's left fallopian tube in 2010, she agreed that the left ovary was also necessarily present at the time that Doctor Rosner performed the 2008 procedure. Doctor Warner also agreed that the procedure that Doctor Rosner performed did not put Cynthia "in a state of sterility."

¶ 32 After calling the aforementioned witnesses, the attorneys for the parties delivered closing arguments. The jury then received a series of relevant instructions. Following deliberations, the jury returned with a verdict in favor of defendants. Plaintiffs filed a posttrial motion challenging the verdict, which the circuit court denied. This appeal followed.

¶ 33 ANALYSIS

¶ 34 Judgment Notwithstanding the Verdict

¶ 35 On appeal, plaintiffs first argue that they are entitled to a judgment notwithstanding the verdict because "no reasonable jury could reach the verdict that the jury in this case reached" because the evidence supported only one conclusion: "Doctor Rosner's tubal ligation procedure did not render [Cynthia] sterile and thus, he was negligent."

¶ 36 Defendants initially respond that plaintiffs' *pro se* appellate brief fails to comply with applicable supreme court rules, and as such, their brief should be stricken and their appeal dismissed. On the merits, defendants argue that the "jury reached a verdict supported by the evidence" and that plaintiffs cannot meet their burden of proving that they are entitled to a judgment notwithstanding the verdict.

¶ 37 As a threshold matter, we acknowledge that plaintiffs' *pro se* appellate brief is deficient in a number of respects. Their brief omits the required introductory paragraph, contains minimal citations to the record, no statement of facts, and an incomplete appendix in contravention of the express requirements set forth in Supreme Court Rule 341(h) (Ill. S. Ct. R. 341(h) (eff. Jan. 1, 2016)). Plaintiffs' *pro se* status does not excuse them from complying with applicable supreme court rules governing appellate procedure, which are designed to establish order and procedural normalcy in the appellate process. *Coleman v. Akpakan*, 402 Ill. App. 3d 822, 825 (2010); *In re Marriage of Barile*, 385 Ill. App. 3d 752, 757 (2008). Nonetheless, it is well-established that " 'our jurisdiction to entertain the appeal of a *pro se* plaintiff is unaffected by the insufficiency of [a] brief,' " as long as a reviewing court can readily ascertain and understand the issues that the *pro se* appellant purports to raise. *Twardowski v. Holiday Hospitality Franchising, Inc.*, 321 Ill. App. 3d 509, 511 (2001) (quoting *Biekecki v. Painting Plus, Inc.*, 264 Ill. App. 3d 344, 354

(1994)). This is especially true when a reviewing court is aided by the receipt of a "cogent brief of the other party." *Twardowski*, 321 Ill. App. 3d at 511. Accordingly, in the interests in fairness, we will address the substantive issues raised by plaintiffs on appeal.

¶ 38 In doing so, however, we observe that plaintiffs have also failed to file a complete record on appeal. As the appealing party, it is plaintiffs' burden to provide this court with a sufficient record and, as a result, this court will construe any doubts that arise from the incomplete record against plaintiffs. See *Foutch v. O'Bryant*, 99 Ill. 2d 389, 391 (1984) ("[A]n appellant has the burden to present a sufficiently complete record of the proceedings at trial to support a claim of error, and in the absence of such a record on appeal, it will be presumed 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"). Keeping this standard in mind, we will address plaintiffs' argument that they are entitled to a judgment notwithstanding the verdict.

¶ 39 A motion for a judgment notwithstanding the verdict should only be granted in limited circumstances, such as when "all the evidence, when viewed in the light most favorable to the opponent, so overwhelmingly favors the movant that no contrary verdict based upon that evidence could ever stand." *Pedrick v. Peoria Eastern Railroad Co.*, 37 Ill. 2d 494, 504 (1967). When reviewing a ruling on a motion for a judgment notwithstanding the verdict, a reviewing court will not reweigh the evidence or evaluate the credibility of the witnesses, as these functions are within the unique province of the jury. *Board of Trustees of Community College District No. 508 v. Coopers & Lybrand*, 208 Ill. 2d 259, 274 (2003); *Drakeford v. University of Chicago Hospitals*, 2013 IL App (1st) 111366, ¶ 7. Ultimately, the standard for entry of a judgment notwithstanding the verdict is " 'high,' " (*York v. Rush-Presbyterian- St. Luke's Medical Center*,

222 Ill. 2d 147, 178 (2006) (quoting *Pasquale v. Speed Products Engineering*, 166 Ill. 2d 337, 351 (1995)) and is "limited to 'extreme situations only' " (*Knauerhaze v. Nelson*, 361 Ill. App. 3d 538, 548 (2005) (quoting *Jones v. Chicago Osteopathic Hospital*, 316 Ill. App. 3d 1121, 1125 (2000)). Indeed, a motion for a judgment notwithstanding the verdict may not be granted simply because a verdict is against the manifest weight of the evidence. *Maple v. Gustafson*, 151 Ill. 2d 445, 454 (1992)). A judgment notwithstanding the verdict is also not appropriate "if there is any evidence, together with reasonable inferences to be drawn therefrom, demonstrating a significant factual dispute, or where the assessment of credibility of the witnesses or the determination regarding conflicting evidence is decisive to the outcome." *Id*. In addition, a judgment notwithstanding the verdict is "not appropriate if 'reasonable minds might differ as to the inferences or conclusions to be drawn from the facts presented.' " *Ramirez v. FCL Builders, Inc.*, 2013 IL App (1st) 123663, ¶ 116 (quoting *Pasquale*, 166 Ill. 2d at 351). When reviewing a circuit court's ruling on a motion for judgment notwithstanding the verdict, the evidence must be considered in the light most favorable to the party opposing the motion. *Thacker v. UNR Industries*, 151 Ill. 2d 343, 353-54 (1992); *Ramirez*, 2013 IL App (1st) 123663, ¶ 116. A motion for a judgment notwithstanding the verdict presents a question of law as to whether there was a complete failure to substantiate a key element of the plaintiff's case, and as such, the circuit court's ruling on such a motion is subject to *de novo* review. *York*, 222 Ill. 2d at 178; *McDonald v. Northeast Regional Commuter R.R. Corp.*, 2013 IL App (1st) 102766, ¶ 20.

¶ 40 To prevail on a medical negligence claim, it is incumbent upon the plaintiff to establish: (1) the standard of care against which the medical professional's conduct is to be measured; (2) a negligent failure by the medical professional to comply with that standard of care; and (3) that the medical professional's negligent conduct proximately caused the injuries that the plaintiff

seeks to redress. *Neade v. Portes*, 193 Ill. 2d 433, 443-44 (2000); *Purtill v. Hess*, 111 Ill. 2d 229 241-42 (1986); *Wiedenbeck v. Searles*, 385 Ill. App. 3d 289, 292 (2008). Unless the medical professional's negligence is so grossly apparent or the treatment at issue is so common that it is considered to be within the common knowledge of a layperson, expert medical testimony is required to establish the applicable standard of care and the medical professional's deviation therefrom. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 112 (2004); *Purtill*, 111 Ill. 2d at 242.

¶ 41 In this case, plaintiffs argue that they are entitled to a judgment notwithstanding the verdict because the evidence "conclusively proved" that Doctor Rosner breached the applicable standard of care when he failed to successfully sterilize Cynthia during the tubal ligation procedure. There is no dispute that Doctor Rosner failed to visualize or tie Cynthia's left fallopian tube. At trial, however, Doctor Rosner and his controlled expert, Doctor Warner, both testified that his conduct complied with the requisite standard of care. Doctor Rosner testified that prior to the procedure, Cynthia had relayed her patient history and had informed him that she had previously undergone a left salpingo oophorectomy. That is, both her left ovary and her left fallopian tube had been removed. Cynthia had also relayed the same information to her previous doctor at the practice, Doctor Goldstone. Based on the medical history that Cynthia had consistently relayed, Doctor Rosner testified that he never intended to perform a bilateral tubal ligation; rather, he intended to simply tie Cynthia's right fallopian tube. After successfully doing so, Doctor Rosner explained he made a "judgment call" not to lyse the thick adhesions that obscured the left side of Cynthia's uterus and her left fallopian tube. He delineated the various risks associated with lysing the adhesions and testified that he believed that the benefits of doing so in order to visualize the left side of Cynthia's uterus did not outweigh the significant risks because he believed that "there was no tube and/or ovary in that area."

¶ 42 Doctor Warner, defendants' retained expert, testified that the standard of care normally requires a doctor performing a tubal ligation procedure to tie both of the woman's fallopian tubes. Doctor Warner explained however, that Cynthia's procedure did not involve a "normal situation" because she had repeatedly informed her doctors that her left fallopian tube and ovary had been removed. Therefore, in her opinion, Doctor Rosner did not deviate from the applicable standard of care when he elected not to take down the adhesions obscuring the left side of Cynthia's abdomen during the procedure. Doctor Warner explained that adhesions that Doctor Rosner encountered during the procedure were consistent with Cynthia's prior statements that she had previously undergone a left salpingo oophorectomy. Given that Doctor Rosner was informed that Cynthia did not have a left fallopian tube or ovary, Doctor Warner opined that he correctly determined that the risks posed by the lysing the adhesions did not outweigh the potential benefits of doing so given that adhesions make surgeries more complicated and risky.

¶ 43 The testimony of plaintiffs' retained expert, Doctor John DiOrio is not included in the record on appeal. Given that this court must construe all doubts arising from an incomplete record against plaintiffs (*Foutch*, 99 Ill. 2d at 391), this omission alone provides this court with a sufficient basis to affirm the circuit court's denial of plaintiffs' motion for a judgment notwithstanding the verdict. Assuming, however, that Doctor DiOrio testified in accordance with the opinion that plaintiffs' relayed in their prior Rule 213(f)(3) (Ill. S. Ct. R. 213(f)(3) (eff. Jan. 1, 2007)) disclosures, we would still nonetheless conclude that a judgment notwithstanding the verdict is not warranted in this case. Based on the information contained in plaintiffs' disclosures, Doctor DiOrio would have opined that Doctor Rosner "violated the standard of care when he failed to verify, adequately assess and evaluate Cynthia Williams[']s ovary and fallopian tube status prior to performing surgery on her." Doctor DiOrio would have further

testified that Doctor Rosner deviated from the applicable standard of care when he "relied on the patient['s] memory to determine which [tube] needed to be tied during surgery," and "when he failed to visualize and attempt to tie both of [Cynthia's] tubes during surgery."

¶ 44 Faced with contradictory testimony from the parties' respective experts, it was the jury's responsibility to consider those discrepancies and evaluate the credibility of those witnesses; it is not this court's duty to reweigh the evidence and make our own determinations. *Maple*, 151 Ill. 2d at 452-53; *Knauerhaze*, 361 Ill. App. 3d at 550. Applying the standard of review applicable to the denial of a judgment notwithstanding the verdict, we are unable to conclude that the jury's verdict is unfounded or that the evidence so overwhelmingly favors plaintiffs that its verdict cannot stand. *Maple*, 151 Ill. 2d at 441-42; *Knauerhaze*, 361 Ill. App. 3d at 550. Accordingly, the circuit court did not err in denying plaintiffs' motion for a judgment notwithstanding the verdict.

¶ 45 We similarly reject plaintiffs' alternative argument that the jury's verdict is against the manifest weight of the evidence.[6] As the trier of fact, it is the jury's role to weigh the evidence, make credibility determinations, and to resolve conflicts in expert testimony. *York v. Rush-Presbyterian St. Luke's Medical Center*, 222 Ill. 2d 147, 179 (2006); *McHale v. W.D. Trucking, Inc.*, 2015 IL App (1st) 132625, ¶ 60. When reviewing a jury verdict, a reviewing court may not substitute its judgment for that of the trier of fact and will not that disturb the verdict unless it is against the manifest weight of the evidence. *Snelson v. Kamm*, 204 Ill. 2d 1, 34 (2003). A verdict is against the manifest weight of the evidence only where the opposite conclusion is clearly apparent or where the jury's findings appear to be unreasonable, arbitrary and not based

[6] We note that we will address the arguments raised by plaintiffs on appeal in a different order than they are discussed by plaintiffs in their appellate brief.

on the evidence. *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38; *Leonardi v. Loyola University of Chicago*, 168 Ill. 2d 83, 106 (1995).

¶ 46 Here, the jury heard testimony from qualified experts who provided opinions as to whether Doctor Rosner complied with the applicable standard of care during Cynthia's tubal ligation procedure. We again reiterate that the testimony of plaintiffs' expert is not included in the record on appeal. Given the verdict, however, the jury evidently found defendants' expert more credible, and this court cannot usurp the function of the jury and substitute our judgment for that of the trier of fact. *York*, 222 Ill. 2d at 179. The mere fact that the jury resolved the conflicting testimony against plaintiffs does not render the verdict in this case against the manifest weight of the evidence. See, *e.g., Snelson*, 204 Ill. 2d at 35-36 (rejecting the defendant's claim that the verdict was against the manifest weight of the evidence where the case involved a "classic battle of the experts" in which the jury resolved the discrepant testimony in favor of the plaintiff); *Gulino v. Zurawski*, 2015 IL App (1st) 131587, ¶ 75 (concluding that "[t]he mere fact that the jury resolved the conflicting [expert] testimony against defendants does not render the verdict in this case against the manifest weight of the evidence"); *Sottile v. Carney*, 230 Ill. App. 3d 1023, 1031 (1992) (rejecting the plaintiff's claim that the jury verdict was against the manifest weight of the evidence where the "medical expert testimony [was] merely conflicting"). Ultimately, following our review of the trial record, we are unable conclude that the jury's verdict is arbitrary, unreasonable and not based on the evidence. We therefore reject plaintiffs' argument that the verdict is against the manifest weight of the evidence.

¶ 47 Jury Instruction Errors

¶ 48 Plaintiffs next argue that the circuit court erred in providing the jury with the long form of Illinois Pattern Instruction Civil (2012) No. 12.05 (IPI Civil No. 12.05), which pertains to the issue of sole proximate cause. Plaintiffs submit that "there was insufficient evidence to support such an instruction."

¶ 49 Defendants respond that the circuit court properly instructed the jury in accordance with the long form of IPI Civil No. 12.05. They contend that the long form of the instruction is appropriate where there is "some evidence" that something other than a defendant's conduct caused the plaintiff's injury. Here, defendants argue that there was evidence that Cynthia's medical history and the information that she provided was the sole cause of her unsuccessful tubal ligation procedure and pregnancy.

¶ 50 The purpose of jury instructions is to convey to the jury the correct principles of law applicable to the submitted evidence. *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 507 (2002). Litigants are entitled to have the jury instructed on any theory that is supported by the evidence. *Leonardi*, 168 Ill. 2d at 100; *Mack v. Anderson*, 371 Ill. App. 3d 36, 56 (2006). "A jury instruction is justified if it is supported by some evidence in the record, and the trial court has discretion in deciding which issues are raised by the evidence." *Clarke v. Medley Moving and Storage, Inc.*, 381 Ill. App. 3d 82, 91 (2008). To determine the propriety of a set of jury instructions, the relevant inquiry is whether the tendered instructions, taken as a whole, fairly, fully and comprehensively apprised the jury of the appropriate legal principles and theories applicable to the case. *Snelson*, 204 Ill. 2d at 28; *Leonardi*, 168 Ill. 2d at 100. The trial court's instructions to the jury will not be deemed improper absent an abuse of discretion. *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 505 (2002). An abuse of discretion will only be found where the instructions tendered to the jury are unclear, misleading or they do not fairly and accurately

state the law. *Dillon*, 199 Ill. 2d at 505; *Johnson v. Johnson*, 386 Ill. App. 3d 522, 542 (2008). Even where the circuit court errs and provides the jury with an improper instruction, the error does not require reversal unless a reviewing court can conclude that the error prejudiced the appellant. *Johnson*, 386 Ill. App. 3d at 542.

¶ 51 The long form of IPI Civil 12.05 provides:

> "If you decide that a defendant was negligent and that its negligence was a proximate cause of injury to the plaintiff, it is not a defense that something else may have also been a cause of the injury.
>
> However, if you decide that the sole proximate cause of injury to the plaintiff was something other than the conduct of the defendant, then your verdict should be for the defendant." IPI Civil No. 12.05.

¶ 52 The second paragraph of IPI Civil 12.05 references sole proximate cause, which is a valid defense in a medical negligence case and may be utilized if evidence exists that tends to establish that the conduct of something or somebody other than the defendant was solely responsible for the plaintiff's injuries. *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 105 (1997); *Jones v. Beck*, 2014 IL App (1st) 131124, ¶ 28. Accordingly, a defendant may endeavor to prove that some other cause was the sole proximate cause of the plaintiff's injury and tender a jury instruction pertaining to that theory if the theory is supported by competent evidence. *McDonnell v. McPartlin*, 192 Ill. 2d 505, 521 (2000). The notes accompanying IPI Civil No. 12.05 specifically state that "the second paragraph should be used only where there is evidence tending to show that the sole proximate cause of the occurrence was something other than the conduct of the defendant." IPI Civil No. 12.05, Notes for Use.

¶ 53 In this case, at the jury instruction conference, defense counsel offered the long form of IPI Civil No. 12.05. In doing so, counsel argued that the long form of the instruction was appropriate because there was evidence that Cynthia provided misinformation about the state of her reproductive organs and that the "[j]ury could decide that the sole proximate cause [was that] she gave [Doctor Rosner] wrong information." The circuit court agreed and provided the instruction over plaintiffs' objections. Upon review, we cannot agree that the circuit court abused its discretion in doing so. In support of defendants' argument that Doctor Rosner complied with the requisite standard of care and did not cause Cynthia to remain fertile, defendants presented evidence that Cynthia had consistently provided a detailed medical history in which she stated that she'd had her left fallopian tube and left ovary removed when she was younger. Doctor Rosner testified that he relied on her medical history when he performed the tubal ligation procedure and when he decided not to lyse the adhesions located on the left side of Cynthia's abdomen. Doctor Warner testified that Doctor Rosner's reliance on the medical history that Cynthia provided was appropriate and complied with the requisite standard of care. Given that the record contains evidence that arguably tends to show that the sole proximate cause of Cynthia's unsuccessful tubal ligation procedure and pregnancy was something other than Doctor Rosner's alleged negligent conduct, we are unable to conclude that the circuit court erred in providing the jury with the long form of IPI Civil No. 12.05. Even if we were to find an error regarding the circuit court's decision to provide the instruction, reversal would not be warranted given the lack of evidence that plaintiffs suffered prejudice as a result of the instruction. See generally *Brooks v. City of Chicago*, 106 Ill. App. 3d 459, 466 (1982) ("A liberal application of the harmless error doctrine to jury instruction issues is favored when it appears that the rights of the complaining party have in no way been prejudiced").

¶ 54 We similarly find no abuse of discretion relating to the circuit court's refusal of plaintiffs' mitigation instruction. Plaintiffs' proposed mitigation instruction provided as follows: "Plaintiffs are required to mitigate injuries using ordinary care. They are not, however, required to mitigate damages by submitting to major surgery, such as abortion surgery." The circuit court, however, found that there was no evidence to support the instruction given that defendants never suggested that plaintiffs' should have mitigated their damages by aborting their child. On review, we agree. Moreover, we note any purported error with respect to the circuit court's ruling is necessarily harmless in light of the jury's verdict in favor of defendants. That is, given the jury's liability finding, it never reached the issue of damages. Therefore, plaintiffs incurred no prejudice as a result of the circuit court's decision not to provide their proposed mitigation instruction to the jury. See, *e.g.*, *McDonnell v. McPartlin*, 303 Ill. App. 3d 391, 401-02 (1991); *Lebrecht v. Tuli*, 130 Ill. App. 3d 457, 476 (1985).

¶ 55 Admission of Demonstrative Exhibits

¶ 56 Plaintiffs next argue that the circuit court erred when it permitted defendants to introduce three demonstrative exhibits at trial that contained images of surgical adhesions.[7] Plaintiffs argue that the photographs were "more prejudicial than probative." The exhibits, however, are not contained in the record on appeal. We reiterate that this court is required to construe all deficiencies in the record against plaintiffs. *Foutch*, 99 Ill. 2d at 391. Given plaintiffs' failure to include the disputed exhibits in the record, we must presume that the circuit court did not abuse its discretion in admitting them. See, *e.g.*, *Redlin v. Village of Hanover Park*, 278 Ill. App. 3d 183, 193 (1996) (rejecting the appellant's argument that the circuit court erred in admitting photographic exhibits where the appellant failed to include those exhibits on appeal, noting that

7 The exhibits were not images of Cynthia's adhesions; rather, they were images of adhesions found in unidentified surgical patients.

the in absence of a complete record it must be "presume[d] that the trial court did not commit reversible error"); see also *Tamalunis v. Georgetown*, 185 Ill. App. 3d 173, 187 (1989) (finding that the appellant waived its argument that the circuit court erred in admitting certain exhibits where the appellant failed to include those exhibits in the record on appeal). We note that even if the pictures plaintiffs describe were included in the record, this court would be hard-pressed to find that the circuit court abused its discretion in allowing defendants to use them given that demonstrative evidence is looked upon "favorably" by courts because it can "help the jury to comprehend the verbal testimony of witnesses and understand the issues raised at trial." *Preston ex rel. Preston v. Simmons*, 321 Ill. App. 3d 789, 801 (2001); see also *Sharbono v. Hilborn*, 2014 IL App (3d) 120597, ¶ 30 (quoting *Schuler v. Mid-Central Cardiology*, 313 Ill. App. 3d 326, 337 (2000) ("The great value of demonstrative evidence 'lies in the human factor of understanding better what is seen than what is heard' "). In this case, the circuit court expressly found that defendants' exhibits depicting adhesions would "assist the jury" to evaluate the testimony that the jury heard regarding adhesions and the complications they posed, an issue discussed extensively during the trial.

¶ 57 Damages

¶ 58 Finally, plaintiffs argue that the circuit court erred when it improperly "limited plaintiffs' recovery of damages for emotional distress." Specifically, plaintiffs argue that they should have been able to seek damages for future emotional distress in addition to past and present emotional distress. The jury, however, never reached the issue of damages given that they found in favor of defendants regarding liability. Accordingly, this issue will not be considered on appeal. See *McDonnell v. McPartlin*, 192 Ill. 2d 505, 532 (2000) ("[E]rrors at trial relating solely to damages will not be considered on appeal where it is evident that the jury, having found in favor of the

defendant as to liability, never reached the question of damages"). We note, however, that there is no indication that the court's decision preventing plaintiffs from seeking damages for future emotional distress had any impact on the jury's liability determination.

¶ 59 CONCLUSION

¶ 60 The judgment of the circuit court is affirmed.

¶ 61 Affirmed.