2012 IL App (3d) 110129-U

Order filed May 17, 2012

IN THE

APPELLATE COURT OF ILLINOIS

THIRD DISTRICT

A.D., 2012

CYNTHIA HANSON, individually and as Special Administrator of the Estate of CHARLES HANSON, deceased, Plaintiff-Appellant, v. MIDWEST UROLOGICAL GROUP, LTD., an Illinois Corporation, JOAN POWERS STANISIC and GEOFFREY STANISIC, as co-Executors of the Estate of THOMAS STANISIC, M.D., THE METHODIST MEDICAL CENTER OF ILLINOIS, an Illinois Corporation, and BRIAN HEYWOOD, M.D., Defendants-Appellees.	)	Appeal from the Circuit Court of the 10th Judicial Circuit Peoria County, Illinois Appeal No. 3-11-0129 Circuit No. 05-L-281 Honorable Stephen Kouri, Judge Presiding.

JUSTICE LYTTON delivered the judgment of the court.
Justice O'Brien concurred in the judgment.
Justice Wright specially concurred.

ORDER

¶ 1 *Held*: In a medical malpractice case, the trial court did not err in (1) allowing treating physicians to testify regarding whether they would have made the same decisions

> as defendants, (2) allowing testimony of the decedent's preexisting medical conditions that were relevant to his treatment, or (3) denying plaintiff a new trial because a defendant contradicted judicial admissions that were presented to the jury.

¶ 2 Plaintiff, Cynthia Hanson, filed a medical malpractice action against the medical providers who treated her husband, Charles Hanson, prior to his death and the entities for which the medical providers were allegedly employed. Following a trial, the jury returned a verdict in favor of all of the defendants. Plaintiff appeals, arguing that (1) the trial court erred in allowing Hanson's treating physicians to testify regarding the standard of care, (2) Hanson's physicians should have been barred from testifying about Hanson's preexisting conditions, and (3) a new trial is warranted because one defendant contradicted his sworn admissions. We affirm.

¶ 3 Charles Hanson was diagnosed with a mass in his left kidney in August 2004. Dr. Stanisic, a urologist, recommended that Hanson undergo a nephrectomy, an operation to remove the kidney. Dr. Stanisic performed a nephrectomy on Hanson on August 24, 2004, at Methodist Medical Center. Following the surgery, Hanson began having complications and was diagnosed with pancreatitis. From August 27, 2004, to September 4, 2004, Dr. Penn, a gastroenterologist, provided conservative care to Hanson.

¶ 4 On September 6, 2004, Dr. Stanisic consulted Dr. Heywood, a surgeon. Dr. Heywood consulted with Dr. Wu, a gastroenterologist, who recommended that an endoscopic retrograde cholangiopancreatogram (ERCP) be performed. Dr. Wu performed and ERCP on September 8, 2004. It showed that the tail of the pancreas was leaking. Dr. Wu placed a stent in the pancreatic duct.

¶ 5 Thereafter, on September 17, 2004, Dr. Heywood performed an exploratory laparotomy on

Hanson. During the procedure, Dr. Heywood dissected Hanson's bowel and placed three drains in the abdomen. Hanson continued to have problems.

¶ 6 On October 18, 2004, another surgeon, Dr. Paulsen performed an exploratory laparotomy on Hanson. Dr. Paulsen cut off the tail of Hanson's pancreas, removed the spleen and removed 17 feet of his small bowel. Hanson lost a significant amount of blood and died the next day. The autopsy showed that Hanson died from "sepsis due to peritonitis due to injury of the pancreas status post left nephrectomy."

¶ 7 Hanson's wife, Cynthia Hanson, filed suit against Dr. Stanisic[1] and his employer, Midwest Urological Group, as well as Methodist Medical Center and its alleged agent, Dr. Heywood. Plaintiff served Dr. Heywood with requests to admit. One request stated: "It is Defendant, Brian Heywood, M.D.'s opinion to a reasonable degree of medical and surgical certainty that Charles Hanson had a Grade III pancreas injury." Heywood's response stated: "Admitted."

¶ 8 Plaintiff filed many motions *in limine*, several of which sought to bar any evidence of Hanson's preexisting medical conditions and his history of smoking and alcohol consumption. Plaintiff also sought to bar defendants from soliciting opinions or testimony from Hanson's treating physicians that Dr. Heywood or Dr. Stanisic complied with the standard of care. Finally, plaintiff sought to bar Heywood and his expert from arguing, testifying or opining that Hanson did not suffer from a Grade III pancreatic injury in light of Dr. Heywood's admission. Defendants objected to plaintiffs' motions *in limine*.

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[1] Dr. Stanisic died after plaintiff filed suit but before trial. The co-executors of Dr. Stanisic's estate were made defendants following Dr. Stanisic's death.

¶ 9 The trial court denied plaintiff's motion to bar evidence of Hanson's preexisting conditions and her motion to bar Hanson's treating physicians from testifying that defendants complied with the standard of care. The trial court granted plaintiff's motion to bar Dr. Heywood or his expert from testifying to anything contradicting Dr. Heywood's admission that Hanson suffered from a Grade III pancreas injury.

¶ 10 At trial, plaintiff presented the testimony of Dr. Stanisic by way of deposition. Dr. Stanisic admitted that he "probably did" cause damage to Mr. Hanson's pancreas during the nephrectomy. However, he did not believe the injury was caused by negligence or a lack of due care on his part because he took "every reasonable precaution to avoid injuring the pancreas." He explained that "[i]njuries occur *** despite our best efforts." He believed that he complied with the standard of care during the nephrectomy and in his treatment of Hanson following the nephrectomy.

¶ 11 Plaintiff's general surgery expert, Dr. Miguel Velez, testified that he determined, to a reasonable degree of medical certainty, that Hanson's pancreas was injured during the nephrectomy performed by Dr. Heywood. He testified that the injury was a Grade III injury, which "needs to be corrected surgically." Dr. Velez testified that Dr. Heywood failed to meet the standard of care in treating Hanson because he did not perform surgery on the tail of Hanson's pancreas. Dr. Velez opined that Dr. Heywood's deviations caused Hanson's adverse medical conditions and eventually his death. Dr. Velez testified that Hanson would have survived if Dr. Heywood had complied with the standard of care.

¶ 12 On cross-examination, Dr. Velez agreed that Hanson"had a very complex array of problems" when Dr. Heywood first saw him and that surgery on a patient like Hanson is a risk. He also agreed

that Hanson's history, which included smoking and diabetes, could make it more difficult for Hanson to recover from pancreatitis and make him more susceptible to infection.

¶ 13 Plaintiff also presented testimony from Dr. Heywood. He testified that he first provided care and treatment to Hanson on September 6, 2004. At that time, Hanson's chief complaint was abdominal pain. One of Dr. Heywood's concerns was an injury to the tail of Hanson's pancreas. An ERCP showed "a ductal disruption" with a large leak at the tail of the pancreas. When asked if it was his opinion that Hanson's injury was a Grade III injury, Dr. Heywood responded, "No." Plaintiff's attorney then showed Dr. Heywood his request to admit, where he admitted that it was his "opinion to a reasonable degree of medical and surgical certainty that Charles Hanson had a Grade III pancreas injury." Dr. Heywood stated that his admission was "taken out of context."

¶ 14 Dr. Heywood agreed that he testified at his deposition that Hanson had a Grade III injury. He further agreed that an authoritative textbook on pancreatic injuries states that one possible treatment for Grade III injuries is removal of the pancreatic tail. However, he stated that the other treatment recommended for a Grade III injury is drainage, which was done in this case. He believes his treatment of Hanson was consistent with the recommendations in the textbook. He further explained that the chapter addressing traumatic Grade III injuries did not apply to Hanson's situation because Dr. Heywood did not see Hanson until weeks after the injury occurred.

¶ 15 After Dr. Heywood's testimony, the parties and the court discussed how to handle Dr. Heywood's judicial admissions. Plaintiff's counsel asked that the admissions be read to the jury, along with a jury instruction, explaining the effect of the admissions. Defense counsel objected to the admissions being read to the jury as substantive evidence. The trial court ruled that the

admissions could be read to the jury along with a one or two sentence statement that "those are not contested facts." Plaintiff's counsel responded, "Fine with me."

¶ 16 Thereafter, in front of the jury, the court stated in part:

> "Dr. Heywood was on the stand and there was questions and answers relative to a document that we call a Request to Admit, and that's something that is, um, prepared and exchanged between the parties long before the trial, but those are considered judicial admissions, which means that those facts are binding in the trial on all the parties and to the extent that these facts may be relevant. You decide what relevance or weight to put on them, but they're binding admissions and they cannot be contested or controverted during the trial."

After some further discussion, plaintiff's counsel read four of Dr. Heywood's admissions, including the following: "It is the Defendant Brian Heywood MD's opinion to a reasonable degree of medical and surgical certainty that Charles Hanson had a Grade III pancreas injury." After presenting some other uncontested evidence, plaintiff rested.

¶ 17 Defendants called four expert witnesses to testify: Dr. Daniel Dalton, Dr. Michael Goldberg, Dr. Robert Volgelzang, and Dr. Joseph Cullen.

¶ 18 Dr. Dalton, a urologist, testified that he has been performing nephrectomies for over 21 years. Dr. Dalton testified that Dr. Stanisic "completely complied with all standards of care in all of his care." He explained that a bad outcome, including death, can "definitely" occur even though the standard of care is complied with because "surgery is controlled violence."

¶ 19 Dr. Michael Goldberg, a gastroenterologist, testified that he has seen a number of patients

with postoperative pancreatitis. How a patient recovers from pancreatitis is based in large part on the individual's underlying health and age. He reviewed Hanson's medical records and concluded that placing a stent in Hanson's pancreatic duct was "definitely" an appropriate way to address the leak at the tail of his pancreas. He testified that most doctors tend to be very conservative when dealing with the pancreas. He explained that surgeons "really don't want to touch the pancreas," which is "probably the right thing to do." He stated: "Basically you want to stay away from that pancreas as much as you can."

¶ 20 Dr. Robert Volgelzang, a diagnostic and interventional radiologist, testified that he regularly treats patients who suffer from pancreatitis. He explained that pancreatitis is complex and requires a "multi-physician effort," requiring surgeons, infectious disease specialists, gastroenterologists and radiologists, among others, to work together. Based on his review of Hanson's medical records, the interventional radiology treatment and management Hanson received "was appropriate in all regards" and complied with the standard of care.

¶ 21 Dr. Joseph Cullen, a surgeon, concluded that Dr. Heywood met the standard of care in his treatment of Hanson. He did not believe that the standard of care required Dr. Heywood to perform surgery on Hanson's pancreas at any time. He believed that if Dr. Heywood had operated on the tail of Hanson's pancreas on September 17, 2004, it would have been "a huge risk" and "would have led to more problems and the patient's death." He testified that nothing Dr. Heywood did contributed to Hanson's death.

¶ 22 Defendants presented the testimony of several of Hanson's treating doctors: Dr. Sarat Sabharwal, Dr. Donald Penn, Dr. Terrance Brady, Dr. David Slagle, and Dr. Brian Heywood.

¶ 23 Dr. Sarat Sabharwal testified that he is a urologist and was a partner of Dr. Stanisic's. He assisted Dr. Stanisic in the nephrectomy performed on Hanson. He did not specifically remember the procedure but testified that he would remember if he had seen an injury to the pancreas. He did not notice anything during the procedure that made him concerned about an injury to the pancreas. If he had seen a problem with the pancreas, he would have "done something about it at the time."

¶ 24 Dr. Donald Penn is a board certified internal medicine doctor with a subspecialty in gastroenterology. Dr. Penn saw Hanson on August 27, 2004, and recommended conservative treatment. He testified that 85% of pancreatitis gets better with conservative management. He explained that more aggressive treatments, including an ERCP or surgery, can actually cause pancreatitis instead of fixing it. Dr. Penn last saw Hanson on September 4, 2004. At that point, he believed Hanson's pancreatitis had resolved. Dr. Penn testified that he would not have recommended surgery on Hanson even if he knew there was damage to the tail of Hanson's pancreas. He would have tried "to hold for three to four weeks and see if things resolve themselves and not get yourself in trouble with surgery."

¶ 25 Dr. Brady, a diagnostic and interventional radiologist, testified that he performs procedures that are less invasive than surgery. He performed an angioembolization on Hanson on September 28, 2004, which uncovered a pseudoaneurysm in Hanson's spleen but no evidence of an active bleed in his pancreas. He did not feel it was necessary to call a surgeon based on his findings.

¶ 26 Dr. David Slagle, who is board certified in internal medicine and infectious diseases, saw Hanson on September 29, 2004. At that time, Hanson was in poor condition and was not a candidate for surgery. He testified that Hanson had several infections and further surgery could cause more

infections, particularly since Hanson had diabetes and was on steroids.

¶ 27 Dr. Heywood was called to testify for the defense. He testified that he complied with the standard of care applicable to a general surgeon in his treatment of Hanson. He testified that Hanson suffered from many problems that would have complicated surgery, including lung problems, renal failure, bleeding, cardiac problems and diabetes.

¶ 28 Dr. Heywood decided that an ERCP and stenting was the most appropriate initial treatment for Hanson. He performed an exploratory laparotomy on Hanson on September 17, 2004, because a CT scan showed a concern for a leak in the small bowel or colon and a possible bowel obstruction that could be life-threatening. He did not operate on the tail of the pancreas during the surgery because he "would be foolish to do that." On September 27, 2004, he asked the I.C.U. team to obtain a second surgical opinion because Hanson took a turn for the worse. Dr. Patel, another surgeon, thought that surgery was not recommended because there was a high chance of injury.

¶ 29 On cross-examination, Dr. Heywood admitted that under the trauma classifications, a pancreatic duct leak "would be considered a Grade III injury." He explained that the surgical textbook from the American College of Surgeons (A.C.S.) recommends distal pancreatectomy when the injury is the result of recent trauma, but that was not what he was presented with. He admitted that Hanson's injury "would be consistent" with a Grade III injury. On re-direct, he explained that the A.C.S. text did not apply when he saw Hanson because Hanson was not a "trauma patient." Dr. Heywood stated: "If he has presented the first day intraoperative with Doctor Stanisic, if he had called me, yes, a ductal injury is consistent – under these guidelines would be classified as a Grade III injury. The problem is that's not how he presented. He didn't present with an intraoperative

injury. ***" Plaintiff's counsel objected, and the trial court instructed the jury that Dr. Heywood's answer was to be disregarded.

¶ 30 The jury returned a verdict in favor of all of the defendants. Plaintiff filed a posttrial motion, seeking judgment notwithstanding the verdict or a new trial. The trial court denied the motion.

¶ 31 I

¶ 32 Plaintiff first argues that the trial court should have prohibited Hanson's treating physicians from providing standard of care testimony. She argues that such testimony was cumulative and served only to corroborate the testimony of defendants and their experts.

¶ 33 A court's evidentiary rulings are not reviewable on appeal if they have not been properly preserved. *Guski v. Raja*, 409 Ill. App. 3d 686, 695 (2011). When the court makes its rulings before trial pursuant to the parties' motions *in limine*, the rulings are interlocutory and remain subject to reconsideration by the court throughout the trial. *Id.* Consequently, denial of a complaining party's pretrial motion to exclude evidence is not sufficient to preserve the issue for appeal. *Id.* The complaining party must also make a contemporaneous objection at trial when the evidence is introduced to allow the court the opportunity to revisit its earlier ruling. *Id.* Failure to object at trial results in forfeiture of the issue on appeal. *Id.*

¶ 34 The exclusion of evidence is within the discretion of the trial court, whose ruling will not be reversed absent a clear abuse of discretion. Dillon v. Evanston Hospital, 199 Ill. 2d 483, 495 (2002). A trial court may allow testimony from treating physicians that is identical to opinions provided by experts. *Cetera v. DiFilippo*, 404 Ill. App. 3d 20, 45 (2010). Treating physicians may render opinions at trial because their opinions are developed in the course of treating that patient and are

not related to any litigation. Id.

¶ 35 " '[S]tandard of care' in a medical malpractice case is a term of art." *Lecroy v. Miller*, 272 Ill. App. 3d 925, 934 (1995). "Standard of care" is "what a reasonably careful doctor would do, under the circumstances similar to those shown by the evidence." *Taylor v. County of Cook*, 2011 IL App (1st) 093085, ¶ 30-33; Illinois Pattern Jury Instructions, Civil, No. 105.01 (2006). Testimony from treating doctors that they would have made the same decision as the defendant is not standard of care testimony. See *Lecroy*, 272 Ill. App. 3d at 934. Because of their involvement and treatment, treating doctors are expected to form opinions as to the cause of their patient's conditions and the appropriateness of treatment. *Bank of Illinois v. Thweatt*, 258 Ill. App. 3d 349, 364 (1994).

¶ 36 Here, plaintiff argues that the court erroneously denied her motion in limine to exclude standard of care testimony from Hanson's treating doctors. However, she failed to renew her objection at trial when testimony she considered to be "standard of care" testimony from Hanson's treating physicians was introduced. Therefore, plaintiff forfeited the issue. See Guski, 409 Ill. App. 3d at 695.

¶ 37 Forfeiture notwithstanding, plaintiff's contention that Hanson's treating doctors provided standard of care testimony is without merit. None of the treating physicians were ever asked or offered opinions that any of the defendants complied with the standard of care or did what a reasonably careful doctor would do. Rather, Hanson's treating physicians merely explained their care and treatment of Hanson and stated that, as Hanson's treating physicians, they would not or did not recommend surgery. Testimony that they would have done what defendants did does not amount to standard of care testimony. See *Lecroy*, 272 Ill. App. 3d at 934. The trial court did not abuse its

discretion in allowing Hanson's treating physicians to testify regarding the treatment Hanson received and the appropriateness of that treatment. See *Cetera*, 404 Ill. App. 3d at 45.

¶ 38 II

¶ 39 Plaintiff next argues that the trial court abused its discretion in allowing Hanson's treating physicians to testify regarding his preexisting medical conditions.

¶ 40 A court's evidentiary rulings are reviewable on appeal only if they have been properly preserved. *Guski*, 409 Ill. App. 3d at 695. Denial of a party's motion *in limine* does not by itself preserve the issue for appeal. *Id*. The complaining party must make a contemporaneous objection at trial when the evidence is introduced. *Id*. Failure to object at trial results in forfeiture of the issue on appeal. *Id*.

¶ 41 The exclusion of evidence is within the discretion of the trial court, whose ruling will not be reversed absent a clear abuse of discretion. *Dillon*, 199 Ill. 2d at 495. For evidence of a prior existing condition to be admissible at trial, the evidence must be relevant. *Voykin v. Estate of DeBoer*, 192 Ill. 2d 49, 57 (2000). Relevancy is established where a fact offered tends to prove that a fact in controversy is more or less probable. *Wojcik v. City of Chicago*, 299 Ill. App. 3d 964, 976 (1998).

¶ 42 Evidence of an injured person's health and condition before an injury is admissible to show the extent, nature and effects of the injury. *Requena v. Franciscan Sisters Health Care Corp.*, 212 Ill. App. 3d 328, 332-33 (1991). Evidence of prior injuries may be relevant to negate causation, to negate or reduce damages, or as impeachment. *Voykin*, 192 Ill. 2d at 57. Evidence of a preexisting condition should be excluded where there is no evidence of a causal connection between the

preexisting condition and the current injury. *Wojcik*, 299 Ill. App. 3d at 976.

¶ 43 Here, plaintiff filed a motion *in limine* to prohibit defendants' witnesses from testifying regarding Hanson's preexisting medical conditions but never objected when such testimony was elicited or offered at trial. As a result, she has forfeited review of this issue. *Guski*, 409 Ill. App. 3d at 695.

¶ 44 Even so, we find that no error occurred. The primary issue in contention at trial was whether Dr. Heywood should have performed surgery to repair Hanson's pancreas at any time. Dr. Heywood testified that certain of Hanson's medical conditions made it more risky to perform surgery. Thus, those conditions were relevant to whether Dr. Heywood should have performed surgery on Hanson's pancreas.

¶ 45 Plaintiff relies on *Voykin* for the rule that evidence of a preexisting condition should be excluded where there is not evidence of a causal connection between the preexisting condition and the current injury. However, this rule only applies when the preexisting injury is being used to negate causation. See *Wojcik*, 299 Ill. App. 3d at 976 (preexisting condition relevant to proximate cause). Here, Hanson's prior medical conditions were not used to negate proximate cause. No one disputed that Hanson's cause of death was pancreatitis. Rather, the conditions were used as support for Dr. Heywood's decision not to perform surgery. Because the prior medical conditions were relevant for that purpose, the trial court did not err in allowing testimony regarding them.

¶ 46 III

¶ 47 Finally, plaintiff argues that the trial court should have granted her motion for a new trial because Dr. Heywood repeatedly contradicted his sworn admission that Hanson suffered from a

Grade III pancreas injury.

¶ 48 We review the trial court's decision denying plaintiff's motion for a new trial for an abuse of discretion. *York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill. 2d 147, 179 (2006).

¶ 49 Judicial admissions are formal admissions that have the effect of withdrawing a fact from issue and dispensing wholly with the need for proof of the fact. *Serrano v. Rotman*, 406 Ill. App. 3d 900, 907 (2011). A party making an admission is bound by that admission and cannot contradict it. *Dean Management, Inc. v. TBS Construction, Inc.*, 339 Ill. App. 3d 263, 272 (2003).

¶ 50 Election by plaintiff's counsel to cure an error committed by the defense waives any right to a mistrial or new trial which may have existed. *Hackett v. Ashley*, 71 Ill. App. 3d 179, 184 (1979). "If the party in a cause believes that something has occurred in the trial which is prejudicial, he should immediately call it to the attention of the Court and move for a mistrial and cannot be heard later to complain." *Gaffner v. Meier*, 336 Ill. App. 44, 48 (1948). A plaintiff cannot on appeal request any more relief than was requested during the course of trial. *Id*. When a plaintiff obtained all the relief that was requested of the trial court, there is no omission or denial that would justify a reversal on appeal. *Id*.

¶ 51 Prior to trial, in response to plaintiff's requests to admit, Dr. Heywood admitted that it was his "opinion to a reasonable degree of medical and surgical certainty that Charles Hanson had a Grade III pancreas injury." However, in his testimony during plaintiff's case-in-chief, Dr. Heywood contradicted his admission, stating that Hanson did not suffer from a Grade III pancreas injury. When Dr. Heywood did so, plaintiff's counsel sought certain relief: that the admission be read to the jury along with an explanation that it was a judicial admission. The trial court granted this relief to

plaintiff. The trial court not only read Dr. Heywood's admission to the jury but also instructed the jury that the admission was "binding" and "cannot be contested or controverted during the trial."

¶ 52 Later, during defendants' case, Dr. Heywood attempted to qualify his admission that Hanson suffered from a "Grade III pancreas injury." When Dr. Heywood did that, plaintiff objected, and the trial court struck Dr. Heywood's response and told the jury not to consider it.

¶ 53 Since plaintiff received the relief she requested, she is not entitled to a new trial. See *Gaffner*, 336 Ill. App. At 48. If plaintiff thought that Dr. Heywood's contradictions were so prejudicial as to warrant a new trial, she should have sought a mistrial when the contradictions were made. Because she failed to do so, she cannot later seek a new trial on that basis. *Id.*

¶ 54 The order of the circuit court of Peoria County is affirmed.

¶ 55 Affirmed.

¶ 56 JUSTICE WRIGHT, specially concurring:

¶ 57 I agree plaintiff forfeited her objection to the testimony she considered to be "standard of care" testimony from numerous other treating physicians who were members of the medical team attempting to resolve Mr. Hanson's postoperative pancreatitis. I note that this issue, regarding the admissibility of the testimony of the postoperative treating physicians, presents an issue of general importance. However, having held the issue has been forfeited, I am reluctant to discuss the merits of this issue by electing to set the principles of forfeiture aside. See People v. Hillier, 237 Ill. 2d 539, 549 (2010). Thus, I do not join the majority's decision to address this forfeited issue, and do not express any opinion regarding whether I agree or disagree with the analysis carefully set out by the majority.

¶ 58 In all other respects, I concur in the majority's analysis of the other issues.