2019 IL App (4th) 180547-U

NO. 4-18-0547

FILED
July 5, 2019
Carla Bender
4th District Appellate
Court, IL

IN THE APPELLATE COURT

OF ILLINOIS

FOURTH DISTRICT

NATHAN CAIN, Independent Administrator of the Estate of Candice Cain, Deceased, Plaintiff-Appellee, v. THOMAS DeWEERT and DIGESTIVE DISEASE CONSULTANTS, LTD., Defendants-Appellants.	))))))))	Appeal from the Circuit Court of McLean County No. 14L28 Honorable Rebecca S. Foley, Judge Presiding.

JUSTICE HARRIS delivered the judgment of the court.
Justices DeArmond and Turner concurred in the judgment.

ORDER

¶ 1 *Held*: (1) The trial court did not abuse its discretion in finding the jury's verdict was not against the manifest weight of the evidence.

(2) The trial court did not abuse its discretion by denying defendants' request to provide a sole proximate cause instruction to the jury.

(3) The trial court did not err in denying defendants' motion for a directed verdict on counts based on the doctrine of *res ipsa loquitur*.

¶ 2 Plaintiff, Nathan Cain, independent administrator of the estate of Candice Cain, his deceased wife, brought a medical malpractice action against defendants, Dr. Thomas DeWeert, a gastroenterologist, and Dr. DeWeert's employer, Digestive Disease Consultants, Ltd. (DDC). Plaintiff alleged Dr. DeWeert breached the standard of care in his treatment of Candice, resulting in her death. In December 2017, a jury found in favor of plaintiff and the trial court en-

tered judgment in his favor. Defendants appeal, arguing (1) the jury's verdict was against the manifest weight of the evidence, (2) the court erred in denying their request for a jury instruction on sole proximate cause, and (3) the court erred in denying their motion for a directed verdict as to all claims based on the doctrine of *res ipsa loquitur*. We affirm.

¶ 3 I. BACKGROUND

¶ 4 In March 2012, Candice underwent surgery to have her gallbladder removed. Following surgery, she experienced abdominal pain and, on three occasions, sought emergency room care. In April 2012, she sought treatment with Dr. DeWeert. On April 4, 2012, Dr. DeWeert performed an endoscopic retrograde cholangiopancreatography (ERCP) on Candice for the purpose of removing what he believed was a stone in her common bile duct. After that procedure, Candice was diagnosed with acute pancreatitis and Dr. DeWeert transferred her to Barnes Jewish Hospital (Barnes) in St. Louis for treatment. At Barnes, Dr. Sreenivasa Jonnalagadda performed a second ERCP procedure. Candice was hospitalized for nine days and then discharged home. Shortly thereafter, she sought emergency room treatment and was returned to Barnes. Candice underwent additional abdominal surgeries, including one on May 10, 2012, performed by Dr. William Hawkins. Candice's condition deteriorated and, on August 12, 2012, she passed away. An autopsy revealed her cause of death to be sepsis with post-ERCP pancreatitis as a contributing factor.

¶ 5 In March 2014, plaintiff filed his initial medical malpractice complaint against defendants. In June 2017, he filed an eight-count amended complaint. In connection with counts I through IV of the amended complaint, plaintiff brought wrongful death and survival claims against both defendants. He alleged that Dr. DeWeert "had a duty to possess and use the

knowledge, skill[,] and care ordinarily used by a reasonably careful gastroenterologist" when treating Candice and performing the ERCP procedure. Plaintiff asserted that Dr. DeWeert breached his duty in the following ways:

> "a. Because of her age, gender, prior cholecystectomy and probable sphincter of Oddi dysfunction, [Candice] was at high risk for pancreatitis and should have been referred to a high volume ERCP center[;]
>
> b. Prior to his attempted ERCP, failing to review available biliary imaging, such as the ultrasound of March 1, 2012[,] or the cholangiogram of March 7, 2012;
>
> c. In the absence of a confirmed bile duct obstruction, proceeding with an ERCP before first using less invasive modalities such as endoscopic ultrasound or [magnetic resonance cholangiopancreatograhy (MRCP)];
>
> d. Repeatedly placing his guide[]wire in [Candice's] pancreatic duct rather than in the biliary duct;
>
> e. While experiencing difficulty, repeatedly attempting cannulation;
>
> f. Perforating [Candice's] pancreas;
>
> g. Failing to recognize the perforation or perforations of [Candice's] pancreas;
>
> h. Failing to place a pancreatic stent;
>
> i. Failing to provide rectal indomethacin following the [ERCP] procedure;
>
> j. Failing to provide aggressive hydration following the [ERCP] procedure[.]"

Plaintiff further alleged that following the ERCP procedure, Candice developed severe peripancreatic and retroperitoneal edema that was consistent with acute pancreatitis. On August 12, 2012, Candice died and an autopsy showed her cause of death was "sepsis due to severe ne-

crotizing pancreatitis secondary to the ERCP." Plaintiff alleged Candice's injuries and death were a direct and proximate result of Dr. DeWeert's negligence.

¶ 6 The remaining counts of plaintiff's amended complaint, counts V through VIII, alleged wrongful death and survival claims against both defendants based on the doctrine of *res ipsa loquitur*. Again, plaintiff asserted that Dr. DeWeert "had a duty to possess and use the knowledge, skill[,] and care ordinarily used by a reasonably careful gastroenterologist." He further alleged that Dr. DeWeert breached that duty by perforating Candice's pancreas during the ERCP procedure "and later that day [Candice] developed severe peripancreatic and retroperitoneal edema consistent with acute pancreatitis." Plaintiff maintained that Candice's injuries occurred while the endoscope used in the ERCP procedure was under the management or control of Dr. DeWeert. He alleged that Candice's injuries would not have occurred if Dr. DeWeert "had used a reasonable standard of professional care while [Candice] was under his management or control."

¶ 7 In December 2017, a jury trial was held in the matter. Evidence showed Candice visited DDC on April 3, 2012, and was examined by Elizabeth Cooper, Dr. DeWeert's nurse practitioner. Cooper noted Candice was 37 years old; "four weeks post" removal of her gallbladder; having moderate epigastric tenderness, *i.e.*, tenderness located under the rib cage, and experiencing persistent elevated liver enzymes. She testified she reviewed a report from a cholangiogram that was performed on Candice at the time of her gallbladder surgery. Cooper described a cholangiogram as a radiologic procedure that was done by surgeons after the removal of a gallbladder "to evaluate the bile duct to see if there might be any stones and/or sludge left in the bile duct." According to Cooper, a radiologist interpreted Candice's cholangiogram as showing

that Candice's common bile duct was dilated, suggesting there was "sludge in the duct." She described "sludge" as referring to "microscopic stones" that were "like sand."

¶ 8 Cooper testified that during her examination of Candice on April 3, 2012, Dr. DeWeert was not present. She stated she "saw [Candice] in the office and [Dr. DeWeert] was not in the office that morning." To the best of her knowledge, Dr. DeWeert did not see Candice on April 3. The parties stipulated that invoicing for DDC did not reflect that Dr. DeWeert tendered any services to Candice on April 3, 2012, nor did it reflect that he examined her on that date.

¶ 9 After assessing Candice, seeing that her liver enzymes were elevated, and reviewing the report from the cholangiogram, Cooper recommended and ordered an abdominal ultrasound. However, the ultrasound was never performed and, instead, Candice was scheduled to undergo an ERCP procedure the following morning with Dr. DeWeert. Cooper stated she dictated what occurred during the ERCP procedure as follows:

> "[T]he guide[]wire consistently tracked into the pancreatic duct. Several attempts were made, including changing guide[]wires and repositioning the patient. However, Dr. DeWeert was again unsuccessful in cannulating the common bile duct. It was decided to terminate the procedure and obtain an MRCP to better evaluate her biliary anatomy."

¶ 10 Following the ERCP procedure, Candice was admitted to the hospital and Cooper ordered the MRCP, which she testified was a magnetic resonance imaging (MRI) of a certain part of the digestive tract and a good mechanism for looking for common bile stones. The MRCP revealed "severe peripancreatic and retroperitoneal edema consistent with acute pancreatitis." A second impression from the MRCP was that there was a "small stone or other piece of debris in

the interior aspect of [Candice's] common bile duct" that "did not seem to be physically obstructing the common bile duct."

¶ 11 Evidence also showed that Candice's pancreatic enzymes, amylase and lipase, were elevated after the ERPC procedure. According to Cooper, before the ERCP, Candice's amylase level was 76, within normal limits. After the ERCP her amylase level was over 4000, or forty times the upper limit of normal. Candice's post-procedure lipase level was over 2400, or more than eight times the upper limit of normal. Cooper agreed that the ERCP procedure Dr. DeWeert performed on Candice appeared to have caused her to develop pancreatitis. She testified that Dr. DeWeert transferred Candice to another hospital for their expertise with ERCP procedures.

¶ 12 On cross-examination, Cooper testified she determined that Candice was a potential candidate for an ERCP procedure based on her persistent pain symptoms, persistently elevated liver enzymes "past what you would expect from simply having had the gallbladder out," and the suggestion from the cholangiogram that Candice's bile duct was dilated. She testified that she suspected that Candice had retained stones or sludge in her bile duct. Cooper further stated that it was not unusual for stones in the bile duct to "become obstructing and nonobstructing from time to time."

¶ 13 Cooper testified that after examining a patient and looking at available medical records, her next step was to have a conversation with Dr. DeWeert about the patient. She clarified that although she did not remember Dr. DeWeert being in the office when she examined Candice, "he was downstairs in the endoscopy area doing procedures." Cooper recalled that she "went downstairs to the endoscopy area" to speak with him about Candice.

¶ 14 Debra Whitley testified she worked for OSF Healthcare (OSF) as the director of Health Information Services and oversaw the maintenance, retention, and delivery of health information. Whitley stated that OSF used electronic medical records that were accessible remotely by healthcare providers. Access logs and audit trails were used to show which healthcare provider accessed a given patient's records, what records the provider viewed, and when the provider viewed the records. According to Whitley, neither Cooper nor Dr. DeWeert were listed as viewing either the images from an abdominal ultrasound performed on Candice on March 1, 2012, or images from the intraoperative cholangiogram performed on Candice on March 7, 2012. However, on April 3, 2012, Cooper was listed as viewing Candice's "chart review encounters tab," which would show "all the results that the patient has," including radiologists' reports. Whitley testified she did not see Dr. DeWeert's name on the audit trail "anywhere around" the dates of April 3, 4, or 5, 2012.

¶ 15 On cross-examination, Whitley testified it was unknown which of Candice's particular records were accessed by Cooper on April 3, 2012. However, the access log for that date did show that Cooper accessed Candice's records several times from 2:11 to 2:26 p.m. and then again at 2:53 p.m.

¶ 16 Dr. Juliette Scantlebury testified that she performed an autopsy on Candice's body on August 13, 2012. She determined Candice's cause of death to be sepsis with a contributing factor of "severe necrotizing pancreatitis secondary to ERCP."

¶ 17 Plaintiff presented the testimony of Dr. Brian Clarke, a gastroenterologist. Dr. Clarke testified he had been a practicing gastroenterology for 27 years. He estimated that he had performed at least 5,000 ERCPs during his career.

¶ 18 Dr. Clarke testified pancreatitis involves inflammation of the pancreas. He stated that the pancreas produces digestive enzymes that become activated in cases of acute pancreatitis and "start digesting the gland itself." The enzymes could also leak out of the pancreas and "can digest tissues around it." Dr. Clarke stated that there may be varying degrees of pancreatitis. There were also many different reasons to perform an ERCP. One goal of that procedure might be to get into the pancreatic duct rather than the common bile duct. When the goal of the procedure is to get into the pancreatic duct, "pancreatitis is a big risk." He described ERCPs as being "the most dangerous procedure" performed by gastroenterologists and testified an ERCP should not be done "without careful consideration because the risks are fairly high." Dr. Clarke understood that the goal of Dr. DeWeert's ERCP was to access only Candice's common bile duct in an attempt to retrieve what Dr. DeWeert thought was a stone. The following colloquy occurred between plaintiff's counsel and Dr. Clarke:

> "Q. When one is attempting to access solely the common bile duct, does the standard of care require the operator to stay out of the pancreatic duct?
>
> A. It is very desirable to avoid cannulating or injecting the pancreatic duct when your goal is to study the bile duct because that raises the risk for post-ERCP pancreatitis. ***
>
> Q. So the standard of care that would apply in this case would have been for Dr. DeWeert to stay completely out of the pancreatic duct, correct?
>
> A. That would be the standard of care is to try to avoid cannulation or injection of the pancreatic duct. That's not always possible, but that's what your goal is."

Dr. Clarke agreed that "just the mere cannulation of the pancreatic duct can cause pancreatitis."

¶ 19 From his review of Candice's medical records, Dr. Clarke found that Dr. DeWeert "was initially into the pancreatic duct and not into the common bile duct" during the ERCP procedure. He also found that that Dr. DeWeert made multiple attempts to get into the common bile duct but never did. Instead, he "kept getting into the pancreatic duct."

¶ 20 Looking at an image from Dr. DeWeert's ERCP procedure, Dr. Clarke opined that Dr. DeWeert punctured or perforated Candice's pancreas. He noted that during Candice's gallbladder removal surgery, surgical staples were placed to clip off the cystic duct. Those staples could be seen in the images from Dr. DeWeert's ERCP procedure. According to Dr. Clarke, Candice's common bile duct was approximately a centimeter away from the staples and, not in the location of Dr. DeWeert's guidewire. He testified that her common bile duct ran between the staples and where the image showed the "guidewire [was] going up." Further, Dr. Clarke testified that the top of Dr. DeWeert's guidewire appeared to be "beyond the limit of the pancreas," indicating that there was a puncture or perforation of the pancreas.

¶ 21 Dr. Clarke opined that Dr. DeWeert deviated from the standard of care when he punctured Candice's pancreas, stating as follows:

> "Well, I must say that you can get punctures from guidewires, but in this situation where you're wanting to study the bile duct and you are trying to stay out of the pancreatic duct, it's hard to—I can't imagine how he could get a perforation of the pancreatic duct in that circumstance unless you were deviating below the standard of care. I think, yes, I think it was."

Further, he stated that perforation of the pancreatic duct when trying to access the common bile

duct does not occur unless there is negligence. Dr. Clarke opined that Dr. DeWeert caused Candice to have severe acute pancreatitis, stating "she would not have had the pancreatitis except for [the ERCP] procedure." He testified that the severity of the pancreatitis "goes up dramatically" when the pancreas is punctured because "more enzymes are released and more digestion occurs."

¶ 22 Dr. Clarke testified he disagreed with the suggestion that there was no perforation of Candice's pancreas because there was no radiographic evidence of extravasation, or leakage of dye. He explained as follows:

> "[T]here w[ere] about—I think about six to seven films during the ERCP. And the first four were of injection of the pancreatic duct. I think the third—the four films that were attained did get contrast all the way out the—toward the body and tail of the pancreas. And then that contrast seemed to drain out. The film—the final two films where you see the guidewire going up out the pancreatic duct, there was very little contrast still left in the duct, and it was distal to where the guidewire is, or it was not enough to make much difference in that area. And I think that could have drained out and you would not see contrast from that perforation."

Dr. Clarke believed that a puncture or perforation to Candice's pancreas was "obvious" from the films. He was surprised that the puncture or perforation was not mentioned in Dr. DeWeert's operative report. Further, Dr. Clarke testified that perforation or puncture should not occur with gentle guidewire probing, *i.e.*, being careful and not "forcing" the guidewire.

¶ 23 Dr. Clarke found Dr. DeWeert's treatment of Candice fell below the requisite standard of care in several other respects. He opined that Dr. DeWeert should have transferred Candice to a high volume ERCP center because she was at a high risk for developing pancreatitis

due to several factors, including her age, gender, prior gallbladder surgery, probable sphincter of Oddi dysfunction, and normal bilirubin. Dr. Clarke opined that Dr. DeWeert acted below the standard of care if he did not look at the films or reports from Candice's previous ultrasound and intraoperative cholangiogram. He also testified that Dr. DeWeert's failure to do an MRCP before Candice's ERCP fell below the standard of care because MRCPs are "helpful" when there is a question as to whether there is a stone in the bile duct.

¶ 24 Dr. Clarke further testified that Dr. DeWeert's failure to place a pancreatic stent during the ERCP procedure was below the standard of care. He acknowledged that Candice's pancreatic duct "had somewhat of an S-shape," but opined that a stent could have been easily placed in that duct because there was "about almost an inch of pancreatic duct" available and there were stents that were less than an inch long. Dr. Clarke opined that the placement of a stent "would have allowed for the pancreatic duct to drain," which could have avoided Candice's development of pancreatitis or reduced its severity.

¶ 25 Dr. Clarke further testified regarding rectal indomethacin, a nonsteroidal anti-inflammatory drug that was given to patients in suppository form. He asserted that in Candice's case, a reasonably careful gastroenterologist would have given that drug "if [he or she] was up on the literature." He testified that in April 2012, the *New England Journal of Medicine* had an article about rectal indomethacin and indicated that use of the drug resulted in a dramatic reduction in post-ERCP pancreatitis.

¶ 26 According to Dr. Clarke, in all cases of pancreatitis, it was "essential" for the patient to "be given aggressive IV fluids." He explained that a patient with pancreatitis loses "intravascular volume" and gets "relatively dehydrated because all [of the fluid that is normally cir-

culated in the blood vessels] is flowing into either the pancreatic tissue itself or around it." Thus, it was necessary to "aggressively replace" fluid that was being lost from blood circulation to maintain "good perfusion to the pancreas." Dr. Clarke asserted that for post-ERCP pancreatitis, the standard of care is to give aggressive hydration, which he defined as at least 250 and up to 400 milliliters of fluid per hour. Dr. DeWeert did not meet the standard of care in this case because he had a standing order of 150 milliliters of fluid per hour, from which he did not deviate. Dr. Clarke noted that following the ERCP procedure, Candice's urine output dropped to 25 milliliters during the morning shift and then to zero during the next shift. According to Dr. Clarke, "normal urine output in a shift is at least 250 milliliters." When urine output drops "it's a sign of shock" and that the person's "intravascular volume is dropping so much or their blood pressure is dropping so much that it's not perfusing the kidneys enough to make urine." Dr. Clarke also described it as "an ominous sign that you're way underhydrating this patient."

¶ 27 Finally, the following colloquy occurred between plaintiff's counsel and Dr. Clarke:

> "Q. Now, Doctor, if this injury to [Candice's] pancreas had been realized at the time of the ERCP by Dr. DeWeert or shortly thereafter, would these interventions that you talked about, aggressive hydration, stenting, [and] rectal indomethacin, have made a difference in her outcome?
>
> A. Absolutely. I believe that she would still be alive today if she was managed appropriately."

¶ 28 On cross-examination, Dr. Clarke testified that he had treated patients who developed post-ERCP pancreatitis and he agreed that pancreatitis was "a common known complica-

tion." He agreed that he had experienced "perforations of the pancreas" in his practice and that perforation "can occur without a breach in the standard of care." Dr. Clarke also acknowledged that, in Candice's case, there was "sufficient indication to do an ERCP." Further, he testified that the standard of care did not require a physician to look at "actual imaging" prior to "taking a patient to ERCP" and that he believed it was satisfactory to look at the report from the imaging.

¶ 29 Dr. Clarke also testified that a guidewire can make its way into the pancreas without a breach of the standard of care and that an inability to place a stent in the pancreas can happen even with appropriate care. He stated that when a patient has "an unusual S anomaly" placement of a stent can bring about pancreatitis. Additionally, Dr. Clarke testified that on April 4, 2012, when Dr. DeWeert performed the ERCP procedure on Candice, articles had been published indicating that use of the drug indomethacin was beneficial but that it was not yet considered the standard of care.

¶ 30 Dr. DeWeert testified that he was a gastroenterologist and had been practicing for approximately 25 years. He did a fellowship at the University of Iowa and stated that, in his training, "[t]here was a lot of emphasis on ERCP." Dr. DeWeert estimated that he performed about 200 ERCPs during his fellowship. Thereafter, he went into private practice in Bloomington, Illinois. He conservatively estimated that he had performed 800 ERCP procedures while in private practice.

¶ 31 According to Dr. DeWeert, it was his routine to review pertinent records for every patient he treated. Cooper did Candice's initial examination and then he and Cooper reviewed the case together. Typically, he and Cooper reviewed cases in Cooper's office and she pulled patient records up on her computer. Dr. DeWeert testified that although Cooper initially ordered an

ultrasound in Candice's case, he canceled the ultrasound because it would not have provided them with any information they did not already have and because an abdominal ultrasound is a poor way of looking at common bile duct stones. Dr. DeWeert opined that it was unnecessary to obtain either an endoscopic ultrasound or an MRCP prior to the ERCP procedure because they had "already had an x-ray of [Candice's] bile duct" from the intraoperative cholangiogram.

¶ 32 Dr. DeWeert testified that Candice was not a high-risk patient for an ERCP procedure. He stated that during her previous gallbladder surgery, small gallstones were observed. Dr. DeWeert noted that common bile duct stones "are just gallstones that have moved out of the gallbladder" and that the presence of known gallstones puts a patient "in the common bile duct stone category." Thus, there was a "fairly high probability" that Candice had a common bile duct stone. Dr. DeWeert also testified that Candice was not high risk because she had a one centimeter bile duct, which he described as being large in size. Dr. DeWeert did not believe Candice had sphincter of Oddi dysfunction, noting that Dr. Clarke was the first doctor to raise that issue. He denied that the standard of care required him to refer Candice to a different location, asserting that he often treated patients with a similar presentation.

¶ 33 Dr. DeWeert testified that during an ERCP procedure, it was routine for a physician to "end up" in either the common bile duct or the pancreatic duct with gentle probing. He noted that the two ducts were separated by a "septum," the location of which could vary from patient to patient. If the physician is in the wrong duct, he or she makes adjustments and tries again. Dr. DeWeert denied using any action with the guidewire other than gentle probing during Candice's ERCP. He acknowledged having difficulty getting into Candice's common bile duct, which was his goal. As a result, he tried using different instruments, including a smaller guide-

wire. Dr. DeWeert also denied that he repeatedly placed a guidewire into Candice's pancreatic duct during the ERCP procedure and maintained that he did not perforate her pancreas. Ultimately, he stopped the ERCP procedure because he was not having success getting into Candice's common bile duct.

¶ 34 When Candice woke up following the ERCP procedure, Dr. DeWeert determined that she had developed pancreatitis. He admitted Candice to the hospital and ordered an MRCP "to get a better feel" for her biliary pancreatic anatomy. The MRCP showed a lot of fluid around the pancreas, which was consistent with pancreatitis, as well as a small stone in the common bile duct. Dr. DeWeert testified that "it was clear she had post ERCP pancreatitis" and he made arrangements to transfer Candice's care to Barnes.

¶ 35 Dr. DeWeert denied that the use of rectal indomethacin was the standard of care at the time Candice's ERCP procedure was performed. Further, he opined that Candice received adequate hydration for her pancreatitis. According to Dr. DeWeert, she received "150ccs an hour, which is more than adequate." He denied that she had any ill effects due to inadequate hydration such as kidney issues or shock.

¶ 36 Regarding the placement of a stent in Candice's pancreatic duct, Dr. DeWeert testified as follows:

> "No, it's not the standard of care to place a pancreatic stent. For me, in this particular case, it wasn't even in the cards. So in order to place a guidewire—in order to place a stent up into the pancreas, you need to secure a wire up in there to put the stent over the guidewire, and I was not having any success in getting a wire up into the pancreas whatsoever. It was just not an option. Furthermore, if I had tried

> at this point to somehow put a—keep going and put a guidewire up there, try to put a stent, I'm certain it would have made matters worse."

Dr. DeWeert stated he used pancreatic stents "very selectively" in his practice. He asserted that stents could cause problems as much as they could help.

¶ 37 Dr. DeWeert testified that after transferring Candice to Barnes, he next had contact with her approximately nine days later when she visited the emergency room following her discharge from Barnes. He was surprised that Candice had been discharged and thought she would remain in the hospital for three or four weeks or more, which was the standard amount of time for moderate or moderate to severe pancreatitis. According to Dr. DeWeert, the best treatment for pancreatitis was to let the pancreas rest and not stimulate it. The way to let the pancreas rest was to have "nothing by mouth." He described Candice's pancreatitis as moderately severe and asserted that according to guidelines, she should have been given "nutrition through the vein" or "a tube" after three or four days. Dr. DeWeert testified that Candice did not get that type of nutrition during her initial nine-day hospitalization at Barnes. He stated that records showed she ate and drank very little. Upon discharge, she was told "more liquids, more food" but became sicker over the three-day period she was at home. Dr. DeWeert opined that it "was a disaster to tell [Candice] to keep drinking and trying to eat" and made "the situation much worse."

¶ 38 Dr. DeWeert further opined that Candice's pancreas was not infected when she was discharged from Barnes and she did not have a necrotic pancreas at that time. He stated that an April 11, 2012, computed tomography (CT) scan showed "inflammatory fat" around the pancreas and that the pancreas was "enhancing normally." According to Dr. DeWeert, such a finding meant that dye put into the bloodstream during the scan showed that the pancreas was getting

good blood flow throughout and, thus, there was not any dead or dying tissue.

¶ 39 Dr. DeWeert testified that he reviewed records relative to the surgery that was performed on Candice on May 10, 2012, by Dr. Hawkins. He stated that with necrotizing pancreatitis, "the key to essential surgery is whether infection is present in the necrosis." Without an infection, "you simply don't operate." Dr. DeWeert stated that "mortality goes up dramatically" for patients once they have had an "open surgery" like the one Dr. Hawkins performed on Candice in May 2012.

¶ 40 Dr. DeWeert opined that the ERCP he performed was not the cause of Candice's death. Specifically, he testified as follows:

> "Well, I did an ERCP which caused pancreatitis. It's a well known risk of the procedure. And I dealt with it promptly, up front, diagnosed the pancreatitis immediately, got her to where she needed to go, and she had a moderately severe case of pancreatitis. And she should have gotten better, like 98[%], 99[%] of these patients do. They're in the hospital for three or four weeks after situations like this, on TPN, on tube feeding, getting intravenous fluids. They do fine. The pancreas heals in situations like this."

¶ 41 Dr. DeWeert denied that imaging from the ERCP he performed showed his guidewire outside of either Candice's pancreatic duct or her common bile duct. He asserted that there was "no contrast outlining any ducts" or other structures and, thus, no "landmarks" to tell you where it is." Dr. DeWeert also stated that extravasation occurs "when dye leaks out of a duct" from a puncture or hole in the duct. Viewing an image from the ERCP, he asserted that there was no dye in either duct "so you can't really tell much."

¶ 42 On cross-examination, Dr. DeWeert acknowledged that the ERCP procedure he performed caused Candice to develop moderately severe pancreatitis. He testified that his operative report from the ERCP procedure did not describe any type of anomaly in Candice's anatomy that would have prevented him from placing a pancreatic stent and that he, in fact, did not try to place a pancreatic stent at the time of Candice's ERCP. Dr. DeWeert agreed that he "didn't inject much dye into [Candice's] pancreatic duct."

¶ 43 Dr. DeWeert further agreed that he was unsuccessful in cannulating Candice's common bile duct, but he denied that he "necessarily" ended up in the pancreatic duct with every attempt he made at cannulation. He testified that his guidewire "[a]t times it was in the pancreatic duct; at times it was coiling; at times it was hitting the septum." He asserted as follows: "I couldn't get it in either duct really. That was the whole problem."

¶ 44 Dr. Malcolm Branch, a gastroenterologist, testified on behalf of defendants. He stated he had been a practicing gastroenterologist since 1987 and taught other physicians how to perform ERCP procedures. Dr. Branch estimated that he had performed approximately 15,000 ERCP procedures during his career.

¶ 45 Dr. Branch opined that Candice was an appropriate candidate for an ERCP procedure, noting she had recently undergone surgery on her gallbladder and was found to have small stones or sludge in her gallbladder. Also, Candice's common bile duct was dilated, she reported abdominal pain, and had elevated liver function tests. Dr. Branch did not believe that Candice was a high-risk patient because she had a dilated common bile duct and findings "that would warrant a concern for biliary tract disease," such as a bile duct stone or sludge. He opined Candice did not have sphincter of Oddi dysfunction because her duct was dilated at the time of her

gallbladder surgery. He also disagreed that Dr. DeWeert had a duty to refer Candice to a high volume ERCP center.

¶ 46 Dr. Branch testified it was reasonable for a gastroenterologist to rely on a radiologist's report and that the standard of care required only that Dr. DeWeert review Candice's records and not necessarily the images from her previous ultrasound and cholangiogram. He further denied that the standard of care required Dr. DeWeert to order either an ultrasound or MRCP prior to proceeding with the ERCP procedure.

¶ 47 Dr. Branch opined that Dr. DeWeert appropriately performed Candice's ERCP. Although he acknowledged that Dr. DeWeert's guidewire went into Candice's pancreatic duct, he denied that such circumstances constituted a breach of the standard of care. Instead, it was "part of what happens with this procedure." Dr. Branch testified as follows:

> "So, the bile duct and the pancreatic duct *** empty out at the same spot. So when you're going into that little area with a wire, the guidewire can go into the bile duct or into the pancreatic duct based on where the little divider or septum is located in that opening. So it is a common occurrence for the wire to go into the pancreatic duct."

Dr. Branch testified it was also not a violation of the standard of care to repeat attempts at cannulation. He stated it was appropriate for Dr. DeWeert to "reposition things" and change guidewires after accessing the pancreatic duct rather than the common bile duct. Ultimately, Dr. DeWeert could not achieve his goal of clearing Candice's bile duct because he could never gain access to that duct. It was then appropriate for Dr. DeWeert to stop the ERCP procedure because "if you continue and you're only gaining access to the pancreatic duct and you continue in the

pancreatic duct, you start to increase the risk of complications, mainly pancreatitis." He stated that pancreatitis was "the most common" complication associated with ERCP procedures "[a]nd to go into the pancreatic duct repeatedly, there's a chance of triggering it."

¶ 48 Dr. Branch further testified that when looking at the images taken during the ERCP procedure he could not "tell that the [pancreatic] duct is perforated," stating there was "no contrast seen leaking from the duct." He stated that extravasation, meaning "x-ray dye that's outside the confines of where it should be," was not shown on any of the images taken during the ERCP procedure. Additionally, the radiologist who interpreted the ERCP images did not indicate that the guidewire perforated the pancreas. According to Dr. Branch, there was also no suggestion in Candice's MRCP report that there had been a perforation of the pancreas.

¶ 49 Dr. Branch opined that Dr. DeWeert did not breach the standard of care by failing to place a pancreatic stent. To place a stent, "you have to be able to get the guidewire into the duct in a region that safely allows you to put the stent in place" and if "you can't safely do it, you should not." He opined that Candice had an anatomical variant, "a reverse S," that affected Dr. DeWeert's ability to place a pancreatic stent.

¶ 50 Further, Dr. Branch testified that use of indomethacin was not the standard of care at the time Dr. DeWeert performed the ERCP procedure on Candice. Additionally, he opined that the amount of fluid ordered by Dr. DeWeert following the ERCP was in an amount that was commonly used at the time.

¶ 51 Finally, Dr. Branch testified regarding Candice treatment at Barnes. He stated there were no findings in her medical records to suggest that she had either an infected or necrotic pancreas at the time of her first discharge from Barnes. He noted that a CT scan showed en-

hancement of the pancreas and that enhancement meant there was adequate blood flow. No enhancement was "a CT definition of necrosis."

¶ 52 Dr. Branch also reviewed records from the surgery Dr. Hawkins performed on Candice in May 2012. He stated the mortality rate goes up for patients undergoing an open procedure. Dr. Branch testified that prior to the May 2012 surgery, Candice's "white count" and temperature were within normal ranges. If Candice had an infection, he would have expected an elevated white count and a fever. Regarding what caused Candice's death, Dr. Branch testified as follows:

> "I think the patient ultimately succumbed to sepsis would be the most likely thing. Exactly all the events that led to that are not quite as clear. *** [T]he patient underwent surgery twice without finding of a clear abscess or a septic source that they were able to treat."

¶ 53 On cross-examination, Dr. Branch agreed that guidelines provided for hydration of 200 to 400 milliliters of fluid per hour in the first 24 hours after a diagnosis of pancreatitis. He also agreed that Candice's cause of death was found to be sepsis that was "secondary to post-ERCP pancreatitis." He testified that he knew "Dr. DeWeert had a complication with pancreatitis." However, Dr. Branch testified that it was unclear to him whether the necrotizing pancreatitis Candice developed was related to Dr. DeWeert's ERCP or a subsequent ERCP performed on Candice.

¶ 54 On cross-examination, Dr. Branch also acknowledged that during Dr. Hawkins's May 2012 surgery, necrotic pancreatic tissue was debrided. He agreed that the progression of Candice's condition in this case was that she developed acute pancreatitis immediately after Dr.

DeWeert's ERCP procedure, she was sent to Barnes, developed necrotizing pancreatitis that became infected, and died from sepsis—an infection.

¶ 55 Dr. Branch testified that pancreatitis is a known risk of any ERCP. When trying to access the common bile duct during an ERCP, the goal is to avoid the pancreatic duct. However, avoiding the pancreatic duct is not easy. Dr. Branch agreed that perforation of the pancreatic duct can be the result of negligence.

¶ 56 Dr. David Bentrem, a surgical oncologist, also testified for defendants. Dr. Bentrem stated he performed gastrointestinal surgery with a special focus on pancreaticobiliary surgery. He reviewed Candice's medical records from Barnes and determined that decisions were made in treating Candice from May to August 2012, "that when you look at how it turned out, was the wrong path."

¶ 57 Dr. Bentrem stated that nutrition was important for patients with pancreatitis and "it didn't seem like [Candice] was taking a whole lot of nutrition or hydration when she went home" after her initial nine-day hospitalization at Barnes. He asserted the fact that she did not eat much at home after her discharge "tells you that she still ha[d] the severe pancreatitis going on." Dr. Bentrem testified that it was possible that Candice's second ERCP procedure, performed at Barnes, "added to her problems."

¶ 58 According to Dr. Bentrem, on May 10, 2012, Dr. Hawkins opened Candice's abdomen, did an exploratory laparotomy, and took out parts of the pancreas. He stated he would not have operated on Candice at that time and that she was "the kind of person that need[ed] more time." Dr. Bentrem stated that Candice seemed to be getting better slowly at the beginning of May 2012 and on May 9, 2012, she was not a candidate for surgery. He noted she was out of

the intensive care unit, did not have a fever, had a normal respiratory rate, and a normal white count. He would have expected a patient with an infection to have elevated white counts. Dr. Bentrem also noted that Candice had been taken off of antibiotics, indicating that she was stable and that doctors were not worried about bacteria in the bloodstream. He testified that CT scans performed before the surgery showed no evidence of pancreatic necrosis. In any event, necrotic tissue around the pancreas was not a reason to operate. Dr. Bentrem testified that doctors "tend not to operate on sterile necrosis," *i.e.*, necrosis with no infection.

¶ 59 Dr. Bentrem stated Candice's condition worsened after the May 2012 surgery. He testified as follows:

> "[T]here's a clear difference from the beginning of May to the end of May ***. You know, the white count is doubled, respiratory rate's doubled, the temperature is elevated. At that point, there's three drains instead of one. Blood in those drains, getting transfused and bile in the wound. So, just an incredibly difficult situation at the end of May to recover from."

¶ 60 On cross-examination, Dr. Bentrem agreed that there was evidence that Candice had a fungal infection, rather than a bacterial infection, prior to her May 2012 surgery. He also agreed that Dr. Hawkins described debriding necrotic tissue from Candice's pancreas at the time of the surgery.

¶ 61 Dr. Jonnalagadda testified he was a gastroenterologist and performed approximately 450 ERCPs a year. On April 6, 2012, he performed an ERCP on Candice and stated the "indication" for his ERCP procedure was to remove a bile duct stone. Dr. Jonnalagadda described the ERCP procedure as technically difficult and complex because the opening of Can-

dice's ducts was swollen and congested, likely due to the earlier ERCP procedure or pancreatitis. Dr. Jonnalagadda stated he cannulated Candice's pancreatic duct but did not have enough wire in the duct to allow stent placement. He agreed that placing a stent in the pancreatic duct can reduce the severity of pancreatitis.

¶ 62 According to Dr. Jonnalagadda, the goal of his ERCP was to clear the bile duct and, as to that goal, his ERCP was successful. He testified that pancreatitis was a risk of an ERCP and that it could occur even if the procedure was performed within the standard of care. There could also be an inability to access the common bile duct even if the procedure was performed appropriately. Dr. Jonnalagadda further testified that "when the stated intent is to get into the bile duct and you have a wire or access to the pancreatic duct [having the guidewire make its way into the pancreas] is an inherent possibility."

¶ 63 Dr. Jonnalagadda testified that there can be bends or curves in the pancreatic duct that make stent placement difficult. Additionally, use of indomethacin was not the standard of care when he performed Candice's second ERCP procedure. According to Dr. Jonnalagadda, Candice would have been considered a high-risk patient when he saw her because of her prior ERCP procedure and her development of pancreatitis. Further, he agreed that at the time of Candice's initial discharge from Barnes on April 14, 2012, a finding was made that her acute pancreatitis had resolved. However, Dr. Jonnalagadda had concerns about that determination. He thought Candice might have been stable, but would not necessarily have found that her pancreatitis had resolved. He opined that discharge may have been appropriate for Candice depending upon her condition.

¶ 64 On cross-examination, Dr. Jonnalagadda agreed that, "when doing an ERCP to

look for a suspected stone, a reasonably careful gastroenterologist avoids cannulating the pancreatic duct." He testified that three ways to reduce the risk of pancreatitis were the placement of a stent, use of indomethacin suppositories, and aggressive hydration. He opined that a reasonably careful gastroenterologist in the context of Candice's case would have ordered aggressive hydration. Additionally, Dr. Jonnalagadda testified that he would have placed a pancreatic stent during the ERCP he performed if he could have gained access to the pancreatic duct. He did not recall Candice's procedure, but from his records determined that he "possibly" could not gain access to the pancreatic duct because of swelling, pancreatitis, or because the duct was not straight. Dr. Jonnalagadda testified that he did place a biliary stent during his procedure and that he did not retrieve a stone.

¶ 65 Dr. Hawkins testified he was a hepatobiliary and pancreatic surgeon. He stated that the decision to discharge Candice from Barnes on April 14, 2012, did not appear incorrect from what was recorded about her condition at the time and noted that most patients with procedural pancreatitis improve. Dr. Hawkins testified that Candice had two indications for the surgery he performed on May 10, 2012—an infected necrotic pancreas, which was difficult to drain by techniques other than surgery, and an unresolving bowel obstruction. During the surgery, he removed infected pancreatic tissue—tissue that looked dead. Consistent with an infection, he observed fluid that was cloudy and foul smelling.

¶ 66 On cross-examination, Dr. Hawkins agreed that surgery should be avoided for patients like Candice if possible and that most get better with supportive care. He also testified that surgery on a sterile pancreas should be avoided. Dr. Hawkins acknowledged that prior to her surgery, Candice was noted in her medical records as having no temperature, a normal white

count, being taken of antibiotics for bacteria, and showing improvement in her bowel obstruction. However, he asserted that such circumstances did not represent the entire picture.

¶ 67 On further examination by plaintiff's counsel, Dr. Hawkins denied that Candice's pancreas was sterile when he operated in May 2012. He testified that, before surgery, Candice was "not getting better systemically." According to Dr. Hawkins, Candice had "a difficult disease and unfortunate results from the treatment." He testified that both "the disease process" and the treatment could cause Candice's condition after surgery. Dr. Hawkins stated he had no disagreement that Candice died from sepsis or that a contributing cause of her death was pancreatitis secondary to ERCP.

¶ 68 Finally, plaintiff presented the testimony of Dr. Richard Gore, a diagnostic radiologist. Dr. Gore testified regarding various images in Candice's case. He stated that images from the ERCP performed by Dr. DeWeert showed that a guidewire went partially "into the pancreatic duct" and then "lacerat[ed] or pok[ed] a hole into the pancreas." Dr. Gore asserted that Dr. DeWeert's guidewire was going in a direction that the pancreas did not go in and testified as follows: "[The guidewire] is going to the left of the midline where it should. So it poked a hole in the pancreatic duct and lacerated the pancreas." Based on the observable location of the surgical clips from Candice's previous gallbladder surgery, Dr. Gore determined the guidewire was not in the common bile duct and not in the pancreatic duct.

¶ 69 Dr. Gore additionally testified that the MRCP performed after Dr. DeWeert's ERCP showed that Candice's common bile duct was not dilated and that there were not "any stones or other junk in it." He testified that inflammatory fluid and what "might be the beginning of necrotizing pancreatitis" could also be seen on the MRCP. Dr. Gore asserted that imaging in-

dicated that pancreatic enzymes leaked out into the abdomen because a hole was poked into the pancreas by the guidewire. He testified that an MRI was more sensitive than a CT scan in depicting subtle pancreatic necrosis or early subtle changes of pancreatitis.

¶ 70 Dr. Gore opined that an April 11, 2012, CT scan performed on Candice at Barnes showed necrotizing pancreatitis. An April 17, 2012, CT scan then showed progressive necrosis of the pancreas. On April 27, 2012, a CT scan showed the pancreatic head was "doing all right" but "the rest of the pancreas [was] doing very poorly." Dr. Gore identified "fluid collections and inflammation." He testified a CT scan on May 7, 2012, showed "abnormal fluid collections." He further identified "recurrent fluid selections, abscesses and things as a result of her rip roaring pancreatitis."

¶ 71 On cross-examination, Dr. Gore acknowledged that he disagreed with the reports of six radiologists in the case, including those from the April 11, 20, 27, and May 7, 2012, CT scans reporting no sign of necrosis. On redirect, he asserted that in his 40 years as a radiologist, he had not seen a guidewire in the position that he observed in this case.

¶ 72 Ultimately, the jury returned a verdict in favor of plaintiff. In December 2017, the trial court entered a judgment in the amount of $4,783,300.14 plus costs in favor of plaintiff and against defendants. In March 2018, defendants filed a posttrial motion, asking the court to enter a judgment notwithstanding the verdict or grant them a new trial. In July 2018, the court denied defendants' motion.

¶ 73 This appeal followed.

¶ 74 II. ANALYSIS

¶ 75 A. Manifest Weight of the Evidence

¶ 76 On appeal, defendants argue that the jury's verdict was against the manifest weight of the evidence. They contend plaintiff failed to establish that Dr. DeWeert breached the standard of care and that each of plaintiff's allegations of medical negligence were groundless. Defendants also claim that none of the claimed negligent acts were shown to have caused Candice's death.

¶ 77 "[O]n a motion for a new trial, the trial court will weigh the evidence and order a new trial if the verdict is contrary to the manifest weight of the evidence." *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38, 983 N.E.2d 414. "A verdict is against the manifest weight of the evidence only where the opposite result is clearly evident or where the jury's findings are unreasonable, arbitrary[,] and not based upon any of the evidence." *Id*. The trial court's ruling on a motion for a new trial will not be reversed "unless it is affirmatively shown that the trial court abused its discretion." *Id*.

¶ 78 On review, "[w]e are mindful that credibility determinations and the resolution of inconsistencies and conflicts in testimony are for the jury." *York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill. 2d 147, 179, 854 N.E.2d 635, 653 (2006). "In determining whether the trial court abused its discretion, we consider whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial." *Hamilton v. Hastings*, 2014 IL App (4th) 131021, ¶ 26, 14 N.E.3d 1278. "Conflicts in the evidence and disagreements among experts do not make a verdict against the manifest weight of the evidence." *Downey v. Dunnington*, 384 Ill. App. 3d 350, 389, 895 N.E.2d 271, 303 (2008).

¶ 79 To prove medical negligence, a plaintiff must establish the proper standard of care against which the defendant's conduct should be measured, an unskilled or negligent failure by

the defendant to comply with the standard of care, and a resulting injury that is proximately caused by the defendant's lack of skill or care. *Garley v. Columbia LaGrange Memorial Hospital*, 351 Ill. App. 3d 398, 404, 813 N.E.2d 1030, 1036 (2004). "Unless the negligence is so grossly apparent or the treatment so common as to be within the everyday knowledge of a layperson, expert medical testimony is required to establish the standard of care and the defendant's deviation from that standard." *Id.* at 404-05.

¶ 80 Here, the jury's verdict was not against the manifest weight of the evidence. There is essentially no dispute that Candice developed acute pancreatitis as a result of the April 2012 ERCP procedure performed by Dr. DeWeert. Dr. Clarke identified several deviations in the standard of care by Dr. DeWeert during his treatment of Candice and performance of the ERCP procedure. Notably, Dr. Clarke testified that Dr. DeWeert punctured or perforated Candice's pancreas during the ERCP. He described how the puncture or perforation was depicted in images taken during the procedure, using staples from Candice's prior gallbladder surgery as a landmark. Dr. Clarke opined that Dr. DeWeert's guidewire was shown "going up" and that it was "beyond the limit of the pancreas."

¶ 81 Dr. Clarke further opined that puncturing the pancreas was a deviation from the requisite standard of care, testifying as follows:

> "Well, I must say that you can get punctures from guidewires, but in this situation where you're wanting to study the bile duct and you are trying to stay out of the pancreatic duct, it's hard to—I can't imagine how he could get a perforation of the pancreatic duct in that circumstance unless you were deviating below the standard of care. I think, yes, I think it was."

Dr. Clarke testified that perforation of the pancreatic duct when trying to access the common bile duct does not occur unless there is negligence and that the severity of pancreatitis "goes up dramatically" when the pancreas is punctured. Dr. Gore testified similarly to Dr. Clarke regarding perforation. He stated that images from Dr. DeWeert's ERCP showed that a guidewire went partially "into the pancreatic duct" then "lacerat[ed] or pok[ed] a hole into the pancreas." He testified that Dr. DeWeert's guidewire was going in a direction that the pancreas did not go in, asserting: "[The guidewire] is going to the left of the midline where it should. So it poked a hole in the pancreatic duct and lacerated the pancreas."

¶ 82 As indicated, Dr. Clarke also identified several other ways in which Dr. DeWeert's treatment fell below the standard of care, including that he did not place a pancreatic stent at the time of the ERCP procedure and because he did not aggressively hydrate Candice upon diagnosing her with pancreatitis. Further, the jury heard evidence that Dr. DeWeert transferred Candice to Barnes for treatment of her acute pancreatitis and that Candice died in August 2012 from sepsis with post-ERCP pancreatitis as a contributing factor.

¶ 83 The evidence presented was sufficient to satisfy the necessary elements of a medical negligence claim. On appeal, defendants essentially point out the conflicting evidence that was presented to refute plaintiff's experts; however, "where conflicting expert testimony is introduced at trial, it is the province of the jury as the trier of fact to resolve the conflict." *Dabros v. Wang*, 243 Ill. App. 3d 259, 264, 611 N.E.2d 1113, 1117 (1993). On review, this court will not "reweigh the evidence or reevaluate the credibility of the witnesses." *Id.*

¶ 84 Additionally, we note that relative to the issue of whether Dr. DeWeert perforated Candice's pancreas, defendants note that Dr. Clarke admitted that there was no radiological evi-

dence of perforation, *i.e.*, extravasation or dye leaking out of the pancreatic duct. They also argue that plaintiff's contention that extravasation "could not be seen because Dr. DeWeert did not use enough contrast" was speculative. We disagree.

¶ 85 Here, Dr. Clarke opined that extravasation could not be seen on the ERCP films because "where you see the guidewire going up out the pancreatic duct, there was very little contrast still left in the duct, and it was distal to where the guidewire is, or it was not enough to make much difference in that area." Although defendants argue such a determination is speculative, the record reflects it is actually supported by Dr. DeWeert's own testimony. Specifically, he stated that the ERCP films did not show his guidewire outside of either the common bile duct or the pancreatic duct because there was "no contrast outlining any ducts." He acknowledged that extravasation occurs "when dye leaks out of a duct" from a puncture or hole in the duct. When viewing an image from the ERCP he performed, he testified that there was no dye in either duct "so you can't really tell much." On cross-examination, Dr. DeWeert agreed that he "didn't inject much dye into [Candice's] pancreatic duct" during the ERCP procedure. Dr. Clarke's opinion regarding extravasation was not speculative and could have appropriately been accepted by the jury.

¶ 86 In this instance, the record contains sufficient evidence to support the jury's verdict. Accordingly, the trial court did not abuse its discretion in finding the verdict was not against the manifest weight of the evidence.

¶ 87 B. Sole Proximate Cause Instruction

¶ 88 On appeal, defendants next argue that the trial court erred in denying their request to provide the jury with an instruction on sole proximate cause. They argue that they were enti-

tled to instructions on their theory of defense that the surgery performed by Dr. Hawkins in May 2012 was the sole proximate cause of Candice's death.

¶ 89 "A litigant has the right to have the jury clearly and fairly instructed upon each theory which was supported by the evidence." *Leonardi v. Loyola University of Chicago*, 168 Ill. 2d 83, 100, 658 N.E.2d 450, 458 (1995). "The decision to give or deny an instruction is within the trial court's discretion." *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 505, 771 N.E.2d 357, 371 (2002). "The standard for determining an abuse of discretion is whether, taken as a whole, the instructions are sufficiently clear so as not to mislead and whether they fairly and correctly state the law." *Id.*

¶ 90 At trial, defendants asked that the jury be instructed pursuant to the long-form version of Illinois Pattern Jury Instructions, Civil, No. 12.04 (approved December 8, 2011) (hereinafter IPI Civil No. 12.04), entitled "Concurrent Negligence Other Than Defendant's." That instruction provides as follows:

> "More than one person may be to blame for causing an injury. If you decide that a [the] defendant[s] was [were] negligent and that his [their] negligence was a proximate cause of injury to the plaintiff, it is not a defense that some third person who is not a party to the suit may also have been to blame.
>
> [However, if you decide that the sole proximate cause of injury to the plaintiff was the conduct of some person other than the defendant, then your verdict should be for the defendant.]" *Id.*

Here, the court denied defendants' request and provided the jury with only the short-form version, *i.e.*, the first paragraph, of IPI Civil No. 12.04.

¶ 91 "The sole proximate cause instruction, like any jury instruction, requires that there be some evidence to justify the theory of the instruction." *McDonnell v. McPartlin*, 192 Ill. 2d 505, 523, 736 N.E.2d 1074, 1085 (2000). More specifically, "[a] sole-proximate-cause instruction is not appropriate unless there is evidence that the sole proximate cause (not *a* proximate cause) of a plaintiff's injury is conduct of another person or condition." (Emphasis in original.) *Petryshyn v. Slotky*, 387 Ill. App. 3d 1112, 1123, 902 N.E.2d 709, 718 (2008). In a medical negligence case, "[i]t is not necessary that the defendant also establish that the nondefendant's conduct was medically negligent." *McDonnell*, 192 Ill. 2d at 516. Additionally, the long-form version of IPI Civil No. 12.04 should be given even if the evidence tending to show sole proximate cause is "slight and unpersuasive." *Ready v. United/Goedecke Services, Inc.*, 238 Ill. 2d 582, 591, 939 N.E.2d 417, 422 (2010).

¶ 92 Here, the trial court rejected defendants' request to submit the long-form version of IPI Civil No. 12.04 to the jury on the basis that it was not supported by competent evidence. Specifically, at the hearing on defendants' posttrial motion, the court stated as follows:

> "Okay. The primary argument made in the defendants' post[]trial motion is that the Court failed to give the long form of the sole proximate cause instruction. And all of the case law tells us that the long form is appropriate where there is some competent evidence that the sole proximate cause of a plaintiff's injury lies in the conduct of someone other than the defendant. Proof of negligence on the part of that third party is not required. However, there must still be some evidence of the cause in the record.
>
> * * *

> The Court finds that there was not sufficient evidence in this record to justify giving the long form."

Here, the record supports the court's determination.

¶ 93 Defendants argue that evidence was presented showing Candice was stable or improving with supportive care at Barnes immediately prior to Dr. Hawkins's May 2012 surgery. They point to Dr. Bentrem's testimony that Candice was "the kind of patient that need[ed] more time." They further point to evidence that open surgeries have a high mortality rate, as well as evidence that Candice's condition worsened after the surgery. However, neither Dr. Bentrem nor any other medical expert testified that the May 2012 surgery was the *sole* proximate cause of Candice's death. At most, the evidence cited by defendants was "some evidence" showing that Dr. Hawkins' conduct was *a* contributing cause of Candice's death. It does not tend to show that the surgery was the sole proximate cause. See *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 134, 679 N.E.2d 1202, 1219 (1997) ("A defendant is not automatically entitled to a sole proximate cause instruction wherever there is evidence that there may have been more than one, or concurrent, causes of an injury or where more than one person may have been negligent.")

¶ 94 As stated, Candice developed acute pancreatitis following the ERCP procedure performed by Dr. DeWeert and was transferred to Barnes for treatment of that condition. Evidence showed she was suffering from pancreatitis both prior to and after the surgery performed by Dr. Hawkins. Further, post-ERCP pancreatitis was determined at autopsy to be a contributing cause of her death. Under the circumstances presented, we find no abuse of discretion by the trial court in refusing to give the long-form version of IPI Civil No. 12.04.

¶ 95 C. *Res Ipsa Loquitur*

¶ 96 Finally, on appeal, defendants argue that the trial court erred by denying their motion for a directed verdict as to all claims based on the doctrine of *res ipsa loquitur*, counts V through VIII of the amended complaint. They assert that such claims fail as a matter of law because the evidence showed that Candice's injury can and does occur in the absence of negligence.

¶ 97 "A motion for a directed verdict should only be granted when the evidence presented, viewed in a manner most favorable to the nonmoving party, is so overwhelmingly in the movant's favor no contrary verdict based on the evidence could ever stand." *Smith v. Illinois Central R.R. Co.*, 2015 IL App (4th) 140703, ¶ 38, 37 N.E.3d 445. "The plaintiff must present some evidence on every essential element of the cause of action; otherwise, the defendant is entitled to a judgment in his favor as a matter of law." *Keiser-Long v. Owens*, 2015 IL App (4th) 140612, ¶ 31, 37 N.E.3d 914. The trial court's ruling on a motion for a directed verdict is subject to *de novo* review. *Id.*

¶ 98 Further, the purpose of the *res ipsa loquitur* doctrine "is to allow proof of negligence by circumstantial evidence when the direct evidence concerning cause of injury is primarily within the knowledge and control of the defendant." *Metz v. Central Illinois Electric & Gas Co.*, 32 Ill. 2d 446, 449, 207 N.E.2d 305, 307 (1965). "[A] plaintiff seeking to rely on the *res ipsa* doctrine must plead and prove that he or she was injured (1) in an occurrence that ordinarily does not happen in the absence of negligence, (2) by an agency or instrumentality within the defendant's exclusive control." *Heastie v. Roberts*, 226 Ill. 2d 515, 531-32, 877 N.E.2d 1064, 1076 (2007).

¶ 99 In his amended complaint, plaintiff brought four counts based on the doctrine of

res ipsa loquitur, alleging Dr. DeWeert breached his duty to act as a reasonably careful gastroenterologist by perforating Candice's pancreas during the ERCP procedure. At trial, defendants moved for a directed verdict as to those counts asserting that, although Candice had post-ERCP pancreatitis, "there's no evidence to say that it was caused by any perforation." The trial court denied defendants' motion, stating as follows:

> "[Dr. Clarke] testified that a puncture is below the standard of care, according to the Court's notes. When wanting to study the common bile duct, he indicated that a perforation in the pancreatic duct when trying to study the common bile duct does not occur outside of negligence."

Additionally, when addressing this issue during posttrial proceedings, the court further stated as follows:

> "With respect to the *res ipsa* [*loquitur*] count[s], the plaintiff did present evidence through Dr. Clarke, his expert, that was sufficient to preclude summary judgment or a directed verdict on the issue. Specifically, Dr. Clarke testified that when performing an ERCP, the goal is to access the common bile duct. However, when accessing the pancreatic duct and a perforation or a tear or a puncture is caused, that does not happen in the absence of negligence. That was sufficient to allow the plaintiff to continue with that theory and present it to the jury."

¶ 100 On appeal, defendants accurately point out that, on cross-examination, Dr. Clarke generally agreed that he had experienced perforation of the pancreas in his practice and that perforation could occur without a breach of the standard of care. However, the questions posed on cross-examination were not specific to the type of ERCP procedure being performed in this case

and, on direct examination, Dr. Clarke provided an opinion that was more specific to the facts at issue. In particular, he testified as follows on direct examination:

> "Q. In this case do you have an opinion as to whether the puncture that occurred was a deviation from the standard of care?
>
> A. Well, I must say that you can get punctures from guidewires, but in this situation where you're wanting to study the bile duct and you are trying to stay out of the pancreatic duct, it's hard to—I can't imagine how he could get a perforation of the pancreatic duct in that circumstance unless you were deviating below the standard of care. I think, yes, I think it was.
>
> Q. And, ordinarily, would a perforation of the pancreatic duct when you're simply trying to get into the common bile duct, just that perforation, does that normally not occur unless there is negligence?
>
> A. Correct."

Dr. Clarke further opined that Dr. DeWeert's conduct caused Candice to develop severe acute pancreatitis, stating "she would not have had the pancreatitis except for [the ERCP] procedure." He testified that the severity of the pancreatitis "goes up dramatically" when the pancreas is punctured because "more enzymes are released and more digestion occurs."

¶ 101 When viewing the evidence in the light most favorable to plaintiff, there was sufficient evidence to establish each element of his *res ipsa* claims. The evidence was not overwhelmingly in the defendants' favor such that no contrary verdict could stand. Accordingly, the trial court did not err in denying defendants' motion for a directed verdict.

¶ 102 III. CONCLUSION

¶ 103 For the reasons stated, we affirm the trial court's judgment.

¶ 104 Affirmed.