

2012 IL App (2d) 110271-U
No. 2-11-0271
Order filed March 12, 2012

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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

SARA WILHELM, a Minor, by her Mother)	Appeal from the Circuit Court
and Next Friend, Joan Wilhelm, JOAN)	of Lake County.
WILHELM, and BARON WILHELM,)	
)	
Plaintiffs-Appellants,)	
)	
v.)	No. 03-L-272
)	
RICHARD FEROLO and PADMINI)	
THAKKAR,)	
)	
Defendants-Appellees)	
)	Honorable
(Tri-County Physicians Association, Ltd.,)	Margaret J. Mullen,
Defendant).)	Judge, Presiding.

JUSTICE BOWMAN delivered the judgment of the court.
Justices Burke and Schostok concurred in the judgment.

ORDER

Held: The trial court properly barred the opinion of plaintiff's expert and properly granted summary judgment in favor of defendants.

¶ 1 Plaintiffs, Sara Wilhelm, by her mother and next friend, Joan Wilhelm, and Joan and Baron Wilhelm, appeal the trial court's order barring certain testimony of their expert witness and granting summary judgment in favor of defendants, Richard Ferolo and Padmini Thakkar. We affirm.

¶ 2

I. BACKGROUND

¶ 3 Sara Wilhelm was born on January 28, 1993. On June 14, 1994, she was diagnosed with retinoblastoma, a cancerous tumor, in her right eye. On June 20, she underwent enucleation, or removal, of her right eye, followed by an intense, year-long course of chemotherapy and radiation. The radiation treatments were alleged to have caused, in part, facial disfigurement on Sara's right side and affected the function of her pituitary gland, requiring further surgeries and medical treatment later in her life. Plaintiffs filed a medical negligence complaint against defendants on March 19, 2003, alleging that the chemotherapy and radiation treatments would not have been necessary had Sara's pediatricians diagnosed the retinoblastoma earlier.

¶ 4 Specifically, plaintiffs' complaint alleged that between January 28 and December 31, 1993, Dr. Ferolo treated Sara. During that time, Joan expressed concern regarding Sara's right eye. In count I, plaintiffs alleged that Dr. Ferolo was negligent during Sara's April, June, July, and October 1993 visits in that he: failed to perform an appropriate eye exam, including a red reflex exam; failed to recognize the signs or diagnose the retinoblastoma or other eye defect; failed to provide proper ophthalmological treatment, including referring Sara to an ophthalmologist; failed to refer Sara to an ophthalmologist in a timely manner when he knew or should have known of the existence of the tumor or other eye disease; and failed to prevent the retinoblastoma from progressing to a Stage V tumor, which necessitated total enucleation of the right eye on June 20, 1994, and an intense year-long regimen of chemotherapy and radiation therapy. Count III alleged that Dr. Thakkar treated Sara between February 1 and May 19, 1994. It alleged that Dr. Thakkar was negligent during Sara's February and May 1994 visits in the same manners alleged against Dr. Ferolo. Counts II and IV were claims based on the Family Expense Act (750 ILCS 65/15 (West 2002)).

¶ 5 In early May 2010, after years of proceedings and discovery, defendants filed motions *in limine* to bar the testimony of plaintiff's expert pathologist, Dr. Elise Torczynski, pursuant to *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923). The motions stated that plaintiffs alleged in part that the right side of Sara's face appeared different from the left side and that the difference was due to the radiation treatments she received following the enucleation of her right eye. Although defendants dispute whether Sara would have required radiation in any event, there was testimony that she required the radiation treatment because the tumor had crossed a structure in the eye known as the lamina cribrosa and had entered the optic nerve. Additionally, there was testimony that one symptom of retinoblastoma was the absence of a red reflex and the presence of a white reflex. A healthy retina shows as red to a physician shining a light into a patient's eye. A diseased retina will show as white. Plaintiffs disclosed some photographs of Sara, taken in November 1993, that showed a white spot on Sara's right eye. According to the motions, Dr. Torczynski testified in a discovery deposition, that the white spot in the photograph was a white reflex, indicating the presence of a retinoblastoma. She further testified that based on the photograph, together with the fact that a few tumor cells were found across the lamina cribrosa and in the optic nerve on June 20, 1994, the tumor in Sara's eye crossed the lamina cribrosa 8 to 10 weeks before its diagnosis on June 20, 1994.

¶ 6 Defendants argued that all other experts and occurrence witnesses had testified that no physician could determine the rate of growth of a retinoblastoma from such a photograph. No other testimony suggested how fast Sara's tumor grew, where it first originated, or when it crossed the lamina cribrosa. They argued that the methods Dr. Torczynski used to reach her conclusions were not generally accepted in the scientific community and did not meet the *Frye* test. Defendants attached portions of the various depositions of the medical witnesses.

¶7 Dr. Elise Torczynski, a pathologist, testified that in her opinion, the tumor cells crossed into the lamina cribrosa approximately 8 to 10 weeks prior to the date of diagnosis on June 20, 1994. She based this opinion on the fact that the tumor was not an aggressively-growing tumor. That opinion was based on the fact that the November 1993 photograph showed that Sara had something obstructing the red reflex in her right eye. Usually something moderately large had to be present to obstruct the red reflex. The tumor must have been present for awhile prior to the November 1993 photograph for it to have grown to a size large enough to obstruct Sara's red reflex at the time of photograph. According to Dr. Torczynski, tumors extend into the lamina cribrosa and into the choroid during the latter stages of development. Thus, in her opinion, the cells crossed into the lamina cribrosa about 8 to 10 weeks prior to diagnosis.

¶8 Dr. Richard Albrecht testified that when he saw Sara, he diagnosed her with a detached retina most likely secondary to some other cause. He could not say with any medical certainty when Sara's tumor first appeared. He could not say with any medical certainty when her retina detached. The growth rate of a tumor in the eye was variable. He also testified that one could have strabismus, or cross-eye, without having a mass. He could not say with any reasonable degree of medical certainty whether a mass or the detached retina was observable or diagnosable in January 1994.

¶9 Dr. Robert Allar, a retinovitreal specialist, testified that he saw Sara on June 17, 1994, and recommended additional testing to determine the possible presence of other conditions, including the possibility of retinoblastoma. He had no opinion as to when the retinoblastoma had invaded Sara's optic nerve. He was not aware of any physician diagnosing the presence or absence of retinoblastoma by the use of a photograph.

¶ 10 Dr. David Mittelman, a pediatric ophthalmologist, testified that he saw Sara on June 18, 1994. Dr. Mittleman testified that the growth rate of a retinoblastoma was not uniform, and that he could not determine the age of such a tumor. In Sara's case, he stated that he only knew that her mother noticed an abnormality two months earlier. He presumed that the abnormality was compatible with a retinoblastoma and presumably could have been diagnosed at that time. Prior to that time, Dr. Mittelman testified that there would be no reason for an ophthalmologist to examine a person unless there was a family history and it was being done as a screening. He acknowledged that family practitioners and internists do general eye examinations on newborns, including red reflex tests. When a tumor reaches a certain size or position, a red reflex test would allow for a diagnosis of a retinoblastoma. However, there could be a retinoblastoma present and a normal red reflex test depending on the location of the tumor. Dr. Mittelman did not know where Sara's tumor first started growing and did not believe anyone could determine that. He knew that the tumor did not start in the optic nerve because there were no cells of that nature in the optic nerve, but he could not determine when the optic nerve became involved.

¶ 11 Dr. Lise Anne Guay Bhatia, a pediatric ophthalmologist, testified that historically it was believed that the optic nerve invasion occurred in the later stages of retinoblastoma. She could not determine when Sara's optic nerve became involved. To diagnose a retinoblastoma, a doctor would have to examine a patient. A doctor could not diagnose the presence of a tumor from a photograph nor could he determine the rate of growth of a tumor by examining it. No one could determine when Sara's tumor first appeared. She also testified that she could not with a reasonable degree of medical certainty determine when Sara's tumor crossed the lamina cribrosa or the choroid.

¶ 12 Dr. Robert Weiss, an ophthalmic oncologist, testified that Sara's tumor was staged at a 5-B on the Reese-Ellsworth system, which is a staging system that involved the likelihood and prognosis for survival of the eye and vision. A 5-B tumor is the most advanced form of the tumor involving the retina or a tumor that had multiple seeds or had seeds in the vitreous (the jelly in the back of the eye). According to Dr. Weiss, vitreous seeding did not "tell you a thing about how aggressive it is." Also, a tumor may change from non-aggressive to aggressive. However, there was no way to backtrack to determine the course a tumor has taken. Based upon the exams and studies performed on Sara, Dr. Weiss could not determine where in the eye her tumor began. However, he knew the tumor did not originate in the optic nerve or in the lamina cribrosa because retinoblastomas originate in the retina. He could not determine when the optic nerve became involved. It could have been affected at the very beginning of the tumor's development, or at the end.

¶ 13 Dr. Weiss was unaware of anyone diagnosing retinoblastoma by use of photographs. A photograph depicting a red reflex is dependent upon the angle of the light used. Dr. Weiss explained that if the light was not exactly shining toward the back of the eye, one may not be able to get a red reflex where one exists, and vice versa. Dr. Weiss could not state when Sara's tumor first appeared. He saw children born with metastatic disease. He also saw children who photographed with a white reflex in one eye and a red reflex in another eye where upon examination, no retinoblastoma existed. He testified that the location of a retinoblastoma peripherally may not show an abnormal red reflex. Dr. Weiss could not determine whether Sara's tumor began in a peripheral or central location. If he saw a photograph of an infant showing red reflexes in both eyes, he did not consider that proof that a retinoblastoma did not exist. If Dr. Weiss saw a photograph of an infant with a white reflex, he would not consider it diagnostic but would consider it suggestive of a tumor.

¶ 14 Dr. Nancy Neidlinger-Low testified that tumors grow at various rates from patient to patient. There was no way to determine how fast a tumor had been growing with any certainty. She had no way to know when the tumor first appeared, where it first appeared in the retina, or when the tumor crossed the lamina cribrosa.

¶ 15 Dr. Cynthia Herzog, a pediatric hematology-oncology specialist, testified that it was possible for a normal eye to appear to have a white reflex in a photograph.

¶ 16 Dr. A. Linn Murphree, an ophthalmic oncologist, testified in his deposition that he did not have an opinion as to the size of Sara's tumor in November 1993, the date of the photograph. He testified that no one could determine that because there was no way to perform a natural history on the tumor. He agreed that it was likely that the tumor grew between November 1993 and June 1994 because most tumors will get larger with time. The rate at which tumors change varies. They may grow rapidly or slowly. Dr. Murphree testified that in order to demonstrate leukocoria (the white reflex), the tumor would have to have been three millimeters. He testified that it was impossible to determine when the tumor first appeared or when it first crossed the lamina cribrosa or the choroid. He believed Dr. Torczynski had no basis for her opinion that the tumor crossed the lamina cribrosa 8 to 10 weeks prior to diagnosis.

¶ 17 Dr. David Bardenstein, an ophthalmology oncologist, disagreed with Dr. Torczynski's opinion that one could determine the age of the tumor at the time of diagnosis or determine when the cells crossed the lamina cribrosa.

¶ 18 A *Frye* hearing on the motions was held on October 1, 2010. Dr. Torczynski testified regarding how she arrived at her opinions. Dr. Torczynski testified that Sara's retinoblastoma extended into the optic nerve one millimeter beyond the lamina cribrosa. A small number of cancer

cells were also found in the choroid, just beyond the Bruch's membrane. Dr. Torczynski identified the November 1993 photograph of Sara and opined that the white reflex in Sara's right eye represented leukocoria, a condition caused by something obstructing the passage of light in the eye. There were many conditions or diseases that could cause the condition. Based on the subsequent enucleation of Sara's right eye and diagnosis of retinoblastoma, Dr. Torczynski testified that in her opinion the leukochoria in the November 1993 photograph was caused by the presence of the retinoblastoma. Based on Dr. Murphree's opinion that a tumor would have to be about three millimeters to obstruct light entering the eye, Dr. Torczynski opined that Sara's tumor was at least that large or larger in November 1993. Dr. Torczynski opined the tumor was indolent, or non-aggressive, based on its size at its removal and the estimated three millimeter size in November 1993.

¶ 19 On cross-examination, Dr. Torczynski agreed that she could not time the crossing of the tumor into the lamina cribrosa without the November 1993 photograph. She acknowledged she had never used a photograph before in timing a tumor's growth into the lamina cribrosa. She also acknowledged that no medical literature or studies existed to support such a method of determination. She acknowledged that as a pathologist, her function was to look at slides to determine what the condition was as it existed at that point in time. She admitted that she could not determine from the 1993 photograph the exact dimension of anything that may have existed in Sara's eye at that time. She also was unable to determine the location of anything that may have existed in Sara's eye from the photograph. Dr. Torczynski also could not determine whether the tumor was early in its development or late in the stages of development from the photograph. From the

pathology report, Dr. Torczynski knew the tumor started in the macula region of the eye, which is the region in the back of the eye.

¶ 20 Dr. Murphree testified at the hearing that he directed the retinoblastoma center at the Children's Hospital in Los Angeles. In his position, his clinic saw about 50 to 60 out of the about 500 new cases of retinoblastoma each year. Dr. Murphree testified that there was no way to know how aggressive or in what manner a retinoblastoma tumor would grow because there was so much variation from tumor to tumor. He rejected anyone's ability to look at a photograph showing a white reflex to determine the size of a tumor. He stated a tumor as small as two to three millimeters may completely fill the pupil. According to Dr. Murphree, the red reflex test was a screening test for any problems and was not ever clinically used to tell anyone anything about a tumor. He testified that he was unable to use a photograph to determine the growth pattern of a tumor. Dr. Murphree testified that one could not predict a tumor's growth pattern from looking at it nor could one do so in retrospect. He rejected Dr. Torczynski's ability to estimate when the tumor crossed the lamina cribrosa because such a timing is not possible given all the variable growth rates and directions of growth in every tumor.

¶ 21 On cross-examination, Dr. Murphree agreed that the November 1993 photograph likely showed leukocoria in Sara, indicating the likely presence of a tumor, based on the fact such a tumor was removed in June 1994. However, he explained that the photograph did not tell him the size or growth rate of the tumor. Dr. Murphree explained the tumor could have been the same size in November 1993 as it was at the time of the removal. He could not, and believed no one could, say how much a cancerous tumor grew or when it grew. Dr. Murphree agreed that when speaking of general populations, the optic nerve was affected in the later stages of a retinoblastoma. He clarified

that one could not estimate when the tumor entered the later stage or when the optic nerve became affected.

¶ 22 On October 22, 2010, the trial court issued a written memorandum granting defendants' motions to bar the testimony of Dr. Torczynski that the tumor invaded the lamina cribrosa 8 to 10 weeks prior to diagnosis. The trial court agreed that Dr. Torczynski did not have two points of data to determine the tumor's rate of growth with any certainty that its crossing of the lamina cribrosa could be narrowed to a specified time period. The trial court noted that Dr. Torczynski herself admitted that no other physician has been able to extrapolate backwards from the known size of the tumor at the time of diagnosis. The court stated it could bar this portion of Dr. Torczynski's testimony under *Frye* as in *Agnew v. Shaw*, 355 Ill. App. 3d 981 (2005), or for failing to meet foundational requirements as in *Noakes v. National R.R. Passenger Corp.*, 363 Ill. App. 3d 851 (2006). The court chose to bar the testimony under *Noakes'* analysis pertaining to foundational requirements but acknowledged the result would be the same under *Frye*.

¶ 23 Following this evidentiary ruling, defendants filed motions for summary judgment. Defendants argued that without Dr. Torczynski's testimony that the tumor crossed into the lamina cribrosa 8 to 10 weeks prior to diagnosis, plaintiffs could not prove their claim that an earlier referral to a specialist by defendants would have prevented the subsequent chemotherapy and radiation treatment that plaintiffs' alleged caused Sara's facial disfigurement and growth problems.

¶ 24 The following deposition testimony was attached to defendants' motions. Dr. Albrecht, an ophthalmologist, testified that he examined Sara on June 14, 1994, and determined that she had a detached retina, likely due to a secondary cause. He immediately referred her to a retina specialist. He could not determine when Sara's retina became detached or when it could have first been

diagnosed because the growth rate of a tumor was not ascertainable. While Sara's mother reported that Sara had a strabismus, or cross-eye, appearance since birth, Dr. Albrecht confirmed that one can have a strabismus without presence of a tumor. Sara's older sister had also had a strabismus but did not have a tumor.

¶ 25 Upon referral, Sara saw Dr. Allar, who testified that he saw Sara on June 17, 1994. He testified that he had the patient history from Sara's mother, who reported that Sara's right eye turned in and that she was concerned about the vision in her right eye. Sara's mother also noticed color changes in the right eye and that the right eye appeared larger than the left. Dr. Allar examined the eye and observed what appeared to be a mass in the lower part of the eye globe. Dr. Allar advised Sara's mother additional testing was needed and that retinoblastoma and other conditions were possible. Dr. Allar did not have an opinion as to when Sara's condition could have first been observed and had no opinion as to the growth rate of her tumor. He had never heard of a physician using a photograph to diagnose the presence of a retinoblastoma.

¶ 26 Dr. Mittelman saw Sara on June 18, 1994, after her mother reported having been to two other ophthalmologists who stated Sara had a detached retina. Sara's mother reported a strabismus in the right eye for most of Sara's life and that her older sister had that condition before. Dr. Mittelman's report also indicated that Sara's mother reported an abnormal pupillary reflex approximately two months prior, which would have been the end of April or beginning of May 1994. After examining Sara's eyes, Dr. Mittelman observed that her right retina was detached and there appeared to be an ocular mass behind the retina. He believed that it was most likely a retinoblastoma based upon its appearance. It was not a common condition; Dr. Mittelman saw about one new case per year in his pediatric practice. He explained that there were two types of retinoblastoma conditions: hereditary

or sporadic. Hereditary retinoblastoma was typically diagnosed in the first year of a child's life and usually affected both eyes. Sporadic retinoblastoma usually affects one eye and was usually diagnosed in the second year of a child's life. Unlike in hereditary cases, where the child was born with mutated cells, sporadic patients experience cell mutation in the eye sometime after birth. Dr. Mittelman had no idea when Sara's cell first mutated. In his opinion, Sara's tumor was probably first diagnosable when her mother first noticed the inward reflex in the eye, which was two months earlier. It also could have been diagnosed earlier had she had been seen for some other reason, "purely by serendipity." The only children screened at an earlier stage are those hereditary cases where parents know of a family history or predisposition for the condition. Otherwise, there was no reason for children to be seen by a specialist to check for the condition unless the child had symptoms.

¶ 27 Dr. Mittelman explained that treatment for retinoblastoma typically involved enucleation. If there was evidence of metastasis, then chemotherapy or radiation would also be required. Sara required such treatment because there was evidence the tumor had involved the optic nerve and the choroid of the eye. However, he could not say when those areas of the eye became involved.

¶ 28 Dr. Bhatia testified that regarding Sara's case, Dr. Bhatia did not know if Sara had hereditary or sporadic retinoblastoma and no determination had been made on the cellular level as far as she knew. She saw Sara upon the referral of Dr. Mittelman. Dr. Bhatia stated that she could not diagnose a retinoblastoma from a photograph. According to her notes, Sara's mother reported cross-eye of the right eye since birth and leukocoria for the two months prior to Dr. Bhatia seeing Sara on June 20, 1994. After seeing Sara, Dr. Bhatia called Dr. Thakkar to obtain the appropriate insurance referrals for additional tests and to request that her siblings be seen in case Sara had the hereditary

form of the disease. Dr. Bhatia suspected retinoblastoma and arranged for the additional tests and subsequent surgery. Dr. Bhatia could not speak to whether a tumor could change from being aggressive to nonaggressive. Because Sara's tumor was quite large, Dr. Bhatia assumed it was not growing for one week. But beyond that, she could not say for certain how long the tumor was growing. Dr. Bhatia assumed it had been growing for months but could not estimate how many months. She also could not determine where in the eye Sara's tumor cells first began to grow. She knew that Sara's tumor had crossed the lamina cribrosa and had entered into the optic nerve. Dr. Bhatia testified that historically, the optic nerve was invaded in the later stages of the disease but she could not state when Sara's optic nerve became involved.

¶ 29 In her opinion, Dr. Bhatia believed that Sara could have been diagnosed earlier than June 20, 1994, if she had been examined by a specialist earlier based upon the size of the tumor and her assumption that the tumor had been growing for months. She could not provide an exact date or timeframe as to when an earlier diagnosis could have been made or when an earlier diagnosis could have prevented the chemotherapy or radiation treatment. Dr. Bhatia also specifically recalled that Sara's eye tumor was large and that her right eye appeared noticeably larger than her left. She recalled that Sara's mother mentioned that she had inquired about the eye on a number of occasions. But, Dr. Bhatia admitted that she did not know exactly when the tumor crossed the lamina cribrosa or hit the choroid, requiring the radiation and chemotherapy.

¶ 30 Dr. Weiss testified that he could not know for sure whether Sara had a hereditary or sporadic retinoblastoma. The tumor was extremely large and appeared to be one enormous tumor but in reality, the tumor had seeded into a multifocal tumor. Dr. Weiss explained that an aggressive tumor will tend to calcify because they are growing faster than the blood can supply it and the tissues die.

Sara's pathology report showed that her tumor was a multifocal, moderately differentiated retinoblastoma with extensive necrosis and vitreous seeding into the subretinal pigment epithelial space, the choroid, and beyond the lamina cribrosa. Dr. Weiss explained multifocal meant that the tumor was growing and it had seeded in multiple spots. He could not determine which was the primary site. Moderately differentiated indicated that the tumor might not be very aggressive because something that is well-differentiated was closer to normal tissue and something that is wildly differentiated indicated more rapid and aggressive growth. The extensive necrosis meant that the tumor was outgrowing its blood supply, indicating aggression. So, Sara's tumor seemed somewhere in the middle of non-aggressive and aggressive. Dr. Weiss testified that tumors did not normally change from aggressive to non-aggressive. He had no way of determining how aggressive a tumor was at a past point in time. Based on his examination of Sara's case, he could not determine where in the eye the cancer began to grow.

¶ 31 Dr. Weiss explained that Sara's cancer cells had crossed into the optic nerve and was beyond the lamina cribrosa, putting it into a different category. The tumor had to originate in the retina so it was impossible for the tumor to have initially started in the lamina cribrosa or in the optic nerve itself. He had no way to determine when the lamina cribrosa or optic nerve became involved. Dr. Weiss also testified that chemotherapy and radiation treatment would be necessary if the choroid was involved, although it would be a judgment call based on the extent of the choroid involvement. Again, Dr. Weiss could not determine when the choroid became involved. He also could not say definitively whether the additional treatment would have been necessary based solely on the choroidal involvement. He opined that it would not have been necessary.

¶ 32 Dr. Weiss was not aware of anyone being able to diagnose retinoblastoma through a photograph. Observing the November 1993 photograph of Sara, Dr. Weiss believed it was suggestive but not diagnostic of the presence of a retinoblastoma. Because he knew Sara had a retinoblastoma, Dr. Weiss could not look at the photograph and say it was not representative of a retinoblastoma. He believed that Sara probably had the tumor at the time the photograph was taken. However, he could not say whether at the time of the photograph the lamina cribrosa had been involved.

¶ 33 Dr. Nancy Neidlinger-Low, a pathologist and radiation oncologist who treated Sara, testified that she recalled speaking to Sara's mother at the time of treatment and that she was upset that she was the one who ultimately had to demand an ophthalmology opinion. In reviewing Sara's records, Dr. Low believed Sara's case was a genetic type of retinoblastoma and was terribly advanced when it was discovered. She acknowledged that the involvement of the lamina cribrosa and the optic nerve was critical in the decision of Sara's medical team to treat her with radiation. Like the other physicians, she did not know when Sara's tumor began to grow or how fast it grew or when it crossed the lamina cribrosa. She did not know when the tumor was first diagnosable or whether her tumor was a particularly fast or slow growing tumor. According to Dr. Low, some retinoblastoma patients do not have to undergo enucleation and may be treated with radiation in order to save the eye and vision. As to the resulting facial deformities that Sara has had surgery to correct later in her life, Dr. Low anticipated such consequences of the radiation treatments. In her opinion, the deformities did not seem as bad as Dr. Low had feared at the time. She also anticipated pituitary gland problems, which Sara had hormone treatment to correct later in her life.

¶ 34 Dr. Cynthia Herzog, a pediatric oncologist, treated Sara after she moved to Texas. She first saw Sara in February 1997. In Dr. Herzog's notes, Sara's mother had reported noticing strabismus at age one month, a change in the iris color and contour at age six months, and visible leukocoria between 6 and 12 months. Dr. Herzog assumed something was present prior to the ultimate diagnosis. She did not know when Sara could have or should have been first diagnosed. She also had no opinion as to how quickly the tumor was growing. She had no opinion as to where in the retina it first began to grow and acknowledged that the tumor's location could impact when it could be diagnosed. She acknowledged that retinoblastoma patients show initial signs and symptoms such as white reflex, strabismus, and blindness in the affected eye. She also acknowledged that it was a long period of time between Sara's diagnosis at 18 months and Sara's mother reporting leukocoria between the ages of 6 and 12 months. Dr. Low could not opine whether a failure to diagnose the condition deviated from the standard of care because she did not know how accurate the information she received from Sara's mother was. Dr. Low believed, given the extent of Sara's tumor, that she received the proper care—enucleation, chemotherapy, and radiation therapy. According to Dr. Low, there was no "typical" case like Sara's because most retinoblastomas in the United States were diagnosed before the lamina cribrosa was involved.

¶ 35 Dr. Low testified that in her opinion, whenever a parent expressed concern over a child's eye, the child should be seen by an ophthalmologist because generally eye complaints are not the type a parent created. She has seen incidents where a parent will recall making a complaint when there is no evidence in the patient's records. However, the extent of Sara's tumor did not cause Dr. Low to believe that there was negligence in the diagnosis. She stated it was possible for the eye to have become as involved as it was in the absence of negligence.

¶ 36 Dr. Murphree testified that he reviewed the records from Dr. Ferolo's office and found that there were no eye complaints documented by anyone in the office. In his notes from June 10, Dr. Ferolo noted pupil asymmetry but noted on the follow-up July 30 visit, the eyes appeared normal. Dr. Murphree did not see any notes that Dr. Ferolo did a red reflex exam. Dr. Ferolo's notes indicated he did perform a red reflex exam on Sara at her April, June, July and October 1993 visits. Dr. Murphree also reviewed Dr. Thakkar's notes. Dr. Thakkar's notes did not indicate that she performed a red reflex exam when she saw Sara in February 1994 or on the May 2, 1994 visit. On May 4, 1994, Dr. Thakkar performed the red reflex and found a yellow reflex. She wanted to get the records and follow-up because she thought Sara might have had a congenital cataract, and Dr. Thakkar wanted to see if Sara's earlier doctors noticed it. Dr. Murphree had no reason to believe that Dr. Ferolo improperly performed the red reflex exam. He also did not believe that Dr. Ferolo violated the standard of care for a primary care physician by not referring Sara to a specialist earlier because unequal pupils and strabismus sometimes resolve as the child develops. Unequal pupils had nothing to do with a retinoblastoma, and that was the only abnormality noted in Dr. Ferolo's notes.

¶ 37 As to Dr. Thakkar's first visit with Sara on February 21, 1994, Dr. Murphree did not believe it was a violation of the standard of care by failing to perform a red reflex exam because there was no evidence of any eye complaints except the testimony of Sara's mother. Dr. Murphree acknowledged that had Sara been seen by an ophthalmologist in February, her tumor would have been diagnosable. Dr. Murphree also did not think the 30-day delay in referring Sara to an ophthalmologist after Dr. Thakkar observed the abnormal red reflex in May 1994 was a deviation from the standard of care.

¶ 38 Dr. Murphree opined that no one could say that this particular tumor changed in size in the past ten weeks. He agreed that had an ophthalmologist examined Sara in November 1993, the time of the photograph showing Sara's right eye with a white pupil, the ophthalmologist would have found the tumor because a tumor as small as three millimeters can obstruct the red reflex. However, Dr. Murphree had no way of determining the size of Sara's tumor at any point prior to its discovery. Most tumors grow larger over time, but Dr. Murphree could not determine the growth rate because tumors vary in their growth. He also could not determine when the lamina cribrosa became involved. Dr. Murphree testified that it could have been months prior or within days of the diagnosis; no one had any way to determine.

¶ 39 Dr. Bardenstein, an ophthalmologist and pathologist in Cleveland, testified that Sara's tumor was large and of the sporadic type. He testified that one could not determine a tumor's rate of growth to determine when the tumor began, where it began, or when it grew past the lamina cribrosa. He agreed that the 1993 photograph of Sara likely showed leukocoria, given her subsequent retinoblastoma diagnosis. However, he testified that one could not diagnose leukocoria or retinoblastoma from the photograph. The lights of the camera may have caused the white appearance. He also agreed, given the subsequent diagnosis, that the picture likely showed leukocoria caused by Sara's tumor. Dr. Bardenstein had no idea how large the tumor was at that time, and he had no way to determine that. According to Dr. Bardenstein, one could not "date" a tumor based upon evidence of necrosis or calcification elements because one cannot determine the rate of growth to know how quickly an area calcified or died. He agreed with Dr. Murphree that had Sara been seen by an ophthalmologist in November 1993, her tumor probably would have been diagnosed. He agreed that Sara's tumor likely grew between November 1993 and June 1994, but

he had no way of knowing when the growth took place or where it took place. While less than 10% of sporadic retinoblastoma cases extend beyond the lamina cribrosa, a smaller tumor may involve it and require the same type of treatment as a larger tumor.

¶ 40 Dr. Thakkar testified that she had no clinical experience with retinoblastoma as of 1994. The first time she saw Sara was February 21, 1994. Dr. Thakkar was not aware of the signs and symptoms of retinoblastoma on that date. Sara was being seen for her one-year physical, accompanied by her mother, Joan. Dr. Thakkar reviewed the patient history form but did not recall having any conversation about Sara's history with Joan. According to Dr. Thakkar, the standard of care for a one-year checkup on a baby included checking the ears, nose, and throat. It also included flashing a light for pupillary reaction, checking the lymph nodes, and listening to the lungs. The heart is checked for any murmurs, the abdomen is examined, and joints are also checked. The only history note on Sara included a problem with her hip at birth, but the hip check was normal. Dr. Thakkar had no other complaints written in the patient chart by either the nurse or herself. Sara's exam was normal, according to her records.

¶ 41 Dr. Thakkar testified that she performed a penlight examination on Sara's eyes for a general screening and to check the pupillary reaction and movement of the eye. Sara's eyes appeared normal. Dr. Thakkar testified that she did not perform a red reflex exam on that date because she never examined the retina on a one-year old patient. She stated that a red reflex exam is performed at birth and up to six months of age. Dr. Thakkar knew that Dr. Ferolo was Sara's prior doctor but she did not have those records at the time of the February 21 visit. She denied that Joan asked for a referral for Sara to see an eye specialist.

¶ 42 Dr. Thakkar saw Sara on February 24, 1994, for a cough and chest congestion. No eye exam was performed on that visit. Dr. Thakkar prescribed some medication and told Sara's mother to bring her back in two weeks if necessary. They did not return. Dr. Thakkar had no recollection of any contact with Joan about Sara between February 24, 1994 and May 2, 1994.

¶ 43 Dr. Thakkar saw Sara for a routine 15-month checkup on May 2, 1994. This checkup was to make sure Sara and her twin sister, Laura, had no infection before receiving vaccinations for measles, mumps and rubella. No eye exam was performed. She had no record of any physical complaints from Joan. She denied that Sara's mother asked for a referral to an eye specialist.

¶ 44 On May 4, 1994, Dr. Thakkar saw Sara's older sister, Jennifer. Joan advised Dr. Thakkar that her mother was having cataract surgery and was worried Sara might have one. Dr. Thakkar asked why she thought that, and Joan stated she just had some concern. Joan had the twins with her so Dr. Thakkar used a penlight and checked for a red reflex but could not see the red reflex in the right eye; it was yellow. She told Joan that if Sara had a congenital cataract then the red reflex would have been missing at birth. Dr. Thakkar wanted to get her records from the hospital to see. She asked Joan to obtain the records. At this point, Dr. Thakkar did not believe it was a medical emergency. She did not refer Sara to an eye specialist because she thought it was appropriate to get the birth records and compare to see if the red reflex was there and then decide to refer her. On May 19, 1994, Joan called Dr. Thakkar's office, stating she thought Sara had an eye infection. She did not recall which eye, but Joan wanted a prescription. Dr. Thakkar wanted Sara to be seen but Joan was a nurse and stated she knew it was an eye infection. Dr. Thakkar prescribed an antibiotic drop for conjunctivitis. On May 28, Joan called with the same complaint for Laura.

¶ 45 Joan then called Dr. Thakkar's office sometime in early June and said she did not want to wait for the hospital records, that she was concerned that Dr. Thakkar could not see the red reflex, and that she wanted to take Sara to an ophthalmologist. Dr. Thakkar verbally authorized the referral so she could go immediately. After Sara was seen by Dr. Albrecht, he called Dr. Thakkar advising her Sara had a detached retina or a tumor and needed to be seen by a retina specialist. Dr. Thakkar called Joan and put in the necessary referral paperwork for Sara to see Dr. Allar immediately. Dr. Thakkar called Dr. Allar and asked to see Sara that day, and he did. The same type of conversations took place for Sara to see Dr. Mittelman and Dr. Bhatia.

¶ 46 Dr. Torczynski's testimony, without the opinion regarding when the lamina cribrosa became involved, was included. The record does not contain the depositions of Dr. Ferolo or Joan Wilhelm, although other witnesses referred to them.

¶ 47 The trial court heard the motions for summary judgment at a hearing on February 8, 2011. The trial court expressed concern over whether there were any inferences that could circumstantially be drawn to establish proximate cause. Defendants argued that no expert or treating physician could put a time frame on a tumor's growth, and the jury would be left to speculate on something that medical science could not do. Plaintiffs argued that the testimony regarding necrosis and calcification indicated the tumor's age, that it was a non-aggressive tumor, that it grew as a contiguous mass, that the optic nerve involvement occurred in the later stages, and that the cancerous cells only recently crossed the lamina cribrosa. On February 18, 2011, the trial court issued its decision, stating that plaintiffs must show that the defendants' negligent failure to diagnose resulted in the damaging treatment that would have been unnecessary. In order to establish this, the failure to diagnose had to have occurred before the tumor cells crossed the lamina cribrosa. Expert

testimony was necessary to establish this fact, and although some expert testimony was presented on the question, it was too vague to support a verdict. The court stated that it could not allow the jury to supply their own answer to the question of when the cells crossed the lamina cribrosa. Without such testimony with an adequate foundation to link defendants' alleged negligent failure to diagnose to plaintiffs' injuries, the court determined the case failed and granted summary judgment in defendants' favor.

¶ 48 On appeal, plaintiffs argue that the trial court erred in: (1) excluding Dr. Torczynski's opinion under *Frye* and for lack of foundation; and (2) granting summary judgment where there is a genuine issue of material fact regarding when the tumor cells extended beyond the lamina cribrosa.

¶ 49

II. ANALYSIS

¶ 50 We first address plaintiffs' argument that the trial court erred in barring Dr. Torczynski's opinion that the tumor cells crossed the lamina cribrosa sometime during the 8 to 10 weeks prior to Sara's retinoblastoma diagnosis. The decision of whether to admit expert testimony is within the sound discretion of the trial court, and its ruling will not be reversed absent an abuse of that discretion. *Snelson v. Kamm*, 204 Ill. 2d 1, 24 (2003). The trial court abuses its discretion only if it acts arbitrarily, exceeds the bounds of reason and ignores recognized principles of law, or if no reasonable person would take the position adopted by the court. *Maggi v. RAS Development, Inc.*, 2011 IL App. (1st) 091955, ¶ 61. In determining whether there has been an abuse of discretion, the reviewing court does not substitute its judgment for that of the trial court. *Id.*

¶ 51 Expert opinions must be supported by facts and are only as valid as the facts underlying them. *Gross v. Illinois Workers' Compensation Commission*, 2011 Ill. App. (4th) 100615WC, ¶ 24. An expert opinion is also only as valid as the reasons for the opinion. *Id.* The proponent of expert

testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Id.* If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. *Id.* The trial court is not required to blindly accept the expert's assertion that his testimony has an adequate foundation, but rather, the trial court must look behind the expert's conclusion and analyze the adequacy of the foundation. *Maggi*, 2011 IL App (1st) 091955, ¶ 63. If the basis of an expert's opinion includes so many varying or uncertain factors that he is required to guess or surmise to reach an opinion, the expert's opinion is too speculative to be reliable. *Id.* Such speculative opinions are inadmissible. *Id.*

¶ 52 In this case, plaintiffs argue that there are two clear points in time to support Dr. Torczynski's opinion that the tumor cells crossed the lamina cribrosa 8 to 10 weeks prior to diagnosis—first, the November 1993 photograph depicting Sara's white reflex and second, the June 28 removal of the tumor. Therefore, plaintiffs argue that Dr. Torczynski's opinion had a proper foundation. Further, plaintiffs argue that the opinion testimony was not subject to *Frye* because it was pure opinion testimony. The trial court barred the testimony, technically speaking, on the ground the opinion lacked foundation. We agree with the trial court, and accordingly we need not evaluate the opinion's admissibility under *Frye*.

¶ 53 In *Maggi*, a bricklayer died several days after a fall through an unprotected window opening at a construction project site. *Id.* ¶ 1. The man's estate sued defendant for negligent acts at the construction site. *Id.* ¶ 7. The defendant countered that the man died of a coincidental heart attack, which caused him to fall. *Id.* The trial court granted the plaintiff's motion *in limine* and barred the testimony of the defense witness, Dr. Barron. *Id.* ¶ 59. Dr. Barron was to testify that the bricklayer had a heart attack seconds before the catastrophic fall based upon his postmortem examination of

the bricklayer's heart. *Id.* ¶¶ 64-65. The trial court did not bar Dr. Barron's entire testimony, but only his specific opinion as to the precise timing of the heart attack. *Id.* The appellate court found no abuse of discretion in barring Dr. Barron's opinion because his opinion as to the precise timing of the heart attack was not supported by any other facts in evidence. *Id.* ¶ 65. Rather, the evidence contradicted the opinion because eyewitnesses stated that the man tried to get up after the fall, and Dr. Barron himself agreed that trauma from the fall could have been the triggering event to a subsequent heart attack. *Id.*

¶ 54 Likewise, in this case, Dr. Torczynski did not provide any underlying facts or reasons to support her opinion that the tumor cells crossed the lamina cribrosa "8-10 weeks" prior to diagnosis.¹ As the trial court pointed out, there were supporting facts and reasons to suggest that Sara's tumor had grown between November 1993 and June 1994, but no exact timeline or growth measurements could be reasonably ascertained. Dr. Torczynski admitted that she could not determine the dimensions of the tumor from the 1993 photograph, assuming the tumor caused the white reflex in the photograph. Dr. Torczynski based her opinion on the fact that Dr. Murphree opined that a tumor would have to be about three millimeters in order to obstruct light to produce the white reflex. However, Dr. Murphree stated a tumor as small as two or three millimeters may completely fill the pupil, causing the white reflex; he did not state that Sara's tumor existed in 1993 or that it was two or three millimeters at that time. Further, Dr. Torczynski admitted that she could not determine an

¹ Plaintiffs argue in their brief that the trial court misunderstood Dr. Torczynski's 8 to 10 week opinion to mean that the cells crossed the lamina cribrosa sometime in the two-week timeframe (April 15 to April 29, 1994) 8 to 10 weeks before diagnosis instead of meaning the cells crossed the lamina cribrosa sometime in the 8-10 weeks, or 2 to 2 ½ months (April to June 20, 1994) prior to diagnosis. While the trial court's order does refer to the timeframe as a two-week period rather than two-month period, this does not change the outcome of the case because there was no foundation to support a concrete conclusion or inference as to when the cells crossed the lamina cribrosa, whether it be within either a two-week or two-month timeframe.

exact dimension or location of any tumor in Sara's eye based on the 1993 photograph. She also could not determine whether the tumor was early in its development or late in the stages of development. Dr. Torczynski could not point to any medical authority or medical literature to support her opinion that based on the photograph, Sara's tumor was about three millimeters, and based on its size at removal, the lamina cribrosa became involved sometime 8 to 10 weeks prior to diagnosis.

¶55 Other facts also do not support Dr. Torczynski's opinion because all testifying doctors agreed that tumors grow at varying rates in varying directions at varying times during their existence. Dr. Murphree, and other doctors in their depositions, testified that the growth and direction of growth varied from tumor to tumor and from patient to patient. He testified that no one could predict a tumor's growth in the future or in retrospect. He explained that the photograph, while suggestive of a tumor given Sara's subsequent diagnosis, told him nothing about the tumor's size, location, rate of growth, or direction of growth. While it was true that the lamina cribrosa or optic nerve generally became affected in later stages of retinoblastomas, Dr. Murphree, and others, testified that no one could determine when Sara's tumor entered the later stages. Given the fact that no one had measurements of Sara's tumor prior to its removal, Dr. Torczynski's opinion was pure speculation and properly excluded by the trial court. Like in *Noakes*, which the trial court relied upon, opinion testimony of an expert is admissible if the expert is qualified by knowledge, skill, experience, training, or education in a field that has at least a modicum of reliability. *Noakes*, 363 Ill. App. 3d at 858. "An expert's opinion, however, is only as valid as the reasons for the opinion." *Id.* Unlike here, the doctors in *Noakes* could opine that the repetitive nature of the plaintiff's job caused his carpal tunnel syndrome where there was a known connection between repetitive motions and the

disease. *Id.* at 857-59. Here, Dr. Torczynski admitted that based on the 1993 photograph, she did not know the size or location of Sara's tumor and there was no method to determine when cancer cells invaded Sara's lamina cribrosa, other than her conjecture. Further, her duties as a pathologist did not include determining the size or characteristics of a tumor at a past point in time, which was something all other physicians said was impossible to determine as no methodology existed to backtrack a cancerous tumor's development with such specificity.

¶ 56 In fact, plaintiffs acknowledge in their brief to this court that medical science is currently unable to provide a specific date as to when the lamina cribrosa would have become involved. They argue, however, that the precise dimensions of the tumor are unknown due to defendants' failure to perform any such examination as of that time and the trial court was therefore creating an impossible standard to meet under any circumstance. We disagree with plaintiffs' argument. Their damages rest upon the additional chemotherapy and radiation treatment that was needed because the tumor had advanced into Sara's lamina cribrosa. Accepting that the 1993 photograph depicted a tumor approximately three millimeters in size, no doctor can determine at what point in time the lamina cribrosa became involved. It could have been involved when the photo was taken, before the photo was taken, a week after the photo was taken, a month after the photo was taken, or the two and a half months' prior to her diagnosis, like Dr. Torczynski opined. It is impossible to determine without pure speculation, and unfortunately, the damages that plaintiffs seek in this case depend on such a determination. Every medical negligence claim does not rest upon such a specific causation nexus as this one, and we disagree with plaintiffs' contention that the trial court's ruling creates an impossible standard for such claims. Accordingly, we find the trial court did not abuse its discretion

in barring Dr. Torczynski's opinion based upon lack of foundation, and we need not address this matter under *Frye*.

¶ 57 Moving on, we next consider whether the trial court properly granted summary judgment in favor of defendants given the exclusion of Dr. Torczynski's opinion that Sara's lamina cribrosa was affected 8 to 10 weeks prior to diagnosis. In order to prove a case of negligence in treatment against a medical professional, the plaintiff must prove: (1) the proper standard of care against which the professional's conduct must be measured; (2) negligent failure to comply with the standard; and (3) that the injury for which the suit is brought had as one of its proximate causes the negligence of the professional. *Pumala v. Sipos*, 163 Ill App. 3d 1093, 1098 (1988). The parties only dispute the proximate cause element on appeal.

¶ 58 Plaintiffs argue that even without the 8 to 10 week estimate, Dr. Torczynski was still allowed to opine that the involvement of the lamina cribrosa and optic nerve was a "recent" development, creating a question of fact as to whether the delay in the referral or diagnosis caused the ensuing chemotherapy and radiation therapy. Plaintiffs rely in part on *Scassifero v. Glaser*, 333 Ill. App. 3d 846 (2002), for their proposition that circumstantial evidence remains, meaning a question of fact exists on proximate cause. We find *Scassifero* distinguishable, and defendants' case, *Reed v. Jackson Park Hospital Foundation*, 325 Ill. App. 3d 835 (2001), applicable to the facts at bar.

¶ 59 In *Scassifero*, the plaintiff alleged that Dr. Glaser negligently performed an epidural injection, which caused the plaintiff to develop an epidural abscess. *Scassifero*, 333 Ill. App. 3d at 849. The plaintiff and his wife testified that at some point during the procedure, Dr. Glaser left the room, which the plaintiff alleged resulted in an improperly maintained sterile field. Dr. Glaser and the attending nurse testified that they did not leave the room during the procedure. *Id.* at 850. The trial

court did not allow the plaintiff's expert to opine that Dr. Glaser's departure from the room contaminated the sterile field around the epidural equipment tray because there was no actual proof the tray was contaminated. *Id.* at 851. The appellate court disagreed, finding there was conflicting testimony as to whether Dr. Glaser left the room. *Id.* at 853. Further, there was ample circumstantial evidence to support the expert's opinion that the sterile field was contaminated as a result of Dr. Glaser's departure from the room, given the subsequent infection at the epidural site and the conflicting testimony regarding his whereabouts during the procedure. *Id.*

¶ 60 Defendants rely on *Reed*, to support their position that Dr. Torczynski's opinion that an earlier diagnosis at one of the appointments with Drs. Thakkar and Ferolo would have prevented the subsequent chemotherapy and radiation was merely a guess. In *Reed*, the trial court barred an expert's opinion that the plaintiff's eye might have been saved had the emergency room physicians sought an ophthalmologist to examine him or ordered more tests on July 3 rather than waiting until he returned on July 7. *Reed*, 325 Ill. App. 3d. at 844. The expert could not say with any certainty that the eye would have been saved, just that there was a small chance that it could have. Ultimately, the expert believed enucleation would have occurred regardless. *Id.* The plaintiff argued that the expert's testimony established proximate cause under the lost chance doctrine. The appellate court disagreed, stating that even if the opinion was allowed in, it did not establish proximate cause under the lost chance doctrine because the expert did not testify to a reasonable degree of medical certainty that the negligent delay in diagnosis would have changed the outcome for the plaintiff. *Id.* at 846-47.

¶ 61 Likewise, in this case, even with Dr. Torczynski's opinion that the lamina cribrosa was "recently" affected, there is no nexus connecting the alleged negligent delay in referral or diagnosis and the lamina cribrosa's involvement. While it was established that had the cancer not spread to

that area, Sara would likely not have been treated with radiation or chemotherapy, Dr. Torczynski's opinion does not establish that any alleged delay in referring her to a specialist preceded the lamina cribrosa's involvement. Thus, in this case, there was no evidence supporting that any alleged delay in referral or diagnosis proximately caused the ultimate chemotherapy and radiation treatment because there was no evidence of when the lamina cribrosa was invaded by the cancer cells. Unlike in *Scassifero*, where there was evidence supporting the expert's opinion that the doctor left the room and therefore breached the sterile field causing the plaintiff's subsequent infection, there was no evidence in this case to establish when the lamina cribrosa was invaded. The size and location of the tumor was simply unknown until the time of diagnosis. Dr. Torczynski's opinion that the lamina cribrosa became involved in the latter stages of the tumor did not establish when the tumor entered the latter stages, and even still when specifically the cells invaded the lamina cribrosa. Such a determination would be impossible for a jury to make without assistance from an expert. While the photograph could lead to an inference that the tumor was present in November 1993, it does not lead to an inference that the tumor cells crossed into the lamina cribrosa at any specific time or range of time.

¶ 62 Here, unfortunately, even the experts cannot make such a determination of when the tumor cells invaded the lamina cribrosa or when the tumor entered the "latter stages" of development at which time the lamina cribrosa would have become involved. The existence of proximate cause cannot be established by speculation, surmise, or conjecture. *Majetich v. P.T. Ferro Construction Co.*, 389 Ill. App. 3d 220, 224 (2009). Circumstantial evidence may be sufficient when an inference may be reasonably drawn from it. *Id.* However, facts will not be established from circumstantial evidence where more than one conclusion may be drawn. *Id.* at 225. In order to defeat a motion for

summary judgment, the plaintiff's circumstantial evidence must be of such a nature and so related as to make one conclusion more probable as opposed to merely possible. *Id.* In this case, the evidence upon which plaintiffs rely to infer that the lamina cribrosa was involved shortly before diagnosis is circumstantial but of such a nature that makes that conclusion merely possible, not more probable than other conclusions. The November 1993 photograph certainly suggests that Sara's tumor was present and probably about three millimeters in size. It was also likely that the tumor grew between November 1993 and June 1994. However, it is just merely possible that the lamina cribrosa was affected shortly before or within months of diagnosis, but none of the evidence makes that conclusion more probable than it having become affected earlier in time because nobody can know when the tumor grew, what direction it grew, how fast it grew, or whether it experienced periods of growth and periods of stability. The mere possibility that the tumor crossed the lamina cribrosa after defendants treated Sara was insufficient to allow the issue to go to the jury. Thus, we agree with the trial court that plaintiffs failed to establish proximate cause and summary judgment for defendants was proper.

¶ 63

III. CONCLUSION

¶ 64 For the reasons stated, we affirm the judgment of the Lake County circuit court.

¶ 65 Affirmed.