

2014 IL App (2d) 130677-U
No. 2-13-0677 & 2-13-0707 cons.
Order filed April 23, 2014

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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

JAIME FRANCISCO, Individually and as)	Appeal from the Circuit Court
Executor of the Estate of MARIA)	of Du Page County.
FRANCISCO, Deceased,)	
)	
Plaintiff-Appellant/Appellee,)	
)	
v.)	No. 07-L-1189
)	
GREGORY KOZENY, M.D., and)	
NEPHROLOGY ASSOCIATES OF)	
NORTHERN ILLINOIS,)	
)	
Defendants-Appellants,)	
)	
and)	
)	
JONATHON PINSKY, M.D., and)	
MIDWEST INFECTIOUS DISEASE)	
SPECIALISTS,)	
)	
Defendants-Appellees)	
)	
(Walter F. Briney, Jr., M.D., James)	Honorable
Scruggs, M.D., and Du Page Medical)	Ronald D. Sutter,
Group, Defendants).)	Judge, Presiding.

JUSTICE SCHOSTOK delivered the judgment of the court.
Justices Hutchinson and Spence concurred in the judgment.

ORDER

¶ 1 *Held:* In this medical malpractice proceeding, the trial court did not err in denying the defendants' motion for a directed verdict or in quashing a trial subpoena. Alleged prejudicial comments made by plaintiff's counsel did not affect the outcome of the trial. The jury's verdict was not against the manifest weight of the evidence.

¶ 2 On November 13, 2007, the plaintiff, Jaime Francisco, executor of the estate of Maria Francisco, deceased, brought a wrongful death/survival action, based on alleged medical malpractice, against the defendants, Dr. Gregory Kozeny, Dr. Jonathon Pinsky, Dr. Walter F. Briney, Dr. James Scruggs, Nephrology Associates of Northern Illinois (NANI), Midwest Infectious Disease Specialists (Midwest), and DuPage Medical Group (DMG). Dr. Briney, Dr. Scruggs, and DMG settled out of the case before trial. Following trial, the jury returned a verdict in favor of the plaintiff as to the claims against Dr. Kozeny and NANI, awarding the plaintiff damages in the amount of \$5,132,197. The jury found Dr. Pinsky and Midwest not liable. Dr. Kozeny, NANI, and the plaintiff appeal. We affirm.

¶ 3 **BACKGROUND**

¶ 4 **The Decedent's Medical History**

¶ 5 In spring 1999, the decedent's primary care physician, Dr. Briney, referred her to a nephrology specialist, Dr. Kozeny, because the decedent was experiencing kidney dysfunction. The decedent's kidneys progressively worsened and she continued to see Dr. Kozeny. On August 23, 2005, the decedent visited the office of Dr. Briney complaining of ankle pain. He prescribed Prednisone for the pain. She again visited Dr. Briney's office on August 29, 2005. Dr. Briney diagnosed her with acute gout. He prescribed the drugs Colchicine, for pain relief, and Allopurinol, to prevent future gout attacks. The prescription for Allopurinol allowed for 11 refills which would last one year if taken as prescribed.

¶ 6 On September 17, 2005, the decedent was hospitalized at Central DuPage Hospital (CDH) for two days due to chest pain. She was diagnosed with indigestion and prescribed Prevacid for that condition. At that time she also had elevated liver enzymes. A medication history taken during this hospitalization indicated that she was prescribed Allopurinol but that it “was stopped.” She was discharged on September 19, 2005.

¶ 7 On October 3, 2005, she visited the Fresenius clinic for dialysis. This was the clinic where Dr. Kozeny’s patients received dialysis. At that visit she was experiencing chills and nausea. In addition to her dialysis, she was given two antibiotics, Vancomycin and Tobramycin, by intravenous injection. On October 5, 2005, she again visited the clinic for dialysis. She was running a fever and the antibiotics were administered to her again that day. In the evening, the decedent went to the emergency room with a rash. She was given Benadryl and went home. On October 7, 2005, the decedent returned to the clinic for dialysis. She had a fever, rash, and elevated liver enzymes. On October 8, 2005, due to her continued fever and rash, she visited Dr. Briney’s office and was treated by Dr. Briney’s partner, Dr. Duval. Dr. Duval diagnosed her with a possible drug reaction secondary to Vancomycin and prescribed Prednisone. She visited Dr. Briney on October 10, 2005, and was treated by him. She had no more fever. Dr. Briney gave the same diagnosis (rash due to Vancomycin). He recommended weaning her off the Prednisone and switching to Benadryl. Notes taken at the Fresenius clinic on October 14, 2005, during a visit for dialysis indicated that the decedent was taking Allopurinol.

¶ 8 On October 18, 2005, the decedent again visited Dr. Briney at his office because her rash was worse. The nurses’ notes for that visit indicated that the decedent was on 300 milligrams (mg) per day of Allopurinol. Dr. Briney sent the decedent to the emergency room at CDH. She was admitted on that day. The medical history on the hospital admission records indicated that

the decedent was on 300 mg per day of Allopurinol. The records also indicated that she told the emergency room doctor, Dr. William Toepper, that she had a medical history of taking Allopurinol.

¶ 9 The decedent was not given Vancomycin or Allopurinol while hospitalized. On October 19, 2005, the attending physician, Dr. Carol Olmstead of DMG, called Dr. Pinsky, an infectious disease specialist, for a consultation to determine if the decedent's rash was due to an infection. Dr. Pinsky ultimately concluded that the decedent's condition was not caused by an infection. On October 20, 2005, the decedent was evaluated by a dermatologist, Dr. James Herrmann. On October 22, 2005, Dr. Harold Mozwecz, a gastroenterologist was called for consultation, evaluated the decedent, and ordered a liver biopsy. The liver biopsy revealed that there was damage to the decedent's liver. The liver biopsy was reviewed by doctors at the Mayo Clinic, who issued a report concluding that the liver damage was consistent with drug injury and may be related to prior antibiotic use. The report also stated that a thorough drug history should be taken.

¶ 10 As of October 24, 2005, the decedent still had the rash, developed eosinophilia (abnormal blood cells) and her liver enzymes were still increasing. Her liver enzymes continued to increase until October 29, 2005. Thereafter, the decedent began to improve and her liver enzymes started returning to normal levels. The decedent's condition ultimately improved and on November 2, 2005, she was discharged from the hospital by Dr. Briney. Dr. Briney's diagnosis included autoimmune hepatitis, chronic renal failure, and "drug rash probably secondary to Vancomycin." The discharge summary indicated that the decedent was instructed to take six medications upon her return home. Allopurinol was not one of the medications she was instructed to take.

¶ 11 On November 8, 2005, the decedent again visited Dr. Briney because she was running a

fever. Records for that office visit indicate that the decedent told the nurse that she was taking Allopurinol. On November 13, 2005, the decedent returned to the emergency room at CDH because her rash had become considerably worse and her skin was peeling. At that admission, she gave a medication history that included taking Allopurinol, Prednisone, Prevacid, and Lopressor. About 40 minutes after her arrival, the decedent was in excruciating pain and her skin rubbed off with even the slightest pressure. After being given pain medication, the decedent was transferred to Northwestern Memorial Hospital (Northwestern).

¶ 12 The decedent was admitted to Northwestern on November 14, 2005. She was immediately treated by Dr. Carol Saltoun. Dr. Saltoun diagnosed the decedent with toxic epidermal necrosis (TEN) and ordered that she be transferred to the burn unit at Loyola. She was transferred that same day. By the time she arrived at Loyola, the decedent's skin was sliding off, she was in multi-organ failure and septic. Loyola ultimately placed the decedent in comfort care due to progressive multi-organ failure. The decedent remained at Loyola until her death on November 21, 2005. A biopsy supported the TEN diagnosis, with a total body surface involvement of 62%.

¶ 13 Trial

¶ 14 A trial commenced on January 25, 2013. Dr. Walter Briney testified that he was the decedent's primary care physician since 1999. In 1999, he diagnosed her with kidney dysfunction and referred her to a specialist, Dr. Gregory Kozeny, employed by NANI. In August 2005, the decedent went to see him due to right ankle pain. Following testing, he diagnosed her with acute gout, an illness caused by excessive uric acid. He prescribed pain medication as well as Allopurinol, a drug that blocks the metabolism of uric acid. The dosage was 100 milligrams per day for a week, 200 milligrams per day for the second week, and 300 milligrams daily

thereafter. The 300 milligram daily dose was prescribed with eleven refills so that it could be taken for up to a year. On cross-examination, Dr. Briney acknowledged that when he prescribed Allopurinol he was not aware that it could cause adverse reactions in a patient with renal failure.

¶ 15 Dr. Briney acknowledged the decedent had been hospitalized from September 17 to 19, 2005, due to chest pains. He was aware of a September 17, 2005, hospital consult note written by another doctor that stated the decedent had been on Allopurinol and Colchicine but that she had stopped taking them. Based upon that note, it was Dr. Briney's belief that the decedent stopped taking Allopurinol a couple of weeks after it was prescribed. That was still his belief at the time of trial.

¶ 16 Dr. Briney testified that upon review of DMG's medical records, the first time the decedent reported having a fever was on October 3, 2005. On October 8, 2005, Dr. Duval, one of Dr. Briney's partners at DMG, saw the decedent for her fever and because she had developed a rash. Dr. Duval's notes indicated that he believed the decedent was having a reaction to the Vancomycin. Dr. Briney testified that he treated the patient on October 10, 2005. She did not have a fever on that date but still had a rash. Dr. Briney believed that her rash was a drug rash, namely, an allergic reaction to Vancomycin. He did not think her rash was due to Allopurinol. The decedent came to his office again on October 18, 2005. He diagnosed her with a drug reaction and sent her to the emergency room at CDH. Dr. Briney believed that her rash was due to a Vancomycin drug reaction.

¶ 17 The decedent was admitted to the hospital on October 18, 2005, and remained there until November 2, 2005. Dr. Briney saw the decedent daily from October 28, 2005, until he discharged her on November 2, 2005. His diagnoses on discharge included chronic renal failure and "drug rash probably secondary to Vancomycin." There was no mention of Allopurinol as he

did not think that it caused any of her symptoms.

¶ 18 During the two weeks that the decedent was in the hospital she was not being given Allopurinol and her rash was improving. On the day of her discharge, Dr. Briney reviewed with the decedent the list of medicines he wanted her to take after she left the hospital. There was no intent to tell the decedent to resume taking Allopurinol. He wanted her to take the six medications listed on her discharge summary and no others. He would have made that clear to her during their discussion. The decedent was provided a copy of the medication schedule she was to follow at home including the specific times of day she was to take each drug. The decedent was a good patient who generally followed his instructions.

¶ 19 On November 8, 2005, Dr. Briney treated the decedent in his office. She came in complaining of a recurrent fever. The decedent still had a rash and Dr. Briney still believed it was due to the Vancomycin. He was not thinking that the rash had anything to do with Allopurinol. DMG medical records for the November 8 appointment listed five drugs that the patient was taking: Prednisone, Metoprolol, Prevacid, Tylenol, and Actigall. These five were written by the nurse, Lima Ardickas. There were three more drugs listed: Tylenol, Allopurinol, and Zyrtec, but Dr. Briney did not know who had written those down. It was not his intent for the patient to be taking Allopurinol after her November 2, 2005, discharge from the hospital.

¶ 20 Dr. Gregory Kozeny testified that he was a specialist in nephrology. At the time he treated the decedent, he was an employee of NANI and he was the medical director of the Fresenius Dialysis Clinic in Glendale Heights (the Fresenius clinic). He provided care to the decedent from 1999 until her death in 2005. In July 2005, he concluded that the decedent needed a kidney transplant or needed to start dialysis. Notes from a September 1, 2005, meeting with the decedent indicated that she was taking Colchicine and 100 mg daily of Allopurinol. He knew

Allopurinol could cause a syndrome known as toxic epidermal necrolysis (TEN) and that it could be fatal. Dr. Kozeny acknowledged that certain drugs were more commonly associated with drug reactions and that Allopurinol was one of those drugs. Dr. Kozeny was aware that a “rechallenge” was when a patient had a reaction to a drug, was taken off of the drug, and then the patient had a subsequent worse reaction when placed back on the drug. Dr. Kozeny testified that he had never seen a patient with TEN.

¶ 21 Dr. Kozeny was aware in 2005 that Allopurinol could be particularly dangerous in a patient with kidney failure because its elimination from the body required proper renal excretion. Accordingly, a patient with kidney failure required reduced dosages. A patient with normal kidney function would be given a dose of 300 mg per day of Allopurinol. Based on the decedent’s kidney function in 2005, her dose of Allopurinol should not have exceeded 100 mg per day. An allergic reaction to a drug usually starts within 7 to 10 days of beginning the drug. If the decedent had been taking more than 200 mg per day of Allopurinol he would have spoken with her primary care physician.

¶ 22 Dr. Kozeny acknowledged that the decedent came to the Fresenius clinic on September 7, 2005, for dialysis. The government-required medical form filled out by the nurse indicated that the decedent was taking “two tabs” of 100 mg Allopurinol. Dr. Kozeny agreed that this would be interpreted as a dose of 200mg per day. Although he had access to these forms, he did not regularly look at them.

¶ 23 Dr. Kozeny further acknowledged that the decedent was admitted to CDH on September 17, 2005, due to chest pains. On September 19, 2005, he checked on the decedent. Her liver enzymes were elevated at that time, which could be explained by Allopurinol, the patient having a drink, or gallstones. Dr. Kozeny acknowledged that a record for the decedent’s visit to the

Fresenius clinic on October 14, 2005, indicated that the decedent was taking Allopurinol.

¶ 24 Dr. Kozeny testified that the decedent reported to the CDH emergency room on October 18, 2005, complaining of fever and rash. Hospital records indicated that the decedent gave the emergency room physician, Dr. Toepper, a medications history that included taking Allopurinol prior to her arrival. Dr. Kozeny was on call and reported to the emergency room. He asked the decedent what medications she was taking at the time she entered the hospital. After evaluating the decedent, his impression was that she was suffering from “pruritic raised rash possibly due to Vancomycin; possibly due to some other causes.” Other causes included a reaction to a different drug, another auto-immune process, or to a virus. Dr. Kozeny acknowledged that once there is a suspected drug reaction the normal procedure is to take the patient off all drugs except those necessary for life support, get a complete drug history, and then treat the symptoms.

¶ 25 Dr. Kozeny testified that Vancomycin can cause a full-blown allergic reaction that can cause a rash. This would normally show up within 7 to 10 days of starting the drug. Even after the last dose is given, it may take a while for the rash to go away. Vancomycin can also result in TEN after a few doses. TEN can be caused by Allopurinol, but if it is a reaction to Allopurinol it usually shows up right away. If there is a rechallenge when a drug is stopped and then restarted, the same type of rash returns. There is not one type of rash and then a different rash on rechallenge. Dr. Kozeny acknowledged that the decedent’s October 18 hospital admission record indicated that the decedent was taking 300 mg per day of Allopurinol. He did not agree that Allopurinol would have caused the decedent’s fever and rash in September and October 2005.

¶ 26 Dr. Kozeny saw the decedent for the last time on October 28, 2005. He acknowledged that, had he looked at the nurse’s notes during that hospitalization, he would have seen that they

charted the decedent as taking Allopurinol. Had he known she had recently taken Allopurinol, it would have been included in his diagnoses as a possible cause of her condition and he would have advised her to stop taking it. He had believed that as of her first admission to the hospital she was no longer taking Allopurinol because it was not listed on her September 19 discharge summary.

¶ 27 Dr. Kozeny acknowledged that he could have ordered the decedent's medical records from the Fresenius clinic when he was investigating the cause of her rash. However, he believed that the attending physician was ultimately responsible for getting a complete medical history. He acknowledged that NANI records showed the decedent was taking Allopurinol. However, he would not have consulted those records when, as in this case, he was able to have a face-to-face discussion with the decedent about the medications she was taking. The decedent never told him she was taking up to 300 mg per day of Allopurinol. He never had a patient with an adverse reaction to Allopurinol but he commonly saw reactions in patients on Vancomycin. He agreed that the decedent started on Allopurinol on August 29, 2005, but did not develop a fever or rash until October 3, 2005. Although it was theoretically possible, it was uncommon for an allergic drug reaction to develop a month after starting a new medication.

¶ 28 Rowena Lomuntad was a registered nurse who was working at the Fresenius clinic in 2005. On September 7, 2005, she documented that the decedent was taking two 100 mg tablets of Allopurinol daily. The decedent gave her that information. The chart where medications are listed is kept in the back in a rack by the nurse's station. The only thing kept at the chair where the patient is receiving dialysis is a treatment record that does not contain a medications list.

¶ 29 Dr. Carol Olmstead testified that she was an internal medicine physician. In 2005, she worked for DMG. She saw the decedent on September 16, 2005, for right ankle and foot pain.

The records suggested that at the time the decedent was taking Allopurinol (300 mg per day), Colchicine, and Tylenol. She prescribed Tylenol 3 for the foot pain and instructed the decedent to stop taking the Colchicine. She saw the decedent during her second hospitalization on October 19, 2005. Her impression was of a possible drug rash with fever. She prescribed Prednisone for the rash and increased the dose when the rash did not respond initially. The decedent told her that the rash developed after the Vancomycin but that the fever developed before she took any Vancomycin. Dr. Olmstead requested a dermatology consult and a consult with Dr. Pinsky because she was not sure whether the fever, rash, and elevated liver enzymes were all related or not.

¶ 30 Dr. Olmstead never reached a conclusion as to the cause of the rash and fever. Dr. Olmstead saw the decedent in the emergency room at CDH on November 13, 2005. The decedent had a list of medications with her, and that list did not include Allopurinol. Dr. Olmstead acknowledged that she had prescribed Allopurinol to dialysis patients with gout in the past. She was aware that the dosage had to be adjusted for renal patients but she did not know Allopurinol could cause fever, rash, and liver dysfunction. She had never cared for a patient that had a severe reaction to Allopurinol. Although Dr. Olmstead had asked the decedent during her October and November hospitalizations what medications she was taking, the decedent never indicated that she was taking Allopurinol.

¶ 31 Nurse Joyce Maldonado testified that she was a triage nurse and had interviewed the decedent upon her arrival to the emergency room at CDH on October 18, 2005. Her triage notes indicated that the decedent told her she was taking Allopurinol. Kimberly Jongsma testified that, after the decedent was admitted to the hospital on October 18, the decedent was placed on her floor. She filled out a patient needs assessment form that included a list of the medications the

decedent had been taking at home. The decedent told her, and she wrote down on the form, that the decedent was taking 300 mg of Allopurinol daily.

¶ 32 Dr. Jonathan Pinsky testified that he was an infectious disease specialist and had treated the decedent in the hospital from October 19-31, 2005. His role as an infectious disease specialist in treating the decedent in the hospital was to rule out an infection as the possible cause of her symptoms. After Dr. Pinsky evaluated the decedent, he spoke with Dr. Olmstead and recommended an allergy consult. They discussed that this was a possible drug reaction and possibly due to Vancomycin. They agreed, however, that “it didn’t all fit,” because the problem was not resolving even though the Vancomycin was stopped. He told Dr. Olmstead to consider other medications as a possible cause. The allergy consult could have helped in determining what other medication could have been causing the decedent’s symptoms. Dr. Olmstead opted to get a dermatology consult rather than an allergy consult.

¶ 33 Dr. Pinsky acknowledged that the decedent’s elevated liver enzymes could have been caused by hepatitis or by a drug reaction. However, because the decedent’s liver enzymes continued to rise between October 18 and 29, it suggested that, if due to a drug reaction, it must be from a drug taken closer in time than the Vancomycin. Dr. Pinsky acknowledged that a fax from DMG to CDH received on October 19 indicated that the decedent was on a prescription of Allopurinol at 300 mg. However, he did not know if that fax ever made it onto the decedent’s chart. Dr. Pinsky signed off on the decedent’s case on October 31, 2005. At that time, he had concluded that there were no infections causing her symptoms. He acknowledged that the results of the liver biopsy were completed on October 31. The results indicated that changes to the liver were consistent with drug injury and that a complete medication history should be done. He was not sure if this was part of the chart prior to the time he signed off or whether he had reviewed it.

Either way, however, his purpose was only to determine whether her symptoms were caused by an infection. It was not his purpose to determine what drug could be causing her symptoms.

¶ 34 Dr. Carol Saltoun testified that she was the attending immunologist at Northwestern in November 2005. All her medical opinions were based upon a reasonable degree of medical certainty. She described TEN as a severe reaction to a medication where there could be fever and a rash that could lead to blistering and desquamation. The decedent was the only patient she had ever treated with TEN. In treating a patient with TEN, she would look at every drug the patient had taken around the time of the rash and up to a month before. Most reactions would occur within two weeks to a month of starting a new drug. Liver enzymes could also be elevated due to a drug reaction. Dr. Saltoun acknowledged that the decedent's liver enzymes continued to rise after October 18 and peak on October 29. She opined that if the decedent had last received Vancomycin at dialysis on October 5, and if the Vancomycin were the cause of the drug rash, the decedent's liver enzymes would have started to decline prior to October 29.

¶ 35 Dr. Saltoun testified that Allopurinol was one of the top drugs that cause severe allergic reactions. If the decedent was taking Allopurinol, it was very possible that it was the cause of the rash. However, the medical records were unclear as to when the decedent was or was not taking Allopurinol. If the decedent's condition on November 14 was caused by the same drug that caused the reaction in October, Dr. Saltoun would have expected a continuation of the same symptoms, namely, increased eosinophils and increased liver enzymes. That did not occur. Dr. Saltoun testified that there was no way to know what caused the decedent's reaction.

¶ 36 On the day the decedent was admitted to Northwestern, Dr. Christina Ciaccio, a fellow working with Dr. Saltoun, viewed the decedent's rash. After completing her evaluation of the decedent at Northwestern, Dr. Ciaccio was of the suspicion that the decedent's rash was caused

by Vancomycin. Dr. Saltoun agreed with that but further noted in the records that the rash could be due to Allopurinol. Dr. Saltoun acknowledged that Dr. Ciaccio prepared a poster for a medical publication in which she concluded that the decedent developed TEN after a rechallenge with Prevacid. Dr. Saltoun's name was also on the poster, meaning that Dr. Ciaccio presented it to her and she approved it. Dr. Saltoun believed that Prevacid, Allopurinol, and Vancomycin were all possible causes of the rash the decedent had prior to her October 18 hospitalization. Dr. Saltoun testified that none of her colleagues who consulted on the case at Northwestern ever documented the decedent as being on Allopurinol prior to her hospitalization there and none of them associated her condition with Allopurinol use. Despite a detailed medications history completed by her and Dr. Ciaccio, there was no indication in the records they reviewed that the decedent took Allopurinol after she was admitted to CDH on October 18.

¶ 37 Dr. Anita Licata, a board-certified dermatologist, testified as an expert witness on behalf of the plaintiff. All her opinions were based upon a reasonable degree of medical certainty. Based on her review of all the available medical records, depositions, and her own knowledge and experience, Dr. Licata opined that the decedent's rash and ultimate death were consistent with a reaction to Allopurinol. Dr. Licata acknowledged that the decedent's pharmacy records indicated that she only filled two prescriptions of Allopurinol: one bottle of 21 pills of 100 mg Allopurinol and one bottle of 30 pills for the 300 mg Allopurinol. If the decedent had taken the medication as prescribed, she would have run out of Allopurinol prior to October 18. However, based on medication histories made by different people after that time, Dr. Licata believed the decedent took Allopurinol sometime after her November 2 discharge from CDH. She did not know how much was taken before October 18 or after November 2. Dr. Licata further testified that even if the decedent had not taken any Allopurinol after November 2, there was still a small

possibility that the decedent continued with the allergic reaction without any additional rechallenge. However, it was more probable that she took Allopurinol after November 2.

¶ 38 Dr. Rodger MacArthur, an infectious disease expert witness for the plaintiff, testified that hypersensitivity syndrome occurs when an individual is overly sensitive to a particular medication, often resulting in fever, liver injury, and rash. Allopurinol was one of the few core drugs that cause hypersensitivity syndrome. He reviewed all the decedent's medical records and the depositions taken in this case. He was familiar with the standard of care as it applied to a reasonably well qualified infectious disease specialist such as Dr. Pinsky, considering the degree of care and skill usually required for the average infectious disease specialist. All his opinions were based upon a reasonable degree of medical certainty. Dr. MacArthur opined that the decedent's death was due to complications related to TEN caused by rechallenge with Allopurinol. He stated that it was a "medical certainty" that the decedent was taking Allopurinol between November 2 and 13. He did not believe that Vancomycin caused the decedent's condition.

¶ 39 Dr. MacArthur opined that Dr. Pinsky's treatment of the decedent, and failure to take a complete medication history, fell below the standard of care and contributed to her death. Based on the continued rise of the decedent's liver enzymes from September and through her October hospitalization, the standard of care required Dr. Pinsky to suspect a drug reaction. The standard of care also required Dr. Pinsky to conduct a thorough medication history by looking at medical records, reviewing notes from the emergency room nurse and the floor nurse, and speaking with the decedent and her family. If Dr. Pinsky had conducted the appropriate medication history, he would have determined that Allopurinol was the cause of the decedent's rash, fever, and high

liver enzymes. Dr. MacArthur acknowledged that Dr. Pinsky complied with the standard of care in determining that the decedent's symptoms were not caused by any infection.

¶ 40 Dr. Carolyn Wolfe testified that she was a board-certified internal medicine physician employed by DMG. She was on call when the decedent was admitted to CDH on September 17. The decedent was experiencing chest pain and Dr. Wolfe concluded that it was due to acid reflux. She discharged the decedent with instructions to take Prevacid daily. She did not order the decedent to discontinue any other medications. When she interviewed the decedent at the start of the hospitalization, she asked the decedent what medications she was taking. The decedent told her she was taking Tylenol III but did not say that she was taking Allopurinol. It was Dr. Wolfe's opinion that the decedent was not taking Allopurinol as of September 17.

¶ 41 Nurse Michelle August testified that she was a registered nurse and worked at CDH. When the decedent came to the hospital on November 13, Nurse August questioned the decedent about what medications she was taking. The decedent said she was taking Allopurinol.

¶ 42 Dr. Alon Vainer, retained by the plaintiff, testified that he was board-certified in internal medicine and nephrology. In his 20 years as a nephrologist, he had seen about 10 to 15 patients have a drug reaction to Allopurinol. He had never seen a patient with TEN. Dr. Vainer defined "standard of care" as "the minimum level of treatment that the physician should be able to give to the patients based on the standard in the community and medical school training." He testified that all his opinions in this case were based upon a reasonable degree of medical certainty.

¶ 43 Dr. Vainer opined that the decedent died due to multi-organ failure due to TEN resulting from the use of Allopurinol. He was 99.99% certain that no other drug could have been the cause of the decedent's condition. He believed the decedent was taking Allopurinol between

November 2 and November 13 because dialysis clinic records, emergency room records, and internist records all indicated she was taking Allopurinol.

¶ 44 Dr. Vainer opined that Dr. Kozeny's conduct fell below the standard of care and was responsible for the decedent's death. Nephrologists know that a patient on dialysis should not be taking more than 50 to 100 mg per day of Allopurinol. The standard of care required Dr. Kozeny to take an accurate physical and medical history. There was evidence in the medical records that showed the decedent was on an improper dose of Allopurinol and Dr. Kozeny was required to know that. The hospital records and the nurses' records for the October 18 hospitalization indicated that the decedent was taking Allopurinol. The decedent's dialysis records at the Fresenius clinic also indicated that the decedent was taking Allopurinol. Dr. Kozeny should have looked at these records. The failure to look at those records resulted in an improper drug history.

¶ 45 Additionally, Dr. Vainer noted that Dr. Kozeny's October 27 progress note indicated that Dr. Kozeny still had concerns over the decedent's fever and rash because of the lack of diagnosis. Dr. Vainer opined that Dr. Kozeny should have gone back to square one and done another medical history, including talking to the family about previous medications and reviewing all the medical records. Dr. Kozeny fell below the standard of care in failing to determine that the decedent was taking Allopurinol and in failing to advise the decedent and the primary care physician that she should not be taking Allopurinol. These failures resulted in the decedent's death. Dr. Vainer acknowledged, however, that had the decedent only taken the six medications set forth by Dr. Briney in the November 2 discharge papers, she would not have had a rechallenge, would not have developed TEN, and would not have died.

¶ 46 Jaime Francisco testified that he was the decedent's widower. He never doubted his

wife's ability to follow a doctor's instructions. He did not know when the decedent was taking Allopurinol. However, he never doubted his wife's ability to follow her doctor's instructions as to when to take medication. Following this testimony, the plaintiff rested his case-in-chief.

¶ 47 At the close of the plaintiff's case, Dr. Kozeny moved for a directed verdict, arguing that the plaintiff's expert, Dr. Vainer, was not qualified to offer expert testimony as to the standard of care required of Dr. Kozeny. Dr. Kozeny also argued that the plaintiff failed to establish proximate cause because, even if Dr. Kozeny had discovered that the decedent was taking Allopurinol and told her to stop taking it, there was no evidence that the decedent would in fact have stopped taking it. Rather, Dr. Kozeny argued, the evidence showed that the decedent had not been a compliant patient because, if she had been, she would have run out of Allopurinol by the time of her October 18 hospitalization. For this reason, Dr. Kozeny argued that Dr. Vainer's testimony was far too speculative to establish proximate cause. The trial court denied the motion for directed verdict. In so ruling, the trial court stated that the plaintiff had made out a *prima facie* case, that there was "at least some evidence" on every element needed to prove the case, and that there were numerous issues of fact to be decided by the jury.

¶ 48 Dr. Steven Korbet testified as a board-certified expert nephrologist for Dr. Kozeny and NANI. His opinions were based upon a reasonable degree of medical certainty. Based on his knowledge and experience, and his review of medical records and depositions related to this case, he opined that Dr. Kozeny complied with the standard of care when treating the decedent. When the decedent was hospitalized in October, Dr. Kozeny was only consulting as a nephrologist, meaning he was required to see that the decedent's dialysis continued while hospitalized. If the decedent was not on dialysis, Dr. Kozeny would not have been consulted at all. The primary care physician was responsible for diagnosing what brought the decedent into

the hospital. Dr. Korbet acknowledged that both the emergency room and floor nurses indicated that the decedent was taking Allopurinol. Dr. Korbet opined that the standard of care did not require Dr. Kozeny to review every medical record. He was being consulted for the purpose of continuing dialysis and only needed to gather the information necessary to that purpose. He opined that verbally asking the decedent what medications she was taking satisfied the standard of care. Dr. Korbet testified that a September 26 note from the decedent's dialysis records at the Fresenius clinic indicated that the decedent was taking Colchicine for her gout. Dr. Korbet opined that it was reasonable for Dr. Kozeny to believe that the patient was not on Allopurinol. It was also reasonable for Dr. Kozeny to believe, during the decedent's October 18 hospitalization, that Vancomycin might have been causing the rash and fever. Vancomycin could cause a severe reaction and it could take weeks for the rash to go away.

¶ 49 Dr. Korbet opined that Dr. Kozeny was being called in on the case to take care of the decedent's dialysis needs. It was not his responsibility to determine the cause of the decedent's fever, rash, and elevated liver enzymes; that was the responsibility of the decedent's primary care physician. At no time did the standard of care require Dr. Kozeny to conduct a second complete medication history. Dr. Kozeny knew what medications the decedent was on in the hospital and knew the medications she was instructed to take upon discharge. Because the decedent was not instructed to take Allopurinol, it was not Dr. Kozeny's responsibility to tell her to stop taking it.

¶ 50 Dr. Robert Citronberg testified on behalf of Dr. Pinsky and Midwest. He testified that he was a specialist in infectious diseases. He received and reviewed the decedent's medical records from CDH, Northwestern, and Loyola. He also reviewed numerous evidence depositions of various doctors. He did not review the nurses' evidence depositions. All his opinions were based on a reasonable degree of medical certainty.

¶ 51 Dr. Citronberg opined that Dr. Pinsky complied with the standard of care at all times in his treatment of the decedent. On October 19, Dr. Pinsky was asked to evaluate the decedent to determine if her symptoms were due to an infectious disease. Dr. Pinsky was a consultant, not a specialist or the attending physician. The attending physician had the overall responsibility for the patient. Dr. Pinsky took a reasonable medication history. He looked at the charts, reviewed the records, and spoke with the patient. After Dr. Pinsky saw the decedent on October 19, he found no sign of infection. Dr. Pinsky told Dr. Olmstead that Vancomycin might or might not be the cause of the fever and rash and that other medications should be considered. He also recommended an allergy consult. Dr. Citronberg opined that Dr. Pinsky's actions were appropriate.

¶ 52 Dr. Citronberg testified that, in conducting a medication history, it was not within the standard of care to expect Dr. Pinsky to go through every page of the decedent's chart, or examine the emergency room nurses' or the floor nurses' notes, or interview the decedent's family, or ask them to bring in all of the decedent's pill bottles. Such steps would be an inefficient use of time, and it was reasonable to rely on conversations with the patient. Even though Dr. Pinsky concluded that there was no infection present, he remained part of the decedent's team of doctors up until her discharge. Dr. Citronberg opined that Dr. Pinsky and Midwest not only complied with the standard of care but exceeded it. Dr. Citronberg opined that the decedent did not take Allopurinol after her November 2 discharge because, if she had been a compliant patient, she would have finished her Allopurinol by then. He did not believe that the conduct of Dr. Pinsky in any way contributed to the decedent's death.

¶ 53 Dr. James Herrmann testified that he was a board-certified dermatologist and was a member of DMG. He was involved in the treatment of the decedent during her October 18

admission to CDH. He was called in as a consultant to evaluate the decedent's rash. As a consultant he would evaluate a patient and then make certain recommendations. However, the primary care physician could then choose whether to follow those recommendations. Before evaluating a patient, he would typically review the admission history and physical, various consultation notes in the chart, and any lab work that was done, and the medications listed in the chart. He would not normally review the emergency room or floor nurses' notes. He typically had a verbal conversation with the patient as to the medication history. Based on his notes, there was no indication that the decedent told him she was taking Allopurinol. In his experience, Vancomycin can cause fever, rash, and hepatitis. The most common drugs that can cause a fever and rash are sulfonamides. Allopurinol was not one of the more common drugs associated with that type of reaction. At the time he evaluated the decedent he believed her rash was either caused by Vancomycin or an infection from her recent trip to the Philippines. He did not know the decedent was taking Allopurinol. Even if she was taking Allopurinol, he believed her symptoms were much more consistent with a reaction to Vancomycin. There had been many reports in the medical literature that Vancomycin can cause the exact same clinical course experienced by the decedent.

¶ 54

Verdict

¶ 55 On February 13, 2013, the jury found in favor of the plaintiff, against defendants Dr. Kozeny and NANI, but for defendants Dr. Pinsky and Midwest. The jury awarded damages of \$5,132,197. The trial court entered judgment on the jury verdict that same day. Following the denial of their post-trial motions, Dr. Kozeny and NANI filed a timely notice of appeal (docketed as No. 2-13-0677). The plaintiff also appealed the verdict in favor of Dr. Pinsky and Midwest (docketed as No. 2-13-0707). Upon motion of the parties, we consolidated the appeals.

¶ 56

ANALYSIS

¶ 57

Case No. 2-13-0677

¶ 58

A. Motions for Directed Verdict and for Judgment N.O.V.

¶ 59 On appeal, Dr. Kozeny and NANI (collectively, Dr. Kozeny) argue that the trial court erred in denying their motion for a directed verdict and their post-trial motion for judgment notwithstanding the verdict (judgment n.o.v.). The plaintiff argues that Dr. Kozeny has forfeited his arguments on appeal by failing to provide a complete record. The plaintiff notes that the record lacks the trial court exhibits as well as four videotaped evidence depositions that were presented at trial. Dr. Kozeny has since supplemented the record on appeal with the missing depositions. There is one demonstrative exhibit that is related to one of the issues Dr. Kozeny raises on appeal that is still missing. However, the failure to include that exhibit in the record does not inhibit our review or raise any doubts that must be construed against Dr. Kozeny. Accordingly, Dr. Kozeny has not forfeited any arguments for lack of a complete record.

¶ 60 Turning to the merits, “[a] trial court should grant a directed verdict or judgment n.o.v. only where all the evidence, when viewed in the light most favorable to the nonmoving party, so overwhelmingly favors the moving party that no contrary verdict based on the evidence could ever stand.” *Perkey v. Portes-Jarol*, 2013 IL App (2d) 120470, ¶ 54. The trial court’s ruling on a motion for judgment n.o.v. or a motion for directed verdict is reviewed *de novo*. *Id.* A directed verdict or a judgment n.o.v. should not be granted “if there is any evidence, together with reasonable inferences drawn from the evidence, demonstrating a substantial factual dispute, or if the assessment of witness credibility or the determination regarding conflicting evidence is decisive to the outcome.” *Id.* In reviewing the trial court’s ruling on a motion for directed verdict or judgment n.o.v., we must not substitute our judgment for that of the jury, reweigh

evidence, or determine the credibility of witnesses. *Donaldson v. Central Illinois Public Service Co.*, 199 Ill. 2d 63, 89 (2002).

¶ 61 Here, Dr. Kozeny first argues that the plaintiff failed to establish the requisite standard of care. In a medical malpractice case, the plaintiff must prove: (1) the proper standard of care against which the defendant's conduct is measured; (2) an unskilled or negligent failure to comply with that standard; and (3) a resulting injury proximately caused by the physician's want of skill or care. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 112 (2004). For an expert to testify as to the proper standard of care, the expert must be a licensed member of the school of medicine about which he proposes to testify and be able to show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians, in either the defendant physician's community or a similar community. *Id.* at 112-13. In Illinois, the standard of care for all professionals is defined as "the use of the same degree of knowledge, skill and ability as an ordinarily careful professional would exercise under similar circumstances." *Advincula v. United Blood Services*, 176 Ill. 2d 1, 23 (1996).

¶ 62 Dr. Kozeny points out that Dr. Vainer, the plaintiff's only expert to have offered standard of care testimony as to Dr. Kozeny, testified that the definition of the standard of care was "a minimum level of treatment that the physician should be able to give to the patients based on the standard in the community and medical school training." Dr. Kozeny argues that this definition does not comply with Illinois law and that Dr. Vainer's opinions as to standard of care, or any deviation therefrom, are insufficient to sustain the causes of action against him.

¶ 63 However, in addition to the above testimony, Dr. Vainer also agreed that he was "familiar with the standard of care as it applies to a reasonably well-qualified nephrology specialist such as Dr. Kozeny *** considering the degree of skill and care which usually should be exercised by

the average nephrology specialist.” He also testified that based on his training, knowledge and experience, he was familiar with the responsibilities of a nephrology specialist called as a consultant in a hospital. Accordingly, viewing Dr. Vainer’s testimony in its entirety, it is clear that his testimony as to the standard of care required by Dr. Kozeny complied with Illinois law. Moreover, the jury was instructed as to the definition of the standard of care. Dr. Vainer’s definition of the standard of care, to the extent it conflicted with the jury instructions, may affect his credibility but it does not serve as a basis for a directed verdict or judgment n.o.v. See *Perkey*, 2013 IL App (2d) 120470, ¶ 55 (citing *Taylor v. County of Cook*, 2011 IL App (1st) 093085, ¶ 33 (although expert witness’s definition of standard of care did not comply verbatim with the jury instruction on the issue, it did not render his otherwise reliable testimony unreliable)).

¶ 64 Dr. Kozeny next argues that Dr. Vainer failed to explain how his conduct fell below the standard of care. Dr. Kozeny argues that Dr. Vainer opined only that, because the decedent died, Dr. Kozeny’s treatment of her must have fallen below the standard of care. See *Kemnitz v. Semrad*, 206 Ill. App. 3d 668, 675 (1990) (one cannot establish negligence through the mere existence of an injury). The record reveals, however, that Dr. Vainer opined that the standard of care required Dr. Kozeny to complete a full drug history of the patient and that, by failing to do so, he failed to identify that Allopurinol was the cause of her condition and failed to instruct her to stop taking it. He further opined that this failure to follow the standard of care contributed to her death. Dr. Vainer testified that the emergency room nurse’s notes and the floor nurse’s notes from the decedent’s October 18 hospitalization, as well as the decedent’s dialysis records, indicated that the decedent was taking Allopurinol and that the standard of care required that Dr. Kozeny review these records. Dr. Vainer also testified that by October 27, when there was still a

lack of diagnosis, the standard of care required Dr. Kozeny to conduct a subsequent complete medication history including talking to the decedent, her family, and reviewing all her medical records. Dr. Vainer testified that Dr. Kozeny's treatment of the decedent fell below the standard of care because he failed to: (1) conduct a proper medication history, (2) identify Allopurinol as the cause of her condition, and (3) instruct her to stop taking Allopurinol. As such, we find that Dr. Vainer adequately explained the standard of care and how, in his opinion, Dr. Kozeny's conduct fell below the standard of care.

¶ 65 Finally, Dr. Kozeny argues that the plaintiff failed to establish proximate cause. One of the elements of a medical malpractice claim is an injury proximately caused by the physician's lack of skill or care. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 112 (2004). To establish proximate causation, a plaintiff must prove that the defendant's negligence "more probably than not" caused the plaintiff's injury. *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 107 (1997). Generally, proximate cause is an issue of material fact to be determined by the jury. *Abrams v. City of Chicago*, 211 Ill. 2d 251, 257 (2004). However, proximate cause may be determined as a matter of law where the facts show that the plaintiff would never be entitled to recover. *Id.* at 257-58.

¶ 66 Dr. Kozeny argues that there was no evidence of proximate cause because the Allopurinol was stopped as of the October 18 hospitalization and the decedent was told not to restart the medication. We acknowledge that Dr. Briney testified that before her November 2 discharge he reviewed with the decedent the medications she was supposed to take at home. Allopurinol was not one of those medications. Dr. Briney testified that he had no "intent" to tell her to restart the Allopurinol and that he believed he would have made that clear. However, he admitted that there were no written instructions advising her not to take Allopurinol. We are also

cognizant of the evidence indicating that, had the decedent taken the Allopurinol as prescribed, she would have run out by October 18. While the foregoing supports an inference that the decedent stopped taking Allopurinol as of her October 18 hospitalization, the record supports the opposite inference as well. Drs. MacArthur, Licata, and Vainer all opined that the decedent took the Allopurinol following her November 2 discharge and that her condition and ultimate death was the result of a rechallenge with Allopurinol. One could infer, therefore, that Dr. Briney did not make it clear to the decedent that she should not be taking Allopurinol. It was within the jury's province to resolve these conflicts in the evidence and determine the facts.

¶ 67 Dr. Kozeny also argues that Dr. Vainer lacked any basis to offer an opinion regarding causation because he testified that he had never seen a reaction to Allopurinol causing TEN in his entire career. Dr. Kozeny argues, therefore, that Dr. Vainer's opinion that the TEN was caused by Allopurinol rather than Vancomycin was pure speculation. Nonetheless, Dr. Vainer's testimony was based not only on his experience, but also on his knowledge and training. Accordingly, the fact that he never treated a patient with TEN resulting from Allopurinol goes to the weight of his testimony rather than the admissibility of his opinions. See *Steele v. Provena Hospitals*, 2013 IL App (3d) 110374, ¶ 74 (expert witness's limited experience in emergency rooms went to weight rather than admissibility of opinion as to the standard of care of an emergency room physician).

¶ 68 In his reply brief and at oral argument, Dr. Kozeny argued for the first time that the jury instructions did not support a determination of proximate cause because "the jury was never asked to decide whether Dr. Kozeny was negligent in failing to advise the decedent to never restart the Allopurinol." An argument raised for the first time on appeal in the reply brief need not be addressed by this court. *In re Marriage of Winter*, 2013 IL App (1st) 112836, ¶ 29 ("an

appellant's arguments must be made in the appellant's opening brief and cannot be raised for the first time in the appellate court by a reply brief); see also Ill. S. Ct. R. 341(h)(7) (eff. Feb. 6, 2013) ("Points not argued are waived and shall not be raised in the reply brief, in oral argument, or on petition for rehearing"). As such, this argument has been forfeited.

¶ 69 Dr. Kozeny also argues that the trial court erred in denying the motion for directed verdict and for judgment n.o.v. because, in doing so, it had stated that the plaintiff had presented "some evidence" on each element of his cause of action. Dr. Kozeny points out that our supreme court has rejected the "some evidence" standard in ruling on a motion for a directed verdict. *Pedrick v. Peoria & E. R. Co.*, 37 Ill. 2d 494, 504 (1967). The proper standard is whether the evidence presented to the jury was sufficient to create a "substantial factual dispute." *Id.* However, the evidence clearly created a substantial factual dispute about whether the decedent's TEN was the result of rechallenge with Allopurinol and whether Dr. Kozeny's conduct fell below the standard of care. As such, the trial court did not err in denying the motions for directed verdict and for judgment n.o.v.

¶ 70 B. Prejudicial Conduct of Plaintiff's Counsel

¶ 71 Dr. Kozeny's second contention on appeal is that the conduct of the plaintiff's counsel during trial was prejudicial. First, Dr. Kozeny complains about an objection made by plaintiff's counsel while Dr. Pinsky's counsel, Attorney David Hall, was questioning Dr. Saltoun. Specifically, when Attorney Hall was questioning Dr. Saltoun, he referred to an exhibit known as Pinsky's Exhibit No. 8. On that exhibit, Attorney Hall had listed the names of the specialists that had treated the decedent at Northwestern and Loyola. The plaintiff argues that this argument is forfeited because Pinsky's Exhibit No. 8 is not part of the record. However, it is not necessary for us to view this exhibit to address this argument and, therefore, it is not forfeited.

¶ 72 During trial, Attorney Hall questioned different witnesses as to whether the doctors listed on the subject exhibit had written in the decedent's medical record that the decedent was taking Allopurinol or whether any of the doctors had concluded that the decedent's condition was caused by Allopurinol. While Attorney Hall was cross-examining Dr. Saltoun, he referred to Pinsky's Exhibit No. 8 and asked her whether the several physicians listed on the exhibit had ever written in their notes that the decedent's condition was due to a drug reaction as a result of Allopurinol. The following colloquy ensued:

“[Mr. Hall] Q. *** And my final question will be with my board.

Dr. Pinsky, No. 8. If I could, I would have done this with each medical record. But I can't do the board and the records at the same time.

So, I just want to ask you so my record is complete. As we went through this all together, when you saw the admitting records, the H&P from the medical ICU folks—both the resident note, the addendum from the attending—you would agree that neither of them in their records in any way indicated an awareness of Allopurinol in their recent drug history; true?

MR. VINKLER [plaintiff's attorney]: Objection your Honor. All of these witnesses Mr. Hall has indicated on the board know she is on Allopurinol. None of them testified—

MR. VINKLER: It's speculation. It asks for someone not here to testify.

THE COURT: All right. It asks for what's in their records. It's proper. The objection is overruled.”

¶ 73 Dr. Kozeny argues that this was an “outrageous and inappropriate” speaking objection. He argues that it suggested to the jury that these other witnesses would have testified that the decedent’s condition was caused by Allopurinol or that the jury could assume that these other doctors were not called as witnesses because their testimony would have been unfavorable. Dr. Kozeny contends that this was the central issue and the case was so close that the error could not be cured through a proper instruction from the trial court.

¶ 74 As a preliminary matter, Dr. Kozeny has forfeited this argument by failing to object at trial. See *Guski v. Raja*, 409 Ill. App. 3d 686, 695 (2011) (failure to object at trial forfeits consideration of a claimed error on appeal). Even absent forfeiture, the argument is without merit. “Where it appears that an error did not affect the outcome below, or where the court can see from the entire record that no injury has been done, the judgment or decree will not be disturbed.” *Both v. Nelson*, 31 Ill. 2d 511, 514 (1964); see also *Sbarboro v. Vollala*, 392 Ill. App. 3d 1040, 1057 (2009). “But where the case is a close one on the facts, and the jury might have decided either way, any substantial error which might have tipped the scales in favor of the successful party calls for reversal.” *Both*, 31 Ill. 2d at 514; *Sbarboro*, 392 Ill. App. 3d at 1057.

¶ 75 In the present case, we cannot say that complained-of error affected the outcome of the trial. The trial court quickly denied the objection set forth by the plaintiff’s attorney and explained that Dr. Saltoun’s testimony would directly address what was in the medical records. Further, Dr. Saltoun immediately testified that none of the physicians listed on the exhibit knew whether the defendant was taking Allopurinol prior to her initial hospitalization or after. She further testified that none of the physicians listed had concluded that Allopurinol was a likely or even possible cause of the decedent’s drug reaction. Based on this testimony, we cannot say that the jury was left with the impression that the listed physicians would have testified that

Allopurinol was the cause of the decedent's condition. Moreover, this was an isolated comment and the plaintiff did not argue in closing that it could be inferred that the listed physicians would have testified that the decedent's condition was caused by Allopurinol.

¶ 76 Dr. Kozeny further argues that the inappropriate objection was compounded by comments made by the plaintiff's counsel during closing argument. Specifically, the plaintiff's counsel stated during closing argument:

“One of the most important things that you need to hear is that a doctor can get up on the stand and say to you I did my job; I did my duty; I followed the standard of care. And in this regard when I brought Dr. Kozeny on and I asked him various things, and he gave different issues and different responses. But when he was put on his own case by Ms. Cunningham [counsel for Dr. Kozeny] and he had the opportunity at that time to explain to you why or how he followed the standard of care, he didn't fall below it. The only thing he talked about was his curriculum vitae. He could not look you in the eye under oath and say I followed the standard of care.”

The plaintiff's counsel also stated:

“Now what you're going to hear then from Judge Sutter is various issues that you have to decide. And so in doing so you have to consider the conduct of each of these individuals [Dr. Kozeny, Dr. Pinsky, and Dr. DeJesus]. And in so doing, Judge Sutter put together eight issues, eight separate issues for these three different Defendants and their corporations. That's a lot of numbers.”

Dr. Kozeny argues that the former comment implied that Dr. Kozeny had the burden to disprove negligence. He argues that the latter comment suggested to the jury that, because the trial court

had approved the issues instructions, it approved of the plaintiff's many allegations of negligence.

¶ 77 Dr. Kozeny did not object to these comments during the closing argument. It was not until after the closing arguments of the plaintiff and Dr. Kozeny, during a break conducted outside the presence of the jury, that counsel for Dr. Kozeny first stated an objection. Specifically, Dr. Kozeny's counsel stated to the trial court that the comment about Dr. Kozeny looking the jury in the eye was "highly improper" and "worthy of a mistrial." Dr. Kozeny's counsel also objected to the latter comment about the issues instructions, arguing that it suggested that the court decided the issues instructions based on what it believed the defendants did wrong. The trial court agreed with both of these objections. As to the comment about the issues instruction, the trial court instructed the plaintiff's counsel to refrain from similar comments during rebuttal. As to the comment about Dr. Kozeny looking the jury in the eye, the trial court instructed the jury "that Dr. Kozeny did not have any obligation to get up on the witness stand and look you in the eye and tell you that he followed the standard of care. As you know, the plaintiff has the burden of proof in this case."

¶ 78 Generally, a failure to make a contemporaneous objection at trial forfeits consideration of a claimed error on appeal. *Guski*, 409 Ill. App. 3d at 695. Accordingly, the plaintiff argues that Dr. Kozeny has forfeited these arguments for failing to make a contemporaneous objection during closing argument. While not contemporaneous, Dr. Kozeny did ultimately raise objections and give the trial court an opportunity to address these alleged errors. Under these circumstances, we decline to find review of the alleged errors forfeited. *O'Casek v. Children's Home & Aid Society of Illinois*, 229 Ill. 2d 421, 438 (2008) (forfeiture is a limitation on the parties and not on this court).

¶ 79 Wide latitude must be afforded counsel in closing argument. *Ellington v. Bilsel*, 255 Ill. App. 3d 233, 238 (1993). Reviewing courts are not concerned that parties receive an error-free trial; rather, our concern is that plaintiffs receive a fair trial, one free of substantial prejudice. *Netto v. Goldenberg*, 266 Ill. App. 3d 174, 184 (1994). Neither of the challenged comments during closing argument resulted in substantial prejudice. As to the comment about Dr. Kozeny failing to look the jury in the eye, the trial court gave a curing instruction. The giving of this instruction cured any prejudicial impact of the error. *Wilson v. Humana Hospital*, 399 Ill. App. 3d 751, 760 (2010). As to the comment about the issues instruction, the trial court instructed the plaintiff's counsel to refrain from any similar comments in rebuttal closing argument. Dr. Kozeny does not argue that there were any other similar comments in rebuttal. Accordingly, we cannot say the original comment denied Dr. Kozeny a fair trial.

¶ 80 Additionally, we note there is no cumulative error. A new trial is necessary when the cumulative effect of trial errors so deprives a party of a fair trial that the verdict might have been affected. *Mueller v. Phar-Mor, Inc.*, 336 Ill. App. 3d 659, 670 (2000). Upon reviewing the record in this case, we cannot say that the cumulative effect of any of the alleged errors denied Dr. Kozeny a fair trial.

¶ 81 C. Post-trial Motion for a New Trial

¶ 82 Dr. Kozeny's final contention on appeal is that the trial court erred in denying his post-trial motion for a new trial. In ruling upon a motion for new trial, the trial court will weigh the evidence and will set aside the jury's verdict and order a new trial only if the verdict is against the manifest weight of the evidence. *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 37. A verdict is against the manifest weight of the evidence only if it is clear from the record that the jury should have reached the opposite conclusion or if the jury's findings are

unreasonable, arbitrary, and not based upon any of the evidence presented. *Id.* On review, the trial court's ruling on a motion for new trial will not be reversed unless the trial court committed an abuse of discretion. *Id.* In determining whether an abuse of discretion has occurred, the reviewing court should consider whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial. *Maple v Gustafson*, 151 Ill. 2d 445, 455-56 (1992).

¶ 83 Dr. Kozeny argues that the evidence in this case was overwhelmingly in his favor. He argues that Dr. Vainer's opinion, that Dr. Kozeny could have learned the specifics of the decedent's Allopurinol use if he had reviewed all the medical records, was based on speculation. He further argues that whether the decedent or Dr. Briney would have acted differently had Dr. Kozeny told them not to restart Allopurinol was also speculation. He also argues that there was no evidence showing whether and how much Allopurinol the decedent took after November 2. The decedent's husband testified that the decedent would have taken her medication as prescribed. If she had done so, the record indicates that she would have run out of Allopurinol before November 2. Dr. Kozeny argues, therefore, that it was mere speculation to believe that the decedent took Allopurinol after her November 2 discharge. Finally, Dr. Kozeny argues that the evidence indicates that the decedent did not die as a result of a rechallenge with Allopurinol and that, if she did, it was the result of her own failure to follow her doctor's orders.

¶ 84 Upon our own review of the record in this case, we cannot say that the jury's verdict was against the manifest weight of the evidence. Numerous doctors testified that Allopurinol was known to cause symptoms similar to the decedents' symptoms and that the decedent died as a result of rechallenge with Allopurinol. Specifically, Dr. Licata opined that the decedent died as a result of rechallenge with Allopurinol. She further opined that all the decedent's symptoms

collectively could only have been caused by Allopurinol and not by any other drug. Dr. MacArthur explained that Allopurinol was among the core group of drugs that causes 80% of all hypersensitivity syndrome cases. He opined that the decedent passed away due to complications related to TEN and that the TEN was caused by a rechallenge with Allopurinol. He testified that it was a “medical certainty” that the decedent took Allopurinol after her November 2 discharge. Dr. Vainer also testified, to a reasonable degree of medical certainty, that the decedent died due to TEN related to a rechallenge with Allopurinol. Because no one told her to stop taking the Allopurinol, Dr. Vainer believed she started to take it again after her November 2 discharge.

¶ 85 Additionally, most of the doctors agreed that the decedent’s symptoms were the result of a drug reaction. Most doctors also acknowledged that Allopurinol was a drug that was known to cause such adverse reactions. There were multiple medical records indicating that the decedent was taking Allopurinol. The records at the dialysis clinic as well as hospital admission records and nurses’ records all indicated the decedent was taking Allopurinol. Dr. Kozeny, however, never conducted a thorough drug history. He failed to look at the dialysis clinic records and hospital records. Dr. Vainer opined that this failure fell below the standard of care. Although the decedent was not advised to take Allopurinol on the day of her November 2 discharge, she was not advised not to take it. Accordingly, the jury could reasonably infer that she started to take the Allopurinol again and that it caused her death. The jury could also infer that Dr. Kozeny’s failure to conduct a thorough medication history and discover that the decedent had been taking Allopurinol fell below the standard of care. The jury’s verdict is therefore not against the manifest weight of the evidence.

¶ 86 Ultimately, this case involved a classic battle of expert witness testimony. The testimony of the plaintiff’s expert witnesses supported the plaintiff’s side of the case and the testimony of

Dr. Kozeny and his expert witnesses supported Dr. Kozeny's side of the case. It was the jury's role to determine whether each expert witness was credible and how much weight to give to each expert's testimony. See *Maple*, 151 Ill. 2d at 452. Under the circumstances present in the instant case, Dr. Kozeny's post-trial motion for a new trial was properly denied. See *Lawlor*, 2012 IL 112530, ¶ 37; *Maple*, 151 Ill. 2d at 455.

¶ 87

Case No. 2-13-0707

¶ 88 In this appeal, the plaintiff argues that the trial court erred in quashing an evidence subpoena that would have aided him in establishing his case against Dr. Pinsky and Midwest (collectively, Dr. Pinsky). The plaintiff also argues that the jury's verdict in favor of Dr. Pinsky was against the manifest weight of the evidence.

¶ 89 The plaintiff first argues that the trial court erred in granting a motion to quash a certain subpoena issued during trial. Prior to trial, on June 3, 2010, the plaintiff issued a subpoena *duces tecum* to CDH for its data output or "audit trail" that showed, by both date and time, which individuals accessed CDH medical records for the decedent during her September 17 and October 18 hospitalizations. CDH sent the requested records to the plaintiff as well as to all counsel of record in this case. For example, the liver biopsy report of the decedent, dated October 26, 2005, and entered electronically into CDH's system concluded:

"The biopsy was reviewed by [doctors] at the Mayo Clinic, and they agree with the diagnosis. They agree that the changes are consistent with drug injury and may be related to prior antibiotics, though a thorough drug history should be taken to identify other possible precipitating drugs.

The CDH audit trail indicated that this report was reviewed by Dr. Pinsky on November 2, 2005, at 9:32 a.m. The plaintiff believed this evidence was critical because Dr. Pinsky had testified

that that he signed off on the decedent's care as of October 31, 2005. However, because he viewed the liver biopsy report on November 2, the plaintiff believed Dr. Pinsky had a duty to conduct a thorough medication history.

¶ 90 After the trial commenced, on Saturday, February 2, 2013, the plaintiff issued a subpoena upon CDH, requesting that the "person most knowledgeable" testify as to the CDH audit trail concerning the decedent's records from her September and October hospitalizations. The subpoena requested that someone appear at trial on February 4, 2013. On that day, during trial, counsel representing CDH, Attorney Jane Stevens, appeared in court to orally request that the plaintiff's subpoena be quashed on the basis that it did not give CDH at least seven days to produce a fact witness and because there was no name listed on the subpoena. She further explained that when she received the subpoena she contacted the plaintiff's counsel and asked what person he was looking for—the person who printed the audit trail, the person who scanned the records in, or the person who knew the record system? The plaintiff's counsel never responded.

¶ 91 The plaintiff's counsel explained that he had sent previous subpoenas to Attorney Stevens in the same manner and never had a problem until this one. After he sent the subpoena request at issue, Attorney Stevens indicated she was no longer accepting service subpoenas. The plaintiff's counsel stated he did not put a name on the subpoena because he thought CDH would just send the person who prints out the audit trail. The plaintiff's counsel explained that the audit trail was important because it would show that Dr. Pinsky looked at various documents even after he claimed that he no longer saw the decedent.

¶ 92 Dr. Pinsky's counsel argued that he originally believed the purpose of the audit trail was to show whether Dr. Kozeny was physically on the premises when the decedent went to the

emergency room on October 18. He stated that this was the first time he was hearing that the audit trail's purpose was to somehow impeach Dr. Pinsky. Counsel argued that Dr. Pinsky had already testified and that there was no plan to bring him back into the case. Counsel objected "for a variety of reasons." Following argument, the trial court, without explaining its ruling, granted the oral motion to quash the subpoena.

¶ 93 At the outset, we note that the parties disagree as to the standard of review to be applied to the trial court's order quashing the subpoena. The plaintiff argues that, because the facts are uncontroverted, the standard of review is *de novo*. Dr. Pinsky argues that at issue are the timing and relevancy of the trial court subpoena, which are not legal questions, and that the standard of review is abuse of discretion. In *People v. Campobello*, 348 Ill. App. 3d 619, 626 (2004), this court stated, in the context of a motion to quash a records subpoena, that the standard of review applicable to a discovery order depends on the nature of the question answered in the trial court. In *Campobello*, a subpoena was challenged on the basis of privilege and constitutionality. This court held that because constitutional interpretations and questions about the applicability of discovery privileges are generally reviewed *de novo*, that the applicable standard of review was *de novo*. *Id.* We agree with Dr. Pinsky that the issues here are the timing and relevancy of the subpoena, that these do not present any legal questions, and that, therefore, the standard of review is abuse of discretion. See *People v. Harlacher*, 262 Ill. App. 3d 1, 9 (1994) (the trial court did not abuse its discretion in quashing a trial subpoena for a doctor whose testimony was not shown to be material).

¶ 94 The plaintiff argues that he was prejudiced by the trial court's ruling because the main issue in the case against Dr. Pinsky was whether he should have conducted a thorough drug history and that the audit trail showed he viewed the results of the liver biopsy which stated that

a thorough drug history should be undertaken. The plaintiff argues that if the jury had heard evidence of the audit trail it could have inferred that Dr. Pinsky was still on the decedent's case as of November 2 and should have conducted a drug history. The plaintiff argues that he is entitled to a new trial.

¶ 95 Upon review of the record in this case, we cannot say the trial court abused its discretion in granting the motion to quash. Supreme Court Rule 237(a) (eff. July 1, 2005) requires that a subpoena be served at least seven days prior to the date on which an appearance is required. The plaintiff presented no valid reason for the non-compliance with the seven-day notice rule. The record indicates that the plaintiff was aware of the biopsy report and the audit trail as of August 24, 2010. Additionally, Dr. Pinsky testified in an August 21, 2009, deposition that he had "signed off" from the decedents' care on October 31, 2005. Dr. Pinsky also made the same statement in his Supreme Court Rule 213(f)(3) (eff. Sep. 1, 2008) opinion served on the plaintiff on September 15, 2012. Accordingly, the plaintiff was aware of Dr. Pinsky's testimony and the audit trail at issue years in advance of trial. The plaintiff had ample opportunity prior to the start of trial to appropriately identify and subpoena a CDH witness to lay the foundation for the audit trail. Instead, the plaintiff waited until two weeks into the trial and after Dr. Pinsky had already testified. Under these circumstances, the trial court did not abuse its discretion in quashing the subpoena as untimely.

¶ 96 Moreover, a party is not entitled to a new trial unless a trial court's erroneous evidentiary ruling was substantially prejudicial and affected the outcome of the trial. *DiCosolo v. Janssen Pharmaceuticals, Inc.*, 2011 IL App (1st) 093562, ¶ 40. Even if the trial court had erred, we could not say that the error was so prejudicial as to warrant a new trial. Nothing in the audit trail conflicted with Dr. Pinsky's testimony. Dr. Pinsky testified that after he conducted his initial

evaluation of the decedent, he discussed with the attending physician, Dr. Olmstead, that the decedent was possibly suffering from a drug reaction and he recommended that Dr. Olmstead seek an allergy consult to help determine what medication could be causing the decedent's symptoms. He testified that he was not sure whether he reviewed the liver biopsy report before or after he had signed off on the decedent's case on October 31. However, the plaintiff's counsel was able to cross-examine him on the significance of the liver biopsy report, which was admitted into evidence, and the comment that a thorough drug history should be taken. Dr. Pinsky testified that his purpose was not to investigate a drug reaction; his purpose was to determine whether the decedent's condition was caused by an infection. By ruling in Dr. Pinsky's favor, the jury apparently agreed. Accordingly, showing via the audit trail that Dr. Pinsky looked at the liver biopsy report on November 2 would not have affected the outcome of the trial.

¶ 97 To the extent the plaintiff argues that it was reversible error for the trial court to entertain the motion to quash of a non-party, who had not entered an appearance or given notice of any such motion, this argument is forfeited for failure to cite to any authority. Failure to cite relevant authority is in violation of Supreme Court Rule 341 and results in waiver of the issue on appeal. 188 Ill. 2d R. 341(e)(7) (eff. Feb. 6, 2013); *Hoff v. Mayer, Brown and Platt*, 331 Ill. App. 3d 732, 741 (2002).

¶ 98 The plaintiff's final contention on appeal is that the jury's verdict in favor of Dr. Pinsky was against the manifest weight of the evidence. The plaintiff argues that there was extensive evidence in this case that the decedent died as a result of rechallenge with Allopurinol and that Allopurinol was one of the most common medications known to cause such drug reactions. The plaintiff further argues that, based on the jury's liability verdict against Dr. Kozeny, the jury apparently agreed that the decedent died as a result of rechallenge with Allopurinol. The

plaintiff notes that Dr. MacArthur opined that Dr. Pinsky failed to meet the standard of care when he failed to conduct a medication history and review all the decedent's medical records, which clearly showed she was taking Allopurinol. Based on these facts, the plaintiff argues that the jury verdict in favor of Dr. Pinsky was against the manifest weight of the evidence.

¶ 99 At the outset, we note that Dr. Pinsky argues that the plaintiff has failed to preserve this issue for review because the plaintiff's post-trial motion contained only the conclusory assertion that the jury's verdict was against the manifest weight of the evidence. Dr. Pinsky relies on *Fedt v. Oak Lawn Lodge, Inc.*, 132 Ill. App. 3d 1061, 1064-65 (1985), which held that a party's "general allegations that the verdict of the jury is against the law and against the manifest weight of the evidence were insufficient to preserve any point of error." However, in *Wolter v. Chicago Melrose Park Associates*, 68 Ill. App. 3d 1011, 1016 (1979), the court found a similar contention to be without merit. In so ruling, the court explained:

"In the present case, plaintiff contends that the jury could not have rendered its verdict based upon all of the evidence. Plaintiff asked the trial judge and is now asking this court to review all of the evidence. Plaintiff is not appealing this case on a specific point not raised at trial, nor is there an issue raised on appeal not brought to the trial judge's attention during the trial. For these reasons, we find the waiver principle inapplicable." *Id.* at 1017.

In *Fedt*, the appellant raised objections to specific errors on appeal, while in its post-trial motion it had only raised a general allegation that the verdict was against the manifest weight of the evidence. As such, the objection to the specific errors was waived. *Fedt*, 132 Ill. App. 3d at 1064-65. In the present case, the plaintiff is not raising an objection to any specific error. Rather, the plaintiff is arguing that, when reviewing the evidence as a whole, the jury's verdict

was against the manifest weight of the evidence. As in *Wolter*, this claim is not forfeited. *Wolter*, 68 Ill. App. 3d at 1016.

¶ 100 As noted earlier, a verdict is against the manifest weight of the evidence only if it is clear from the record that the jury should have reached the opposite conclusion or if the jury's findings are unreasonable, arbitrary, and not based upon any of the evidence presented. *Lawlor*, 2012 IL 112530, ¶ 37. Based on the evidence presented, we cannot say that the jury's verdict in favor of Dr. Pinsky was arbitrary or unreasonable. The evidence showed that Dr. Pinsky was an infectious disease specialist that consulted on the decedent's case at the request of her primary care physician. Dr. Pinsky was asked to determine whether the decedent's condition was the result of an infection. After evaluating the decedent and conducting the appropriate testing, Dr. Pinsky determined that the decedent's condition was not caused by an infection. Nonetheless, recognizing that a drug reaction could be the cause of the decedent's condition, Dr. Pinsky recommended to the decedent's primary care physician that an allergy consult be obtained.

¶ 101 Dr. Pinsky's expert, Dr. Citronberg, opined that Dr. Pinsky complied with, and even exceeded, the standard of care in treating the decedent. Dr. Citronberg testified that it was reasonable for Dr. Pinsky to rely on his conversation with the decedent and her primary care physicians with respect to the medications she was taking. Dr. Citronberg opined that, with respect to conducting a medication history, it was not within the standard of care for Dr. Pinsky to go back through all the decedent's medical records or ask her family to bring in all her pill bottles. Rather, that was the responsibility of the primary care physician. On the contrary, Dr. MacArthur opined that the standard of care required Dr. Pinsky to conduct a thorough medication history by looking at medical records, reviewing notes from the emergency room nurse and the floor nurse, and speaking with the decedent and her family. Dr. MacArthur further

opined that the standard of care required Dr. Pinsky to determine that the decedent was taking Allopurinol and to advise her to stop taking it. It was for the jury to resolve the conflict in the expert testimony (*In re Commitment of Trulock*, 2012 IL App (3d) 110550, ¶ 50) and determine whether Dr. Pinsky complied with the standard of care. Because there was evidence supporting the jury's determination, we cannot say the verdict was against the manifest weight of the evidence.

¶ 102

CONCLUSION

¶ 103 For the foregoing reasons, the judgment of the circuit court of Du Page County is affirmed.

¶ 104 Affirmed.