2015 IL App (2d) 140515-U
No. 2-14-0515
Order filed March 27, 2015

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IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

ROBERTA DAVIDSON,	)	Appeal from the Circuit Court
	)	of Kane County.
Plaintiff-Appellant,	)	
	)	
v.	)	No. 09-L-457
	)	
DEAN P. SHOENER and SURGERY	)	
GROUP, INC.,	)	Honorable
	)	Keith F. Brown,
Defendants-Appellees.	)	Judge, Presiding.

JUSTICE JORGENSEN delivered the judgment of the court.
Justices McLaren and Birkett concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court did not err in finding that defendant surgeon's statements did not constitute judicial admissions. Denial of motion for judgment *n.o.v.* or a new trial affirmed.

¶ 2 Plaintiff, Roberta Davidson, sued defendants, Dr. Dean P. Shoener and his employer, Surgery Group, Inc., for negligence after Dr. Shoener failed to remove plaintiff's appendix (and removed a piece of fat instead) during an intended laparoscopic appendectomy, necessitating a second and open surgery two days later. The jury issued a verdict in defendants' favor. The trial court denied plaintiff's post-trial motion for judgment notwithstanding the verdict (*n.o.v.*) or,

alternatively, a new trial. Plaintiff appeals, arguing that Dr. Shoener's testimony concerning what he visualized during the first surgery (*i.e.*, the cecal appendiceal junction, a marker for the location of the appendix) constituted a judicial admission that he breached the standard of care. We affirm.

¶ 3 I. BACKGROUND

¶ 4 Dr. Shoener treated plaintiff for acute (*i.e.*, sudden onset) appendicitis (*i.e.*, inflammation of the appendix). This case arose after defendant, on September 2, 2008, performed a laparoscopic appendectomy, intending to remove plaintiff's appendix. However, he removed a piece of fat (*i.e.*, an appendix epiploica) instead of the appendix (*i.e.*, the vermiform appendix, a tubular structure that connects to and communicates with the large intestine at the cecum, the end of the large intestine). Two days later, plaintiff underwent an open surgical procedure (an open laparotomy) to remove her appendix, which was found in a retrocecal position (*i.e.*, behind the cecum). In 2009, plaintiff sued defendants, alleging medical negligence. A four-day jury trial commenced on December 16, 2013.

¶ 5 A. Plaintiff's Case – Dr. Dean P. Shoener

¶ 6 Dr. Dean P. Shoener testified that he is a board-certified general surgeon. He attended medical school at the University of Iowa and obtained his medical degree in 1994. In 1999, he became board-certified in general surgery. He is on staff at four hospitals: Delnor Hospital, Central DuPage Hospital, Sherman Hospital, and St. Joseph's Hospital (in Elgin). Dr. Shoener also serves on various hospital committees and is an assistant professor in the physician's assistant programs at Midwestern University and Rosalind Franklin University. The most common surgeries he performs are: gallbladder removals (the most common), hernias, appendectomies, and bowel surgery. He performs about 45 appendectomies per year. Most

appendectomies are performed laparoscopically (with three small incisions for inserting surgical tools—trocars and a camera).

¶ 7 Dr. Shoener explained that inflammation can irritate the appendix and can be painful. Appendicitis is a very common condition. On September 2, 2008, there was diagnostic uncertainty as to plaintiff's condition; however, after he completed the first operation, Dr. Shoener's impression was that plaintiff had a ruptured appendix. He explained that, generally, appendices are between four and nine centimeters long. The appendix is tubular and is part of the colon (*i.e.*, large intestine). Human waste and fluid, before it leaves the body, travels through the large intestine, which "communicates with" the appendix. In contrast, the appendix epiploica is physically connected to the large intestine, but it does not have an intralumen that directly connects to the colon lining; it attaches to the outside of the colon. The mesoappendix is an appendicular artery that supplies blood to the appendix. Dr. Shoener testified that, in a patient without appendicitis, the appendix differs in color from fat. In an uncomplicated appendicitis, it sometimes, but not always, differs in color.

¶ 8 Addressing the variations in appendix position, Dr. Shoener testified that, generally, there are about five main anatomical positions for the appendix. However, regardless of which position a particular appendix is in, it is always connected to a specific point where the three teniae intersect—the cecal appendiceal junction—but that point can be different based on the position of the cecum. A reasonably careful general surgeon knows that the appendix can be in a variety of locations, including a retrocecal position.

¶ 9 On September 1, 2008, an emergency room doctor had diagnosed plaintiff with acute appendicitis. A CT scan reflected severe inflammatory changes around the cecum; it did not show the appendix. The pathologist's note also stated that the findings were most concerning for

acute appendicitis with developing phlegmon (abscess). Dr. Shoener first examined plaintiff on September 2, 2008. His initial impression was right lower quadrant abdominal pain, and his second impression was probable acute appendicitis. Dr. Shoener recorded acute appendicitis as his preoperative diagnosis; similarly, he recorded acute appendicitis in his postoperative report. After also speaking with the pathologist, Dr. Shoener recommended that plaintiff undergo a laparoscopic appendectomy. He discussed with plaintiff the risks of the surgery and had her sign a consent form. In the consent form that plaintiff signed, there is a reference (written by Dr. Shoener) to a laparascopic appendectomy and a possible open laparatomy, the latter of which involves an incision to open her abdomen (*i.e.*, open surgery). On September 2, 2008, Dr. Shoener removed an appendices epiploicae (or appendix epiploica), a specific structure within the abdominal cavity that is made up of adipose (*i.e.*, fat) tissue; it has a serosal lining and a blood supply.

¶ 10 On September 2, 2008, Dr. Shoener performed the first surgery. He did not remove plaintiff's vermiform appendix, mesoappendix, or the divided appendicular artery. Rather, Dr. Shoener observed an inflamed appendix epiploica that was the size and shape of what he considered to be an appendix, and he removed it. Specifically, he identified what he thought was a thickened appendix, grasped and elevated it, removed a stool ball that was next to it, drained an area of abscess or infection, and elevated the structure again and teased away the tissues. He dissected the tissue down and identified what he thought was the appendicular artery, which is part of the mesoappendix. Dr. Shoener testified that he "saw a structure that looked like an artery that was coursing right up into the structure that I thought was the appendix." He divided the artery and fired two rows of staples. He used the stapler again to divide what he thought was the appendix from the cecum. He then placed the tissue in an "endobag." He looked at the

tissue through the clear plastic endobag and rolled it around in his hands. Dr. Shoener then sent it to the pathology department for evaluation.

¶ 11 Dr. Shoener explained:

> "In [plaintiff's] case, I used a little different approach because of the amount of inflammation. I actually picked up the end of the appendix and dissected towards the cecum.
>
> Normally, I'll start at the cecum in a case of simple appendicitis, divide the appendix first, and then divide the mesoappendix.
>
> In [plaintiff's] case, I actually used a clip applier, which I normally don't use."

¶ 12 After the pathologist notified Dr. Shoener the next day that he had not removed the appendix, Dr. Shoener ordered a CT scan. Although plaintiff's white blood cell count was in the normal range when she had presented to the emergency room, it had moved to a high level by September 4, 2008, (before her second surgery), which can indicate infection. Before and after her second surgery, Dr. Shoener diagnosed peritonitis (*i.e.*, pus from the appendix, spreading throughout the abdomen and causing pain). He did not note such diagnosis in his pre- and post-operative reports relating for the first surgery, but testified at trial that she did have peritonitis on September 2, 2008.

¶ 13 Plaintiff's second surgery was an open appendectomy utilizing a midline (*i.e.*, belly button to pubic bone) incision, which gives the surgeon more flexibility. Plaintiff remained hospitalized until September 13, 2008. Dr. Shoener saw plaintiff several times after that and released her to return to full unrestricted activity on November 7, 2008.

¶ 14 Plaintiff's counsel questioned Dr. Shoener about what he visualized during the first surgery, which is the subject of this appeal:

"Q. And so that's what you're trained – that's your job, is to go in there and weed through that. My point is if you ever can't see what you're doing, then you don't just keep doing it without seeing, if it is a critical part of the surgery; correct?

A. It becomes a judgment call then. It's a real-time decision, you know; am I at a point where I can't do the surgery and have to make a bigger incision.

Q. Right. And if you couldn't see critical parts of [plaintiff's] surgery, you would have converted to an open procedure; correct?

A. Possibly, yes.

Q. But we know, in [plaintiff's] case, you didn't have that problem because you specifically were able to visualize the critical parts of the surgery when you were using the laparoscope; correct?

A. Well, it was my judgment that I could go ahead and proceed with that surgery safely laparoscopically.

Q. That wasn't my – my next question is, you could visualize clearly the critical aspects of [plaintiff's] surgery that you needed to see; correct?

A. In my judgment, I could, yes.

Q. Do you now believe that judgment was flawed?

A. No."

¶ 15 Dr. Shoener testified about his visualization of the cecal appendiceal junction, which is the focus of this appeal:

"Q. And when you were performing the laparoscopic appendectomy on [plaintiff], you were able to clearly visualize her cecal appendiceal junction; correct?

A. I'm sorry, that was the first surgery?

Q. Yes.

A. I believe given the amount of inflammation that she had that I immobilized the structure enough that, yes, I did visualize – I did clearly visualize that."

¶ 16 Dr. Shoener was questioned about what he recorded in his operative report concerning his visualizations during the surgery:

"Q. Would one of the reasons the structure – we know it wasn't the appendix. When you described a thickened appendix was identified, what you were looking at was not the appendix.

Will you agree with that as we sit here today?

A. In retrospect, yes.

Q. All right. You – well, never mind.

Then this is you describing yourself looking at the appendix; correct?

A. Correct.

Q. And when you are looking at it, you are looking at the middle of the appendix?

A. Correct.

Q. And you see evidence of a perforation. So what you are telling us is that what we now know is a piece of adipose tissue had what you thought was a perforation in it like an appendix would have; correct?

A. Correct."

¶ 17 Dr. Shoener was asked again about his visualizations:

"[Plaintiff's Counsel]: If you were looking at the anatomical location of the cecal appendiceal junction when you said you clearly visualized that specific anatomical spot, the vermiform appendix should have been right there, correct?

[Dr. Shoener]: Not – in my report I was describing what I thought I was visualizing.

[Plaintiff's Counsel]: I understand that. But what I'm asking you is if you were truly, as you used the word, if you were at the true cecal appendiceal junction in your operative report, you should have seen the vermiform appendix there even if it was right next to the piece of fat that you removed, correct?

[Dr. Shoener]: Correct. I don't disagree if I had seen that junction that I would be where the appendix was."

¶ 18 Dr. Shoener further testified that plaintiff's appendicitis (and first surgery) was a complicated case. In a simple case of appendicitis, patients present after 24 to 48 hours of pain, initially as a vague abdominal pain and then as one in the right lower quadrant. Complicated appendicitis, such as plaintiff's case, presents differently, in that the symptoms occur over a longer time and, when the patient presents at the hospital, there are more extensive findings in the CT scan. "Actually sometimes a little bit more difficult to diagnose." Also, in a simple appendicitis, the area of inflammation is limited to the appendix or the mesoappendix. In a more complicated appendix, the changes are more extensive, including colon thickening and exudates not just on the appendix, but also in the right lower quadrant or throughout the abdomen.

¶ 19 In terms of visualizations in a complicated case, Dr. Shoener testified that it is "extremely difficult" to visualize because the tissues are inflamed, thickened, and there's fluid in the area. Structures such as the cecum and small intestine can be visualized with the camera, but "as far as

seeing specific tenial bands, it gets very, very difficult." Also, generally, appendectomy surgeries can take anywhere from 20 minutes to several hours. Plaintiff's first surgery took 46 minutes.

¶ 20 Before plaintiff's case, Dr. Shoener had never before removed a piece of appendix epiploica and thought it was the appendix. Addressing why he believed the structure he identified was the appendix and mesoappendix, Dr. Shoener explained:

> "There are actually a multitude of reasons. The first thing I did when I got into the abdominal cavity is you get kind of a sense of reference. You identify where – you can see where the cecum is. You can see where the small intestine is and generally where it is going into the cecum. Again, this is all framed in those, you know, intense inflammatory changes that you saw on that picture.
>
> Basically I saw a structure in the area where I would normally expect to see an appendix. The reason I thought that this was an appendix was because it was about the length of an appendix. It had kind of a bulbous end like I normally see with an appendix. It was thickened.
>
> When you grab fat, sometimes those graspers that I showed you kind of completely go through the fatty tissue. This structure had some substance to it. So I was able to grasp it and elevate it anteriorly like I described, like I should be able to with an appendix.
>
> I saw a fecalith, which is consistent with perforated appendicitis. That was next to an area, kind of a notch in the mid portion of the structure, where I typically see an appendicitis periphery. It tends to be on the anterior border, what we call the antimesenteric border. To me, that was consistent with perforated appendicitis and kind

> of a hostile operative field. Laterally or on the outside, I saw an abscess. This is that collection of pus, which I do see with perforated appendicitis.
>
> So in my mind, this all made sense. Even though there was a lot of inflammation, everything kind of came together. Even when I was dissecting out the structure, I saw what looked like an appendiceal artery. I took some time to make sure that this structure was going into the cecum like an appendix should. So putting all those things together, that's why I came to the conclusion that this was appendicitis, and that's why I removed that structure that day."

¶ 21 During the first surgery, Dr. Shoener also drained an abscess, removed the fecalith, irrigated plaintiff's bowel, and inserted a drain in her abdomen to drain out any fluid or other infected material. He then placed her on antibiotics. All of these actions, he testified, were advantageous to plaintiff. After he found out the following day that he had not removed the appendix, Dr. Shoener contacted the pathologist to discuss his findings. He also called the hospital and spoke with the nurse. Dr. Shoener learned that plaintiff was stable and that her pain was controlled (a 4 on a scale of 1 to 10). He ordered a CT scan that day of her abdomen and pelvis, which revealed inflammatory change; it did not show the appendix. Dr. Shoener explained that the fluids put in her body (for the surgery) caused the results to look like there was more inflammation than before. He also spoke with plaintiff. Plaintiff wanted Dr. Shoener to perform the second operation, which he performed on September 4, 2008. He recommended to plaintiff that it be performed as an open laparotomy because: (1) there was still some diagnostic uncertainty (the CT scans did not show the appendix, she had a history of breast cancer, and plaintiff's husband wanted Dr. Shoener to look at plaintiff's liver); and (2) there was

inflammatory change, and he believed he could better perform the operation (if plaintiff had appendicitis) through an open procedure rather than laparoscopically.

¶ 22 During the second surgery, which was one hour and 10 minutes long, Dr. Shoener made the incision below plaintiff's belly button and to her pubic bone; after he entered the abdominal cavity and saw the degree of inflammation, he extended the incision a little above the belly button. However, even with the larger incision, he could not locate the appendix (*i.e.*, by first visualizing the cecal appendiceal junction). Ordinarily, he would pick up the cecum or move it to the side. Here, because of the inflammation, he went to the side and divided the attachments where the cecum attaches to the peritoneum on the side. He turned over the cecum and saw the appendix. However, the appendix was embedded into the cecum ("It was just kind of part of the outside wall of the cecum.") Dr. Shoener removed the appendix and divided the mesoappendix. Plaintiff was discharged from the hospital on September 14, 2008. She followed up with four office visits, and her recovery went "quite well."

¶ 23 Dr. Shoener further testified that, to a reasonable degree of medical certainty, he complied with the standard of care of a reasonably careful general surgeon in all aspects of treating plaintiff from September 2, 2008, through November 7, 2008. He explained that, even though he did not remove plaintiff's appendix, his thought process was correct in a "very difficult and complicated case of appendicitis." Dr. Shoener disagreed that he misdiagnosed plaintiff's condition. "I think I used judgment. I think I removed a structure that I thought was the appendix. It's true, ultimately, that it was not the appendix." Plaintiff's white blood cell count was normal (*i.e.*, about 10,000) on September 2, 2008, but was high (*i.e.*, 17,000) on September 4, 2008. Dr. Shoener explained that, after you remove an abscess, which he did on September 2, 2008, the white blood cell count rises.

¶ 24 He summarized plaintiff's case as a "perfect storm," in that it was a complicated appendicitis (so, there was a lot of inflammation), her appendix was retrocecal (tucked behind the cecum), and there was another structure (appendices epiploica) present that "we normally don't see there. *** So it's kind of a combination of those three factors that led me down this path."

¶ 25 Dr. Shoener testified that the appendix could not have been removed laparoscopically during the initial surgery:

> "I don't believe so. And the reason is that, again, I removed the structure that I thought was the appendix. Given what I saw at the time of that operation, [if] the skies had parted and somebody touched the back of my shoulder and said that's not the appendix, I would have opened at that time. I would not have proceeded laparoscopically."

¶ 26 B. Plaintiff

¶ 27 Plaintiff, age 60, testified that she has been married for 38 years and lived in St. Charles at the time of the surgeries at issue. She has two children and two grandchildren. Between 2000 and 2008, plaintiff saw her children and grandchildren two to three times per week; she also played tennis two to three times per week.

¶ 28 On September 1, 2008, plaintiff went to the emergency room at Delnor Community Hospital. Five or six days earlier, she had started experiencing a stomach pain that felt like a muscle pull. On September 1, 2008, the pain, which was near her belly button, "was intense." The emergency room doctor examined plaintiff and ordered a CT scan, which revealed a ruptured appendix. Plaintiff was instructed to select a surgeon. An acquaintance of plaintiff's

had spoken positively about Dr. Shoener, and plaintiff selected him as her surgeon. The surgery was scheduled for the following day, and plaintiff was administered morphine.

¶ 29 When Dr. Shoener met with plaintiff before the first surgery, he did not mention that she might need a second surgery. After the first surgery and after the anesthesia had worn off, plaintiff experienced a lot of pain; more than before her hospital admission. She could not sleep or lie still, and she asked for stronger pain medication. Between the two surgeries, plaintiff experienced the "worst pain I've ever had in my life. Scary. Wouldn't go away. Never went away." Over time, plaintiff was administered Dilaudid, which provided some relief, but she asked for more medication when it wore off. "I couldn't sit up, I couldn't talk, I couldn't eat, I couldn't go to the bathroom. I couldn't do anything."

¶ 30 On September 3, 2008, Dr. Shoener called plaintiff and told her that the pathologist had informed him that the appendix was not removed; instead, he had removed a piece of fat. According to plaintiff, Dr. Shoener also stated that the pathologist was wrong. He ordered another CT scan. On the morning of September 4, 2008, Dr. Shoener came to plaintiff's hospital room and told her that he was going to have to perform a second surgery. "He said the reason was there was stool in my drain and my white cell count was elevated." Plaintiff was scared, confused, sick, and felt like she was going to die.

¶ 31 Plaintiff had one drain after the first surgery, and she had several more after the second surgery (including a catheter in her nose and an IV). She stayed in bed. Plaintiff felt a lot of pain from the incision. She had no bowel movements until five days after the second surgery, and, "from then on[,] it was constant diarrhea." She was also very nauseated. It was not until a couple of days before she was discharged from the hospital on September 14, 2008, that she started to feel better; she was able to eat at this time. She was administered antibiotics during her

entire stay and received a prescription for more when she was discharged. At home, plaintiff required her husband's and her mother's help with "everything."

¶ 32 Plaintiff could not drive until one month after she returned home. She did not feel fully healed until six months after the second surgery. During the six months, she felt much pain and discomfort before a bowel movement. She had a seven-inch incision.

¶ 33 Plaintiff further testified that she has ongoing problems as a result of the surgeries, including a weakness in her core, which she experiences daily. She is unable to sit up without assistance; has weakness standing up from the floor, cannot lift her grandchildren or heavy objects. She limits herself. Plaintiff further testified that she returned to playing tennis about three months after her surgery (December 2008). She has not done any activities to strengthen her core. Plaintiff's medical bills from the second surgery totaled $72,442.02.

¶ 34 C. Dr. Paul E. Collier

¶ 35 Dr. Paul E. Collier, a 28-year board-certified general surgeon (with qualifications in vascular surgery), testified as plaintiff's expert witness. Dr. Collier has testified in the past, about 70% of the time on behalf of injured plaintiffs. During his entire career, Dr. Collier has performed at least 1,000 appendectomies, about one third of which were laparoscopic. In 2008, nearly all of the appendectomies Dr. Collier performed were done laparoscopically. He gave a number of opinions, all of which were given to a reasonable degree of medical certainty.

¶ 36 Dr. Collier opined that Dr. Shoener's care of plaintiff was below the accepted standard of care (*i.e.*, negligent) because he did not remove her appendix on September 2, 2008. As a result, plaintiff suffered an injury, including that she remained in pain for two extra days, required a second operation that was performed through a large midline incision, experienced post-

operative problems (severe pain, bowel obstruction, wound infection, and fluid overload), and core muscle weakness.

¶ 37 Dr. Collier explained that appendicitis is a very common condition. Most appendectomies are "pretty simple straightforward operations." The appendix is a small closed tube that comes off of the base of the cecum (which is the start of the colon). When there is an obstruction (with lymph nodes that swell or a piece of feces or a seed), it blocks the appendix. The appendix then swells and causes pain. Over time, as the swelling increases, blood vessels start to die and the appendix starts to die.

¶ 38 In Dr. Collier's opinion, there was no reason plaintiff's appendix could not be removed laparoscopically on September 2, 2008. Dr. Collier testified that there is nothing prohibiting the laparoscopic removal of an appendix, other than "intense scarring or something. The only reason you would not do it laparoscopically [is] if you were concerned you were going to injure something else." Plaintiff's appendix was *not* fully retrocecal. (About 20% of appendixes are in the retrocecal position.) It was more medial or anterior towards the front.

¶ 39 Plaintiff has a core weakness and the condition is permanent. Had Dr. Shoener successfully performed the laparoscopic appendectomy on September 2, 2008, plaintiff would not have sustained core muscle weakness. This constituted a breach of the standard of care; additionally, the injury would not have occurred in the absence of negligence. However, Dr. Collier has not examined plaintiff and, generally, if he was asked to evaluate whether she had core muscle weakness, he would refer her to a physiatrist.

¶ 40 According to Dr. Collier, the standard of care for locating an appendix during a laparoscopic appendectomy is as follows: first, about half of the time, "you put your scope in and say there's the appendix"; and second, or the other half of the time, the surgeon may have to

move over the intestines, grab the cecum and pull it toward himself or herself, toward the belly button, to see the cecal appendiceal junction. "The whole trick is to find the cecum and to roll it up so the appendix comes with it." Referring to plaintiff's exhibit No. 3, Dr. Collier explained that the "tenia come right here. Here is another tenia. Here is the back tenia coming here at the appendix." The point where the appendix connects to the cecum is not a broad area; Dr. Shoener was incorrect in his anatomy when he stated otherwise. The point where the appendix connects to the cecum is at that point where the three teniae come together. In contrast, the "appendix epiploica are not at the convergence of the three teniae." This is so because:

> "[n]othing else can be there. There is only enough space for the appendix, so you don't get appendix epiploica there. The appendix epiploica are usually shorter. They look yellowish, more like the fatty tissue. Whereas the appendix has this mesoappendix which obviously looks fatty but it also has this pinkish or grayish silvery structure, this tubular structure coming off, and it's generally longer than the appendix epiploica."

¶ 41 Addressing the importance of visualizing the point where the three teniae come together at the cecal appendiceal junction, Dr. Collier testified that "if you can clearly visualize where the three teniae are coming together, then you're sure what's coming off there is the appendix." The standard of care in terms of differentiating between the vermiform appendix and the appendix epiploica, once the cecal appendiceal cecal junction is located: "[w]ell, again, the first thing is as in real estate[,] location, location, location. You've got the location. You should be sure that's the appendix. The color and size is another tip-off. The fact that an appendix epiploica does not have an mesoappendix." Further, after the appendix is cut, the surgeon inspects the staple line. "If it is an appendix epiploica, there is still a little bit of tissue on the far side of the staples. It's not like it's perfectly stapled down." A doctor will see the fat, whereas, with an appendix, he or

she will see what looks like lumen (*i.e.*, the internal tube of the appendix) and mucosa. A patient returns home after a laparoscopic appendectomy in one or two days.

¶ 42 According to Dr. Collier, Dr. Shoener "was attempting – he thought he was mobilizing the appendix, but he was further up the cecum because he didn't follow the teniae. He was actually mobilizing a piece of the colon upstream from where the appendix was. He just mistook it calling it the appendix when it really wasn't. *** He said the appendiceal artery was divided, but again the appendix epiploica doesn't have an artery. *** He must have made a hole through the appendix epiploica assuming – I can't imagine what he was seeing. And then put the stapler." "He somehow divided this or made a split in this thing and figured one side was the artery and one side was the appendix."

¶ 43 It would have been within the standard of care if Dr. Shoener converted the first surgery to an open laparotomy if he felt he was not going to damage any other structure. If he had converted the surgery, he would have been able to do the McBurney's incision, not the "monstrous incision" he made during the second surgery. Dr. Collier has never performed an open appendectomy with a vertical incision above and below the belly button; he cannot think of one that would require such an incision. Although inflammation and scarring make an operation more difficult, under the circumstances of this case, "most likely," the second surgery could have been performed laparoscopically.

¶ 44 Dr. Collier testified that plaintiff's case was *not* complicated. "I mean, an appendectomy is not a very complicated procedure to start with in terms of general surgery. It didn't appear to be complicated from the CT scan or what he saw in there." Dr. Shoener deviated from the standard of care in not differentiating between the vermiform appendix and the appendix epiploica, and he deviated from the standard of care when he failed to properly identify or locate

plaintiff's vermiform appendix during the first surgery. According to Dr. Collier, Dr. Shoener also deviated from the standard of care in the manner in which he inspected the tissue that he removed during the first surgery: "I don't think he inspected it at all, at least from his operative notes, so that's below the standard of care." If he had inspected it, under the standard of care, he would have determined that there was no lumen. "If you have any doubt, you could cut it in half, do his own mini pathology, just cut it and make sure there is lumen there."

¶ 45 Dr. Shoener complied with the standard of care during the second surgery. Plaintiff's recovery period was within the range to what other people have with open laparotomies.

¶ 46 D. Defendants' Case - Dr. William D. Soper

¶ 47 Dr. William D. Soper, a board-certified general surgeon, testified as defendants' expert witness. About 90% of the cases he has reviewed have been on behalf of defendant physicians. Dr. Soper, who graduated medical school in 1973, testified that Dr. Shoener complied with the standard of care for general surgeons. That is, the fact that Dr. Shoener did not remove the appendix during the first surgery is a recognized risk of laparoscopic surgery that occurred in the absence of negligence. As a result of not having her appendix removed during the first surgery, plaintiff continued to suffer from acute appendicitis up to and including September 4, 2008.

¶ 48 Appendicitis is inflammation of the appendix, almost always involving an obstruction (such as hard stool). It turns into an abscess (pus, with pressure), ruptures, and spills bacteria and possibly feces into the abdomen. Dr. Soper explained that the appendix is not in a fixed position and can be tucked down into the pelvis, next to the small bowel, or behind the cecum. A doctor may not see it at all from the standard view. When there is a perforation in the appendix and an inflammatory process involving the cecum and appendix, "you lose the ability to see that

very well. Everything becomes swollen and thickened and it's difficult to tell sometimes one structure from another. Sometimes you can't see the appendix at all."

¶ 49 Plaintiff's appendicitis was "definitely a complicated" one. The CT scan did not identify the appendix. Dr. Shoener's report described that he had properly performed a laparoscopic appendectomy. Dr. Soper disagreed with Dr. Collier's opinion that the standard of care required that the tissue removed during the first surgery should have been dissected in the operating room by Dr. Shoener. The appendix epiploica is connected to the outer surface of the cecum and into the intestinal tract. The pathologist's report described the appendix epiploica as pink, gray, and yellow, with areas of dark red discoloration and gray/white exudates, and it was 5.5 centimeters long. Plaintiff's actual appendix was described as tan and dull, with areas of dark red discoloration and gray exudates, and it was 6.2 centimeters long. Dr. Soper testified that an appendix epiploica can have the same color and length as an appendix. Here, in terms of gross description, they were "very similar."

¶ 50 During the first surgery, Dr. Shoener saw a piece of tissue that was the same color and size, had the same characteristics, and was in the same location as an appendix. A reasonably careful surgeon viewing through a laparoscope would not see an appendix in the retrocecal position unless he or she mobilized the cecum. During the first surgery, Dr. Shoener achieved draining the abscess, relieved pressure that could have gone into sepsis, cleaned things out (removing infection of the fecalith and pus), and he kept plaintiff on antibiotics.

¶ 51 In Dr. Soper's opinion, it was acceptable to wait until September 4, 2008, to perform the second surgery. If, during the first surgery, Dr. Shoener had recognized that he had not removed the appendix, he would have needed to convert the procedure to an open surgery. This would have been a safer option because he could use his hands, which are gentler than the graspers and

because there is a risk of perforation when trying to mobilize the cecum when it is hard and inflamed. If Dr. Shoener had converted to an open surgery, he would have used the midline incision, just as he did during the second surgery. "I definitely would not use a McBurney's incision through the muscle. That leaves you very limited exposure. And if you ended up with a tumor in the colon, you would still have to close that incision and make another incision in order to take out the part of the colon that needed to be removed. So I think that was definitely the right decision to make."

¶ 52 Dr. Soper opined that, if Dr. Shoener had performed an open laparotomy on September 2, 2008, plaintiff's hospital course and recovery period would probably have been "very similar" to what she experienced after September 4, 2008. "It's hard to know if there would have been, you know, complications or whatnot. But I would think it would have gone the same way and pretty much same recovery."

¶ 53 In a complicated case such as plaintiff's case, the first priority is to avoid causing more harm, treat the infection, and remove the source of the infection. Dr. Shoener did that. He did not cause further harm, he treated the infection by removing the abscess, and he removed what he felt was causing the problem. "He, you know, went there to find a source and felt that he had seen it. The fecalith was sitting right there and I think that that's all within the standard of care. Certainly anyone that's done a lot of appendectomies has been in a similar situation where they could not find the appendix. And I have backed out myself on appendectomies because I couldn't find the appendix and just drained it. And I've seen other times when we've had similar findings with the appendix epiploica."

¶ 54 Dr. Soper did not review plaintiff's actual CT scans, but reviewed the CT scan reports; he does not need to look at the scans themselves. He has never removed a piece of fat or appendix

epiploica and thought he had removed the appendix. In his report, the pathologist had also noted that, in his career, he had never examined a piece of fat that was marked as an appendix. Reasonably careful surgeons can attain at least as good visualization laparoscopically as they can with an open procedure. It is very common for general surgeons to deal with inflammatory changes in performing an appendectomy, and the mere presence of such changes (in the appendix and surrounding tissue) is not a reason for a surgeon to determine that the surgery cannot be performed laparoscopically. In his practice, Dr. Soper has laparoscopically removed appendixes that were in the retrocecal position.

¶ 55 Dr. Soper opined that, assuming Dr. Shoener clearly visualized the cecal appendiceal junction, a reasonably careful surgeon would be able to differentiate between the vermiform appendix and the appendix epiploica. Dr. Soper again addressed visualization of the cecal appendiceal junction:

> "Q. Doctor, in print in Defendant Shoener's own dictation report that he authored at or near the time of the surgery, he reported the cecal-appendiceal junction was clearly visualized; do you see that?
>
> A. I do.
>
> Q. If Defendant Shoener was, as he reports, clearly looking at the cecal-appendiceal junction, you would agree with me that as a reasonable careful general surgeon, he should have been able to differentiate between vermiform appendix and appendix epiploica?
>
> A. If he really clearly visualized it, yes."

¶ 56 Dr. Soper testified that Dr. Shoener did not actually see the cecal appendiceal junction. This was due to the inflammatory changes in the area. The tenia was obscured by severe

inflammation. However, Dr. Soper also testified that, in his operative report, Dr. Shoener did not state that he could not visualize the tenia; he stated that he could clearly visualize the cecal appendiceal junction, which is where the three tenia come together (although he did not use the term tenia). Dr. Shoener did not state in his report that he clearly saw the tenia. Dr. Shoener stated that he saw no reason to convert to an open surgery.

¶ 57 If an appendix is retrocecal, it is possible to have an epiploica in the same area where the appendix would normally be attached to the cecum (or right next to it) at the cecal appendiceal junction. Dr. Soper further testified that reasonably careful surgeons identify what they believe is the appendix and the mesoappendix and identify them independently to confirm they are in the proper location instead of a piece of appendix epiploica. The tenia is one method or roadmap a reasonably careful surgeon uses to identify the connection point for the appendix.

¶ 58 Dr. Soper testified that "I'm sure what he saw was not that," referring to the cecal-appendiceal junction. However, on cross-examination, he testified that, to know whether Dr. Shoener actually saw the junction, he had to rely on what Dr. Shoener said:

> "Q. And in order for a doctor to determine if Defendant Shoener was able to clearly visualize the cecal-appendiceal junction, we need to rely on him because he was the one in the surgery, right?
>
> A. That's right."

¶ 59 Dr. Soper has performed operations where he did not remove the appendix. These situations involved an anatomy that was not clear, was inflamed with an abscess and perforation, and had extensive infection. Other times, it was necrotic and he could not identify "good" anatomy. The safer route was not to dissect things out, but to leave a drain. If a doctor has doubts about whether he or she has removed an appendix, the doctor needs to look at it outside

the body to see if there is a lumen, or he or she can have the pathologist come to the operating room to look at it.

¶ 60 In a complicated case, the patient does not ordinarily go home in less than two or three days. If Dr. Shoener had known that the appendix was not removed, Dr. Soper does not know if he would have tried again with the scope. "But in very badly inflamed tissues, [it] may be appropriate just to go straight to the laparotomy."

¶ 61 E. Verdict and Subsequent Proceedings

¶ 62 The jury returned a verdict in defendants' favor, and the trial court entered judgment on December 19, 2013. Plaintiff filed a post-trial motion seeking judgment *n.o.v.* or, alternatively, a new trial, arguing that Dr. Shoener had testified that he clearly visualized the cecal appendiceal junction, which constituted a judicial admission, and that Dr. Soper had testified that the standard of care requires that a reasonably careful general surgeon who clearly visualizes the junction must differentiate between the vermiform appendix and an appendix epiploica; further, it was undisputed that Dr. Shoener had failed to properly differentiate between the two structures.[1] On May 20, 2014, the trial court denied the motion, finding that, although Dr. Shoener stated that he did clearly visualize the cecal appendiceal junction, "his other testimony at trial casts doubt on how unequivocal the statement really was." Further, the court found that it was not apparent that Dr. Shoener's statements concerned a concrete fact, as opposed to an opinion. In denying plaintiff's motion for a new trial, the trial court found that both Dr. Shoener and Dr. Soper testified that Dr. Shoener complied with the standard of care in that there were significant inflammatory changes and that he visualized a structure with characteristics like an appendix.

[1] Plaintiff had raised the same arguments in her motion for a directed verdict at the close of defendants' case. The trial court denied her motion.

Further, Dr. Soper testified that the fact that the appendix was not removed can occur in the absence of negligence and is a recognized risk of laparoscopic surgery. Plaintiff appeals.

¶ 63 II. ANALYSIS

¶ 64 A. Motion for Judgment *N.O.V.*

¶ 65 Plaintiff first argues that the trial court erred in denying her motion for judgment *n.o.v.* She contends that both Dr. Shoener's and Dr. Soper's testimony established that Dr. Shoener breached the standard of care, which proximately caused plaintiff's injury. The focus of plaintiff's appeal is based upon Dr. Shoener's and the experts' (Dr. Soper's and Dr. Collier's) agreement that the standard of care required that, *if Dr. Shoener was able to clearly visualize the cecal appendiceal junction during the first surgery*, he differentiate between the vermiform appendix and an appendix epiploica. Plaintiff's position is that Dr. Shoener *unequivocally* testified that he was able to clearly visualize the cecal appendiceal junction during plaintiff's first surgery (and still believes that he visualized it) and that this constitutes a judicial admission, establishing a breach of the standard of care. Defendants respond that Dr. Shoener's testimony reflected that, in retrospect, he believes that he did not actually see the cecal appendiceal junction and, thus, his statement is a mistaken opinion and cannot constitute a judicial admission. For the following reasons, we agree with defendants that Dr. Shoener's testimony did not constitute a judicial admission and reject plaintiff's claims.

¶ 66 "[V]erdicts ought to be directed and judgments *n.o.v.* entered only in those cases in which all of the evidence, when viewed in its aspect most favorable to the opponent, so overwhelmingly favors [a] movant that no contrary verdict based on that evidence could ever stand." *Pedrick v. Peoria & Eastern R.R. Co.*, 37 Ill. 2d 494, 510 (1967). Judgment *n.o.v.* is not appropriate if "reasonable minds might differ as to inferences or conclusions to be drawn from

the facts presented." *Pasquale v. Speed Products Engineering*, 166 Ill. 2d 337, 351 (1995). When a trial court has erroneously denied a motion for judgment *n.o.v.*, we reverse the verdict without a remand. *Maple v. Gustafson*, 151 Ill. 2d 445, 454 (1992). We review *de novo* the trial court's denial of a motion for judgment *n.o.v. Lazenby v. Mark's Construction, Inc.*, 236 Ill. 2d 83, 100 (2010).

¶ 67 Dr. Soper, plaintiff notes, testified that, to know whether Dr. Shoener in fact visualized the junction, he had to rely on what Dr. Shoener himself stated. According to plaintiff, Dr. Shoener unequivocally testified that he was able to visualize the cecal appendiceal junction during plaintiff's first surgery:

> "Q. And when you were performing the laparoscopic appendectomy on [plaintiff], you were able to clearly visualize her cecal appendiceal junction; correct?
>
> A. I'm sorry, that was the first surgery?
>
> Q. Yes.
>
> A. I believe given the amount of inflammation that she had that I immobilized the structure enough that, yes, I did visualize – I did clearly visualize that."

¶ 68 Plaintiff further contends that Dr. Shoener's foregoing trial testimony was consistent with his statement in his operative report that "[t]he cecal-appendiceal junction was clearly visualized." She also notes that Dr. Shoener was given the opportunity to explain whether, in hindsight, he felt that he had not clearly visualized the junction at the time:

> "Q. And so that's what you're trained – that's your job, is to go in there and weed through that. My point is if you ever can't see what you're doing, then you don't just keep doing it without seeing, if it is a critical part of the surgery; correct?

A. It becomes a judgment call then. It's a real-time decision, you know; am I at a point where I can't do the surgery and have to make a bigger incision.

Q. Right. And if you couldn't see critical parts of [plaintiff's] surgery, you would have converted to an open procedure; correct?

A. Possibly, yes.

Q. But we know, in [plaintiff's] case, you didn't have that problem because you specifically were able to visualize the critical parts of the surgery when you were using the laparoscope; correct?

A. Well, it was my judgment that I could go ahead and proceed with that surgery safely laparoscopically.

Q. That wasn't my – my next question is, you could visualize clearly the critical aspects of [plaintiff's] surgery that you needed to see; correct?

A. In my judgment, I could, yes.

Q. Do you now believe that judgment was flawed?

A. No." (Emphasis added.)

¶ 69 Plaintiff argues that Dr. Shoener's testimony that he could clearly visualize the cecal appendiceal junction during the first surgery constitutes a judicial admission that cannot be contradicted by speculation from Dr. Soper or any other witness. We disagree.

¶ 70 The question whether a statement constitutes a judicial admission has been reviewed on appeal utilizing both the *de novo* and abuse-of-discretion standards of review. *Crittenden v. Cook County Comm'n on Human Rights*, 2012 IL App (1st) 112437, ¶ 46 (citing cases). This court applies the abuse-of-discretion standard, but has noted that "a case applying the abuse-of-discretion standard still requires the statement to be 'clear, unequivocal, and uniquely within the

party's personal knowledge' [citation], and a case applying *de novo* review also looks at the context of the statement [citation]." *Kovac v. Barron*, 2014 IL App (2d) 121100, ¶ 60, n.3. Our holding is the same under either standard of review.

¶ 71 A judicial admission is a deliberate, clear, unequivocal statement of a party about a concrete fact within that party's peculiar knowledge. *In re Estate of Rennick*, 181 Ill. 2d 395, 406 (1998). In contrast, a statement that is a matter of opinion, estimate, appearance, inference, or uncertain summary is not a judicial admission (but is an evidentiary admission). *Caponi v. Larry's 66*, 236 Ill. App. 3d 660, 671 (1992).

¶ 72 A judicial admission "carries with it an admission of other facts necessarily implied from it." *Id.* Judicial admissions are binding on the party making them, and they may not be controverted at trial or in a motion for summary judgment. *Rennick*, 181 Ill. 2d at 406-07; see also *Tom Olesker's Exciting World of Fashion, Inc. v. Dun & Bradstreet, Inc.*, 71 Ill. App. 3d 562, 568 (1979) (a party cannot introduce an affidavit or testify contrary to a prior judicial admission). Ordinary evidentiary admissions, however, may be controverted or explained. *Rennick*, 181 Ill. 2d at 406.

¶ 73 " 'Judicial admissions are not evidence at all but rather have the effect of withdrawing a fact from contention.' " *Pryor v. American Central Transport, Inc.*, 260 Ill. App. 3d 76, 85 (1994) (quoting M. Graham, Evidence Text, Rules, Illustrations and Problems, at 146 (1983)). "The purpose of the rule is to remove the temptation to commit perjury." *Rennick*, 181 Ill. 2d at 407. Included within the rule are admissions in court. *Dora Township v. Indiana Insurance Co.*, 67 Ill. App. 3d 31, 33 (1979). "A party cannot create a factual dispute by contradicting a previously made judicial admission." *Burns v. Michelotti*, 237 Ill. App. 3d 923, 932 (1992). However, " '[t]he doctrine of judicial admissions requires thoughtful study for its application so

that justice not be done on strength of a chance statement made by a nervous party.' " *Smith v. Pavlovich*, 394 Ill. App. 3d 458, 468 (2009) (quoting *Thomas v. Northington*, 134 Ill. App. 3d 141, 147 (1985)).

¶ 74 Further, a statement must be given a meaning consistent with the context in which it is found and considered in relation to the other testimony and evidence presented. *Augenstein v. Pulley*, 191 Ill. App. 3d 664, 671 (1989). A statement does not constitute a judicial admission when the party's testimony is inadvertent, uncertain, amounts to an estimate or opinion, or relates to a matter as to which the party could easily have been mistaken. *Brummet v. Farel*, 217 Ill. App. 3d 264, 268-69 (1991) (swiftly moving events preceding a collision). See also *Hanson v. Darby*, 100 Ill. App. 2d 339, 348-49 (1968) ("party may not be absolutely concluded by his admissions as to physical facts. If his testimony with reference to physical facts is doubtful or inconclusive, or if other testimony or evidence is contradictory and persuasive, the effect of the party's testimony" is for the jury to assess); *Lindenmier v. City of Rockford*, 156 Ill. App. 3d 76, 87-88 (1987) (mistaken perception of traffic signal); compare *Caponi*, 236 Ill. App. 3d at 671-673 (the defendant's deposition testimony that he had a solid brake pedal, that it was all the way to the top, and that it would not move down at all did not contain any equivocation and constituted a judicial admission; condition of the brake pedal before the collision was not an opinion, estimate, or inference, but was an observed fact solely within the declarant's knowledge; trial court properly struck defense expert's contradictory testimony). The evaluation should be made based upon the declarant's (and the contradictory occurrence testimony of other parties, *not* an expert witness) entire testimony, not just a part of it. *Caponi*, 236 Ill. App. 3d at 672. "[A]ny admissions not the product of mistake or inadvertence become binding judicial admissions." *Rynn v. Owens*, 181 Ill. App. 3d 232, 235 (1989). "Because penalizing confusion

or an honest mistake is not among the purposes of the doctrine of judicial admissions, it must appear that the party making the statement had no reasonable probability of being mistaken in order for the statement to qualify as a judicial admission." *Herman v. Power Maintenance & Constructors, LLC*, 388 Ill. App. 3d 352, 361 (2009).

¶ 75 Here, plaintiff argues that the question whether Dr. Shoener visualized the cecal appendicual junction during the first surgery is something within his particular knowledge and that his ability to see it is a concrete fact; thus, it constitutes a judicial admission. Further, she asserts that Dr. Shoener testified clearly and unequivocally to this. He was asked whether, in retrospect, he believed that his judgment was incorrect about whether he visualized all of the critical aspects of the surgery that he needed to see, and he clarified that his judgment was not incorrect. Plaintiff agrees that Dr. Shoener mentioned several times that he encountered inflammatory changes in plaintiff's abdomen during her surgery, but she contends that none of his testimony contradicted or created a factual dispute as to his testimony that he "believe[s] given the amount of inflammation that she had that [he] immobilized [*sic*] the structure enough that, yes *** [he] did clearly visualize that [*i.e.*, the cecal appendiceal junction]." Also, plaintiff notes that Dr. Shoener agreed that reasonably careful general surgeons know what the cecal appendiceal junction is and know how to locate it. She contends that the foregoing statement reflects that he did clearly visualize the cecal appendiceal junction despite inflammatory changes and that there was nothing in his testimony that raises the inference that he actually did not visualize it; thus, his statement constitutes a judicial admission.

¶ 76 Plaintiff further asserts that Dr. Shoener testified that he clearly visualized the cecal appendiceal junction. She urges that whether a person saw a particular thing is a fact, not an opinion, and constitutes a judicial admission. Plaintiff argues that it is speculative for anyone

other than Dr. Shoener to assume that he did not actually visualize the junction based on the fact that he misidentified an appendix epiploica as being the vermiform appendix and removed the wrong structure. Dr. Shoener, plaintiff again urges, is an experienced surgeon who knows what anatomic structures he is seeing during surgery. It is not his opinion, she argues, that he visualized these structures during surgery; it is a fact established by his own testimony and it is not subject to different interpretations. Finally, plaintiff also argues that Dr. Soper agreed that, if Dr. Shoener in fact visualized the junction, then, as a reasonably careful surgeon, he should have been able to differentiate between the vermiform appendix and an appendix epiploica. Dr. Soper's testimony also established a breach, she urges, of the standard of care, in that he testified that Dr. Shoener failed to differentiate the structures.

¶ 77 We agree with the trial court that Dr. Shoener's statement did not constitute a judicial admission. We begin by examining his testimony as a whole. Given the context of his other testimony and the fact that the statement is subject to different interpretations, we conclude that the statement was not unequivocal. Dr. Shoener's testimony, as a whole, did not reflect that he stated that he actually visualized the cecal-appendiceal junction or the vermiform appendix. Rather, as a whole, he testified that the structure he described in his operative report was what he *thought at the time* was the cecal appendiceal junction and he admitted that, if he had seen the true junction, then he would have seen the vermiform appendix, which, in retrospect, he did not.

¶ 78 Plaintiff primarily relies on the following exchange:

> "Q. And when you were performing the laparoscopic appendectomy on [plaintiff], you were able to clearly visualize her cecal appendiceal junction; correct?
>
> A. I'm sorry, that was the first surgery?
>
> Q. Yes.

A. I believe given the amount of inflammation that she had that I immobilized the structure enough that, yes, I did visualize – I did clearly visualize that."

In our view, the foregoing testimony, on its own, reflects that Dr. Shoener is describing his thoughts either at the time of the surgery and/or his view afterwards. The following exchange (and others described below), however, provides some more clarity:

"[Plaintiff's Counsel]: If you were looking at the anatomical location of the cecal appendiceal junction when you said you clearly visualized that specific anatomical spot, the vermiform appendix should have been right there, correct?

[Dr. Shoener]: Not – in my report I was describing what I thought I was visualizing.

[Plaintiff's Counsel]: I understand that. But what I'm asking you is if you were truly, as you used the word, if you were at the true cecal appendiceal junction in your operative report, you should have seen the vermiform appendix there even if it was right next to the piece of fat that you removed, correct?

[Dr. Shoener]: Correct. I don't disagree if I had seen that junction that I would be where the appendix was."

Plaintiff asserts that the foregoing exchange is consistent with the one previously quoted and does not contain a statement or implication that, in retrospect, he does not believe he clearly visualized the cecal appendiceal junction. She argues further that the testimony does not contain any equivocation by Dr. Shoener about his belief, given the amount of inflammation plaintiff had, that he clearly visualized the junction. Plaintiff further claims that Dr. Shoener did not state that he did not visualize the cecal appendiceal junction. She asserts that, when he stated that he described in his report what he thought he was visualizing, this was fully consistent with the

previously quoted, ambiguous exchange where he testified that he "did visualize" the junction (further noting that the testimony was in the present tense—*i.e.*, something he believed at the time of his testimony).

¶ 79 Plaintiff's argument that none of Dr. Shoener's answers amount to equivocation that he was able to see the junction given the amount of inflammation plaintiff had is unavailing. This is so because his testimony, as a whole, reflects that, in hindsight, he did not visualize the true cecal appendiceal junction:

> "Q. Would one of the reasons the structure – we know it wasn't the appendix. When you described [in the operative report] a thickened appendix was identified, what you were looking at was not the appendix.
>
> Will you agree with that as we sit here today?
>
> A. In retrospect, yes."

He further testified, "I think I used judgment. I think I removed a structure that I *thought* was the appendix. It's true, ultimately, that it was not the appendix." (Emphasis added.) Addressing his operative report, again, Dr. Shoener testified:

> "[Plaintiff's Counsel]: If you were looking at the anatomical location of the cecal appendiceal junction when you said you clearly visualized that specific anatomical spot, the vermiform appendix should have been right there, correct?
>
> [Dr. Shoener]: *Not – in my report I was describing what I thought I was visualizing.*
>
> [Plaintiff's Counsel]: I understand that. But what I'm asking you is if you were truly, as you used the word, if you were at the true cecal appendiceal junction in your

operative report, you should have seen the vermiform appendix there even if it was right next to the piece of fat that you removed, correct?

[Dr. Shoener]: *Correct. I don't disagree if I had seen that junction that I would be where the appendix was*." (Emphases added.)

¶ 80 Having examined Dr. Shoener's testimony as a whole and having concluded that he testified, as a whole, that he mistakenly believed he had identified the cecal appendiceal junction during the first surgery, we turn next to assess the implications of this testimony. Plaintiff argues that whether Dr. Shoener visualized the cecal appendicial junction during the first surgery is an observed fact solely within his knowledge. We reject this argument. We agree with the trial court that Dr. Shoener's testimony was not a concrete fact, but a matter of opinion. It constitutes his mistaken perception at the time of surgery. As such, it does not constitute a judicial admission. See *Brummet*, 217 Ill. App. 3d at 268-69 (statement that relates to a matter as to which a party could easily have been mistaken does not constitute a judicial admission); *Rynn*, 181 Ill. App. 3d at 235 (same); see also *Herman*, 388 Ill. App. 3d at 361 (same). *Caponi*, upon which plaintiff relies, is not on point because it involved an expert, non-occurrence witness whose testimony was used in an unsuccessful attempt to cast doubt (*i.e.*, render equivocal) on the defendant's testimony concerning his observations prior to a collision. *Caponi*, 236 Ill. App. 3d at 671-73.

¶ 81 Finally, we address *Carman v. Dippold*, 63 Ill. App. 3d 419 (1978), a medical malpractice case upon which plaintiff relies. We conclude that her reliance on *Carman* is misplaced because that case did not involve a dispute with regard to the defendant's testimony. In *Carman*, the jury entered a verdict in favor of the defendant obstetrician after the defendant delivered the plaintiff's baby, who was in the breech position, through the birth canal and the

baby died several hours later. During the breech delivery, the defendant did not use (or have available) forceps; rather, he used a maneuver in which he inserted two fingers in the baby's mouth to lower his chin. It took the defendant 10 minutes to deliver the aftercoming head, during which time the baby's oxygen supply was cut off, and, as a result, the baby died. At trial, the plaintiff's two expert witnesses testified that, during the delivery of a baby in breech position to a first-time mother, such as the plaintiff, Piper forceps should have been used if other maneuvers proved unsuccessful. The defendant presented no expert testimony in support of his continued use of the alternative procedure. The appellate court held that the trial court erred in denying the plaintiff's motion for judgment *n.o.v.* on the forceps issue. *Id.* at 428. It noted that the three medical experts were "in total accord as to the proper standard of care." *Id.* at 427. That testimony established a standard of care that included the availability and use of Piper forceps. *Id.* at 428. The evidence strongly indicated that the failure to follow that standard proximately caused the baby's death. *Id.*

¶ 82 Here, plaintiff argues that this case is similar to *Carman* because both Dr. Soper and Dr. Collier testified that the standard of care required that, if Dr. Shoener could clearly visualize the cecal appendiceal junction, he differentiate between the vermiform appendix and an appendix epiploica. We disagree that *Carman* is helpful to plaintiff's case. It is factually distinguishable, and did not involve a dispute concerning the defendant's testimony. Here, in contrast, there is a dispute as to whether or not Dr. Shoener now believes that he visualized the cecal appendiceal junction during the first surgery.

¶ 83 In summary, we reject plaintiff's argument that Dr. Shoener's testimony constituted a judicial admission. Viewing the evidence in the light most favorable to Dr. Shoener, the nonmovant, specifically, that Dr. Shoener did not actually see the cecal appendiceal junction

during the first surgery and accepting Dr. Soper's, defendants' expert's, testimony that Dr. Shoener did not breach the standard of care and that the failure to remove a plaintiff's appendix is a recognized risk of laparoscopic surgery that can occur in the absence of negligence, the trial court property denied plaintiff's motion for judgment *n.o.v.* See *Maple*, 151 Ill. 2d at 454 ("The court has no right to enter a judgment *n.o.v.* if there is any evidence, together with reasonable inferences to be drawn therefrom, demonstrating a substantial factual dispute, or where the assessment of credibility of the witnesses or the determination regarding conflicting evidence is decisive to the outcome.").

¶ 84 B. Motion for a New Trial

¶ 85 Next, plaintiff argues in the alternative that the trial court erred in denying her motion for a new trial. We disagree.

¶ 86 In contrast to a motion for judgment *n.o.v.*, "[o]n a motion for a new trial[,] a court will weigh the evidence and set aside the verdict and order a new trial if the verdict is contrary to the manifest weight of the evidence." *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38. "A verdict is against the manifest weight of the evidence where the opposite conclusion is clearly evident or where the findings of the jury are unreasonable, arbitrary and not based upon any of the evidence." *Villa v. Crown Cork & Seal Co.*, 202 Ill. App. 3d 1082, 1089 (1990).

¶ 87 Here, plaintiff argues that the evidence was undisputed that Dr. Shoener breached the standard of care, which proximately caused her injuries. She asserts that the expert testimony was in accord as to what the standard of care required if Dr. Shoener was able to clearly visualize the cecal appendiceal junction, which, again, she argues he unequivocally stated that he was able to visualize, an argument we rejected above.

¶ 88 Plaintiff has not established that the trial court abused its discretion in assessing the jury's verdict, which, in our view, was not unreasonable. The evidence was sufficient to establish that Dr. Shoener did not breach the standard of care. Dr. Shoener's testimony reflected that plaintiff's case presented with significant inflammatory changes. His testimony concerning his visualization of the cecal appendiceal junction did not, as we determined above, constitute a judicial admission and, thus, it was for the jury to assess his credibility on this issue. We cannot conclude that its resolution was unreasonable. *Serrano v. Rotman*, 406 Ill. App. 3d 900, 910 (2011) (in the case of conflicting testimony, "the question of whom to believe and what weight to give to all the evidence [i]s a decision for the trier of fact, whose determinations should not be upset on review unless manifestly erroneous"). Dr. Soper, defendants' expert, testified that the fact that the vermiform appendix was not removed during the surgery can occur in the absence of negligence and is a recognized risk of laparoscopic surgery. Although Dr. Collier, plaintiff's expert, disagreed, testifying that Dr. Shoener breached the standard of care, it was, again, for the jury to assess their credibility and resolve this conflict. We cannot conclude that the trial court erred in assessing the jury's verdict in defendants' favor and denying plaintiff's motion for a new trial.

¶ 89 III. CONCLUSION

¶ 90 For the reasons stated, the judgment of the circuit court of Kane County is affirmed.

¶ 91 Affirmed.