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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

RAYMOND SEIBERT,)	Appeal from the Circuit Court
)	of McHenry County.
Plaintiff-Appellant,)	
)	
v.)	No. 11-LA-374
)	
EUGENE LEE, M.D., Individually, and as)	
Agent for RICHARD E. LIND, M.D., S.C.,)	
d/b/a SURGICAL ASSOCIATES OF FOX)	
VALLEY,)	Honorable
)	Thomas A. Meyer,
Defendants-Appellees.)	Judge, Presiding.

JUSTICE BURKE delivered the judgment of the court.
Presiding Justice Schostok and Justice Spence concurred in the judgment.

ORDER

¶ 1 *Held:* The trial court did not err in granting defendant's motion for a directed verdict on the medical battery count and in denying plaintiff's motion for a judgment n.o.v. or a new trial on the negligence count. We assume the trial court did not abuse its discretion in granting defendant's motion *in limine* barring testimony of an alleged party admission as plaintiff failed to present an adequate record on appeal. Remarks made by defense counsel during closing argument were either promptly sustained, a fair and accurate statement of the forthcoming instruction, or forfeited. We assume the trial court did not abuse its discretion in refusing to instruct the jury on the role insurance could play in the jury's decision as plaintiff failed to present an adequate record on appeal. Affirmed.

¶ 2 Defendant, Dr. Eugene Lee, mistakenly cut the common bile duct of plaintiff, Raymond Seibert, instead of the cystic duct when attempting to remove plaintiff's gallbladder during laparoscopic surgery. Plaintiff filed a four-count complaint for negligence and medical battery against Dr. Lee, individually, and as agent for Richard E. Lind, M.D., S.C., d/b/a Surgical Associates of Fox Valley (counts II and IV for vicarious liability for negligence and battery were voluntarily dismissed). The circuit court of McHenry County directed a verdict in defendant's favor on the medical battery count. The jury returned a verdict in defendant's favor on the negligence count and the court denied plaintiff's motion for a judgment notwithstanding the verdict (judgment n.o.v.) or, in the alternative for a new trial, on the negligence count. Plaintiff raises five contentions challenging the court's ruling on (1) defendant's motion for a directed verdict on the battery claim; (2) the denial of plaintiff's motion for judgment n.o.v., or, in the alternative, for a new trial, on the negligence claim; (3) defendant's motion *in limine*; (4) defense counsel's improper remarks during closing argument; and (5) the trial court's refusal to submit plaintiff's tendered Illinois Pattern Jury Instructions, Civil, No. 3.03 (2011) (hereinafter, IPI Civil (2011) No. 3.03) to the jury. We affirm.

¶ 3

I. FACTS

¶ 4 Plaintiff developed acute gallbladder pain and was admitted to Centegra Hospital in McHenry, Illinois, under the care of Dr. Michael Sherrow, a general surgeon. Sherrow informed plaintiff that he had a diseased gallbladder that needed to be removed. Plaintiff needed to have a cholecystectomy and signed a consent form for a laparoscopic procedure with the understanding that it might need to be converted to open surgery if Sherrow ran into difficulty during the procedure. The consent form, signed by plaintiff, authorizes "Dr. Sherrow and any assistants

and/or designees determined by him/her to perform” a “laparoscopic cholecystectomy—possible open.”

¶ 5 Laparoscopic surgery is performed through small incisions in the abdomen. Compared to open surgery, it is less invasive, less painful, quicker to heal, and results in less time spent in the hospital. Laparoscopic surgery also has less risk of infection, less scarring, and fewer complications.

¶ 6 As to the medical battery count, the issue presented at trial was whether defendant performed the surgery without plaintiff’s consent. The issue regarding negligence was whether defendant failed to use the proper surgical technique to identify the cystic duct.

¶ 7 Plaintiff testified to the following at trial:

“MR. SNYDER [Defense Counsel]: You would agree when you had that discussion—or at least with respect to Dr. Sherrow that if he got into trouble during the surgical procedure and needed help, you would want him to call in somebody to help him? Would you agree that that would be your desire?

A. Well, I would want a safe outcome for the surgery, whatever that took, yes.

Q. And if it took calling in somebody else for—if it took Dr. Sherrow, if he had to call in somebody else in his judgment to help him with the surgery, that was acceptable to you; is that correct?

A. Sure, yes.

¶ 8 Sherrow and defendant were employed by Surgical Associates of Fox Valley. Sherrow was in his first year of training and was not board certified. Defendant, however, was a board certified surgeon who had performed over 1,500 gallbladder surgeries.

¶ 9 Once plaintiff was prepped and under anesthesia for laparoscopic surgery, Sherrow made a small incision in the abdomen and placed a “trocar” through it. A “trocar” is a medical device that functions as a portal for the subsequent placement of other instruments in the abdomen that are necessary to perform the surgery, such as scissors, graspers, and a camera. Because plaintiff was very large, Sherrow used a “bariatric trocar,” which is longer and can make dissection more difficult.

¶ 10 Once Sherrow placed the first trocar, plaintiff’s abdomen was “insufflated” by injecting gas through a needle to inflate the abdomen to improve visualization of the internal organs. He then placed a camera through the trocar so that he could see the interior of plaintiff’s abdomen on a 24-inch color television monitor as he performed the surgery.

¶ 11 Laparoscopic cholecystectomy involves identifying anatomical landmarks. The surgeon must trace down the gallbladder to locate a tubular structure called the cystic duct and transect or sever the duct in order to remove the gallbladder through one of the ports. Seventy-five percent of patients do not have “normal” textbook anatomy. Adhesions, such as thickened, hardened scar tissue, and inflammation can make it very difficult to expose the gallbladder. The cystic duct can also look identical to the adjacent common bile duct with regard to its color and size. Based on his training and experience, Sherrow’s practice was to convert to open surgery if, after beginning laparoscopic cholecystectomy, he could not see the anatomical structures. The open procedure would allow him to use tactile sense to locate the structures.

¶ 12 Sherrow began the surgery and discovered visualization of the anatomy was inadequate. Plaintiff’s abdomen was described as having a significant amount of “omentum”—an apron of fat hanging down from plaintiff’s colon. Plaintiff’s liver, behind which the gallbladder is

generally located, was not immediately visible. Sherrow made three more ports in different areas of the abdomen, placed bariatric trocars in each one, and adjusted the position of plaintiff's body. Sherrow encountered a significant amount of fat again, as well as dense adhesions attached to the top and side of plaintiff's liver.

¶ 13 Sherrow then used a dissector to cut away the adhesions and fat on the liver in an attempt to expose the gallbladder. In his operative report, he stated that “[i]t was puzzling that even after removing all of the omental attachments, there was no clear gallbladder visible on either side of the liver.” The nurse operating the camera during the procedure agreed that plaintiff's abdomen was abnormal.

¶ 14 When Sherrow eventually located plaintiff's gallbladder, it was shrunken and nearly absent-looking. He dissected some of the dense adhesions surrounding it; the organ appeared to be ruptured and some gallstones had escaped from it. Sherrow dissected some more of the adhesions and “realized the visualization was not—it was not ideal. I could not see the structures that I wanted to see.”

¶ 15 Sherrow understood the consent form's use of the word “designee” referred to “anyone that I deemed during the surgery that could help me or assist me in any way.” He instructed one of the nurses to call the medical group's office for help. Sherrow wanted not only a “second set of hands” to help him convert the operation to an open surgery if necessary, but a second set of eyes “to look at this because it was clearly abnormal.”

¶ 16 Defendant responded to the call for assistance and requested that Sherrow hold off from pulling the trocars. Sherrow agreed and plaintiff was held under anesthesia for about 15-20 minutes until defendant arrived. Sherrow complied with defendant's request to keep the trocars in place because he was not sure whether there would be a need to convert to open surgery.

Sherrow wanted defendant, who had significantly more experience, to assess the situation and attempt to complete the surgery laparoscopically so that plaintiff could avoid the heightened risk of morbidity associated with open surgery.

¶ 17 Defendant surveyed the state of the dissection on the television monitor. No one discussed who was “in charge.” Sherrow did not recall exactly what, if anything, he said to defendant at that moment. Sherrow explained that defendant had been asked to assist and, in order to do so, defendant had to stand where the surgeon stands. Sherrow yielded his position to defendant, in effect signaling to defendant that it was now defendant’s surgery and that Sherrow would assist. When asked whether defendant exceeded “the scope of your permission at any point during the procedure,” Sherrow responded, “No, he did not.”

¶ 18 Tina LeJeune, R.N., was the nurse who contacted defendant at Sherrow’s request. She told Sherrow of defendant’s request to leave the trocars in place. The scrubbing nurse, Loretta Kilman, R.N., who was working in the sterile field with the surgeons, had no memory of Sherrow saying he wanted to convert the operation to an open surgery. After defendant entered, he used the graspers and the scissors to continue dissecting where Sherrow had left off. Kilman testified: “It was a very difficult case. It truly was a very difficult case.” She had seen situations where the primary surgeon ran into difficulty, called for help, and then became the assistant. Kilman did not remember whether defendant gave Sherrow any directions.

¶ 19 Donna Spark, R.N., held the camera that had been inserted through one of the trocars. She heard Sherrow say that it was very difficult to dissect and that he could use a second set of eyes. Sherrow continued to dissect while waiting for defendant to arrive. When defendant entered the operating room, he came to plaintiff and took control of the instruments. Sherrow did not ask him to, did not ask him to cut or do any further dissection; “he didn’t say one way or

the other.” It was her observation that Sherrow “just wanted to keep dissecting to see if they could get at it through the laparoscope.”

¶ 20 When defendant took over, he surveyed the portal area to orient himself to where Sherrow had left off. Defendant could see that plaintiff’s gallbladder was covered with thickened adhesions and inflammation that made it very difficult to expose. When everything was inflamed like this, it was very hard to see the organ. This was as far as Sherrow had gone. He had created a hole in the adhesions through which you could see the gallbladder.

¶ 21 Defendant identified the edge of the liver, the stomach, and the small bowel. He could see the stones that had escaped from the gallbladder where Sherrow had created the hole, and he began to trace down the gallbladder to find the cystic duct.

¶ 22 He believed he found the cystic duct, clipped it, and began to transect it. But, when he pulled slightly on the duct, he realized that when the gallbladder did not move with it, it was the common bile duct attached to the liver, not the cystic duct that he had cut. At that point, he and Sherrow opened plaintiff’s abdomen, completed the surgery necessary to remove the gallbladder, and repaired the cut in the common bile duct. The common bile duct was not completely severed, so defendant was able to line up the edges and repair it. Plaintiff fully recovered.

¶ 23 Nurse LeJeune testified at deposition that, before defendant transected the common bile duct, he conversed briefly with Sherrow and then remarked “no guts, no glory.” She could not hear what the doctors discussed before defendant made this comment. The trial court excluded defendant’s remark pursuant to defendant’s motion *in limine*. Plaintiff has not provided this court with a transcript of the hearing on the motion. The only record of the judge’s reasoning is from a sidebar during the trial, when the judge mentioned that it was unclear what defendant meant when he made the remark, that it was not probative of the standard of care, that it had the

potential to mislead the jury, and that its limited probative value was substantially outweighed by undue prejudice.

¶ 24 The experts for both parties agreed that the risk of common bile duct injury in open and laparoscopic gallbladder surgeries is well-recognized. Of the 600,000 gallbladder surgeries performed each year in the United States, about 3,000 to 6,000 result in injuries similar to the one plaintiff suffered. The rate is one-half percent for open surgeries and between one-half and one percent for laparoscopic procedures. The experts testified that such injuries can occur in the absence of any negligence.

¶ 25 Plaintiff's expert, Jeffrey Freed, M.D., testified that he uses the "critical view of safety technique." He stated that the "critical view" is 100% effective in properly identifying the cystic duct, and that this is the technique he teaches residents at the hospital where he practices. During cross-examination, Freed admitted that this was an "overstatement." Despite the use of the "critical view," Freed acknowledged that common bile duct injuries do occur during laparoscopic procedures at his hospital with the same frequency as the national average.

¶ 26 Freed also referenced an article he characterized as a "classic work" by Dr. Lawrence Way, which discussed the phenomena of visual misperception that occurs during laparoscopic procedures because of the two-dimensional view of the internal organs that a television monitor provides to the surgeon while he or she is operating. According to the article, the surgeon's brain believes it is actually a two-dimensional view; "you don't really know that orientation or what's behind it or where things are really going or coming from."

¶ 27 Freed opined that defendant partially transected the common bile duct because "he thought he saw a structure that looked like this, the cystic duct. He was actually looking at the common duct *** and cut it." Freed believed the error was due to the fact that defendant was

looking at a “two-dimensional image” and “so we can be fooled about the identification of things
*** our minds are playing tricks on us.”

¶ 28 During cross-examination, Freed agreed with the statement in the Way article that “errors leading to laparoscopic bile duct injuries stem principally from misperception, no error of skill, knowledge or judgment,” and that “the usual misperception error underlying laparoscopic bile duct injuries does not meet the defining criteria of medical negligence.”

¶ 29 Defendant’s expert, Gregory Ward, M.D., also attributed the partial transection of plaintiff’s bile duct to a misperception error. As cited in the Way article by plaintiff’s expert, such errors are not negligence. Ward opined that defendant used “a reasonable and recognized technique” for locating the cystic duct by dissecting down along the gallbladder to its base, where the cystic duct is normally found. Ward further stated that an open procedure could have just as easily resulted in the same injury because of plaintiff’s body size, abnormal anatomy, his intrahepatic gallbladder (meaning it was covered by the liver), and the adhesions and inflammation that were present. While Ward agreed that an open surgery permits the surgeon to use his fingers to feel structures, he observed there would be no way to distinguish the cystic duct from the common bile duct based on how they felt. Ward opined that defendant exercised his judgment appropriately and within the standard of care.

¶ 30 Plaintiff called LeJuene to testify at trial. Prior to her taking the stand, plaintiff asked the court to reconsider its ruling barring her testimony that she heard defendant say “no guts, no glory” before he cut the wrong duct, and other testimony by her as to her personal knowledge that defendant had made the same statement during other surgeries as well. Plaintiff’s counsel argued the statement was a party admission relevant to the standard of care issue, but the court refused to reverse its earlier ruling.

¶ 31 As stated, the trial court entered a directed verdict in favor of defendant at the close of plaintiff's case on the medical battery count, and the jury returned a verdict on the negligence count in defendant's favor. Following the denial of plaintiff's motion for a judgment n.o.v. or a new trial, plaintiff timely appeals.

¶ 32

II. ANALYSIS

¶ 33

A. Directed Verdict for Medical Battery

¶ 34 Where an unauthorized surgeon operates, he or she commits a technical trespass to the patient resulting in the intentional tort of battery. *Guebard v. Jabaay*, 117 Ill. App. 3d 1, 7 (1983). A plaintiff claiming medical battery must establish one of the following: (1) no consent to the medical procedure performed; (2) the procedure was contrary to the injured party's will; or (3) substantial variance of the procedure from the consent granted. *Holzrichter v. Yorath*, 2013 IL App (1st) 110287, ¶ 83. "The gist of an action for battery is the absence of consent on the plaintiff's part." *Holzrichter*, 2013 IL App (1st) 110287, ¶ 83 (citing *Gaskin v. Goldwasser*, 166 Ill. App. 3d 996, 1012 (1988)).

¶ 35 Plaintiff claims that the trial court erred in granting a directed verdict in favor of defendant on the medical battery count because there was conflicting evidence concerning whether the release signed by plaintiff authorized defendant to take over the surgery without being designated to do so by Sherrow. Because we review directed verdicts *de novo*, we perform the same analysis as the trial court: we ask whether all the evidence, viewed in a light most favorable to the opponent, so overwhelmingly favors the movant that no contrary verdict could ever stand. *Friedman v. Safe Security Services, Inc.*, 328 Ill. App. 3d 37, 47 (2002).

¶ 36 The issue is whether Sherrow designated defendant to take over the surgery before he cut the wrong duct. In the absence of an emergency, the language of the consent determines who

may operate. *In re Estate of Allen*, 365 Ill. App. 3d 378, 385-86 (2006). Plaintiff points to defendant's testimony and that of Nurse Donna Spark as evidence showing that defendant took over the surgery without any conversation between defendant and Sherrow as to who was to be the primary surgeon. Spark testified Sherrow did not ask defendant to do so. Sherrow testified somewhat equivocally that he said something to let defendant know that he was allowing defendant to take over the surgery. Plaintiff points to Sherrow's operative notes that indicate that Sherrow did not become the assistant until after the duct was cut. Plaintiff maintains that Sherrow yielded to defendant to permit him to stand where the surgeon normally stands only so that defendant could use the camera to see the anatomy; that this was not a "signal" for defendant to take over; and that it was defendant who made the decision to become the surgeon, without discussing it with Sherrow and without being designated by him to do so, although the written consent required designation.

¶ 37 Plaintiff signed a release for Sherrow and "any assistants and/or designees determined by him" to perform the gallbladder surgery. Sherrow began the laparoscopic surgery but ran into difficulty locating and attempting to remove the gallbladder. He called for another surgeon to assist him. Defendant responded to the call and asked Sherrow to leave the laparoscopic trocars in place and hold off converting this to an open surgery until defendant arrived. Defendant, who had much more surgical experience than Sherrow, attempted to complete the surgery laparoscopically when he cut the wrong duct.

¶ 38 We agree with the trial court that Sherrow "actually gave permission, authority, consent to [defendant] to continue with the surgery" prior to the alleged injury. Sherrow, who was one year out of residency and not board certified, ran into trouble during the surgery. He called for assistance, and defendant, a board certified surgeon who had performed over 1,500 gallbladder

surgeries over 30 years, responded. At defendant's direction, Sherrow left the trocars in place and stepped aside when defendant entered the operating room in order to allow defendant to attempt to complete the surgery laparoscopically. Sherrow testified that defendant never exceeded the scope of his permission at any time. It is clear that Sherrow designated defendant to attempt to complete the surgery laparoscopically to reduce the risk of an open procedure. These actions, that several witnesses testified were routine during surgery, were not outside the scope of the written consent.

¶ 39 We also agree with defendant that the consent form's inclusion of the word "designees" makes this case dissimilar from other decisions involving the medical battery tort. In *Guebard*, 117 Ill. App. 3d at 6-7, and in *Lane v. Anderson*, 345 Ill. App. 3d 256, 261 (2004), the plaintiffs argued that residents who performed most of the surgery while supervised by the primary physicians to whom the plaintiffs' consent was given were not "assistants." These cases did not consider a consent form giving the surgeon the authority to choose a "designee," which is broader than the ones considered in either *Guebard* or *Lane*. We also find plaintiff's reliance on *Guebard* misplaced because the plaintiff in *Guebard* withdrew the medical battery count prior to trial. *Guebard*, 117 Ill. App. 3d at 7.

¶ 40 Accordingly, the evidence, viewed in a light most favorable to plaintiff, so overwhelmingly established plaintiff's consent to defendant's performance of the surgery that no contrary verdict could ever stand.

¶ 41 B. Judgment n.o.v./New Trial for Negligence

¶ 42 Plaintiff contends that the trial court erred in denying his motions for judgment n.o.v. and, alternatively, for a new trial on the negligence claim. He contends that the un rebutted expert testimony showed that the standard of care by 2010 when dissecting during laparoscopic

surgery was the “critical view method.” Because defendant did not use this method and cut the wrong duct, plaintiff maintains the jury verdict in favor of defendant cannot stand.

¶ 43 A party is entitled to a judgment n.o.v. only in cases where all the evidence, when viewed in a light most favorable to the opponent, so overwhelmingly favors the movant that no contrary verdict based on the evidence could ever stand. *Pedrick v. The Peoria and Eastern Railroad Company*, 37 Ill. 2d 494, 510 (1967). Application of the *Pedrick* standard to medical malpractice cases requires the reviewing court to scrutinize the evidence submitted by the plaintiff in support of his case. *Schuchman v. Stackable*, 198 Ill. App. 3d 209, 222 (1990).

¶ 44 We have examined the entire record and conclude that plaintiff’s motion for judgment n.o.v. was properly denied. In a medical malpractice action, the plaintiff bears the burden of establishing the standard of care by which the defendant physician’s conduct is to be measured and the breach of that standard which resulted in the injury. *Id.* Where the parties offer conflicting medical testimony concerning the applicable standard of care and the defendant’s breach of that standard, the jury is uniquely qualified to resolve the conflict, and a judgment n.o.v. is not required. *Id.*

¶ 45 Here, defendant’s expert, Dr. Ward, testified that defendant’s method of tracing the gallbladder to its base where the cystic duct should be located was within the standard of care at the time of the surgery, and plaintiff’s expert, Dr. Freed, testified that using the critical view method still, at times, results in common bile duct injuries. Nevertheless, it is apparent from the facts set forth above, that the parties offered conflicting expert testimony relating to the proper standard of care and defendant’s alleged breach thereof. Thus, the conflicting testimony was sufficient to raise a question of fact to be decided by the jury, and the trial court properly denied plaintiff’s motion for entry of judgment n.o.v.

¶ 46 In ruling on a motion for granting a new trial, the trial 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. *Mizowek v. DeFranco*, 64 Ill. 2d 303, 309-310 (1976). A verdict is contrary to the manifest weight of the evidence when the opposite conclusion is clearly apparent or the verdict is palpably erroneous and clearly unwarranted. *Cadral Corporation v. Solomon, Cordwell, Buenz and Associates, Inc.*, 147 Ill. App. 3d 466, 483 (1986). In view of the conflicting expert testimony, the verdict here may not be said to be contrary to the manifest weight of the evidence, and the trial court did not abuse its discretion in denying plaintiff's posttrial motion for a new trial.

¶ 47 *C. Motion In Limine*

¶ 48 Plaintiff contends that the trial court abused its discretion in granting defendant's motion *in limine* by refusing to allow testimony from Nurse LeJeune that defendant made the comment "no guts, no glory" before he transected the common bile duct. The admission or exclusion of evidence is reviewed for an abuse of discretion. *Gill v. Foster*, 157 Ill. 2d 304, 312-13 (1993). According to plaintiff, the remark was an admission against interest because it tended to show defendant violated the standard of care by "taking a chance in cutting anatomy he had not properly identified." Plaintiff claims that Nurse LeJeune also would have testified that defendant made the same remark on other occasions and that it reflected a bias against converting laparoscopic procedures to open surgery.

¶ 49 Defendant counters that plaintiff has not presented an adequate record on appeal. The Illinois Supreme Court "has long held that in order to support a claim of error on appeal the appellant has the burden to present a sufficiently complete record." *Webster v. Hartman*, 195 Ill. 2d 426, 432 (2001) (citing *Foutch v. O'Bryant*, 99 Ill. 2d 389, 391-92 (1984)). "In fact,

‘[f]rom the very nature of an appeal it is evident that the court of review must have before it the record to review in order to determine whether there was the error claimed by the appellant.’ ” *Id.* (quoting *Foutch*, 99 Ill. 2d at 391). “Where the issue on appeal relates to the conduct of a hearing or proceeding, this issue is not subject to review absent a report or record of the proceeding.” *Id.* “Instead, absent a record, ‘it [is] presumed that the order entered by the trial court [is] in conformity with the law and had a sufficient factual basis.’ ” *Id.* (quoting *Foutch*, 99 Ill. 2d at 392).

¶ 50 Plaintiff asserts that, because he made timely objections at trial and in his posttrial motion, and the trial and posttrial transcripts have been provided, the issue was properly preserved for appeal. Plaintiff may have preserved the issue for appeal, but the record does not contain any transcript of proceedings from the hearing on the motion *in limine*. While we do get “snippets” of the trial court’s reasoning when it was asked to reconsider the issue at trial and when it entertained plaintiff’s posttrial motion, without the transcript, which would contain the arguments of the parties as well as the trial court’s full reasoning, it is difficult to ascertain the trial court’s reasoning and how it exercised its discretion when it made the ruling that plaintiff now challenges. Accordingly, any doubts must be resolved against plaintiff and we cannot say that the trial court abused its discretion in granting defendant’s motion *in limine*.

¶ 51 D. Closing Argument

¶ 52 Plaintiff complains about four comments made during closing argument by defense counsel. The scope of closing argument is within the sound discretion of the trial court, and the argument must be prejudicial for a reviewing court to reverse. *Kayman v. Rasheed*, 2015 IL App (1st) 132631, ¶ 52; *Drakeford v. University of Chicago Hospitals*, 2013 IL App (1st) 111366, ¶ 50.

¶ 53 Prior to closing argument, plaintiff and defendant agreed to a modified instruction to be given to the jury that would inform them that the court had determined that medical battery was no longer a part of the case and it was not an issue that the jury needed to decide. In reliance on the agreed-upon amended instruction, plaintiff's counsel did not discuss the medical battery claim in closing. During closing argument, however, defense counsel made the following remarks to the jury:

(1) "There were a number of questions during the case that talked about who was the primary surgeon and who took control of what part of the case. And when the Plaintiff first brought the case to you all throughout jury selection, all throughout the opening argument, there was a lot of talk about a claim for medical battery;" (2) "One of the things that you'll find is that the court will instruct you that the medical battery claim has been *** ;" and (3) "I believe you're going to get an instruction specifically with respect to that aspect of the Plaintiff's case."

¶ 54 Plaintiff's counsel lodged an objection after the first two remarks, and the trial court sustained the objections. The trial court's act of promptly sustaining an objection to a closing argument comment is generally sufficient to cure any error that may have occurred. *People v. Hope*, 168 Ill. 2d 1, 26 (1995). The jury also was instructed later that closing arguments are not evidence and that any statement or argument not based on the evidence should be disregarded.

¶ 55 Defense counsel's third remark, that the trial court would later instruct the jury on the medical battery claim, was a fair and accurate statement of the instruction that was impending. Trial counsel are allowed to refer to instructions the court will give to the jury and, when not too lengthy or misleading, to read instructions or portions of them as part of closing argument. Counsel may state their belief as to the content of anticipated instructions in developing their

closing argument, with the *caveat* that such remarks not be misleading. *Ficken v. Alton & Southern Railway Company*, 255 Ill. App. 3d 1047, 1066 (1993); *Sidorewicz v. Kostelny*, 102 Ill. App. 3d 851, 854 (1981).

¶ 56 The last remark of which plaintiff complains, where defense counsel remarked “some things are not exactly as they’re advertised,” has been forfeited because plaintiff neither made a contemporaneous objection to the comment nor did he specifically include an objection to it in his general claim of error concerning closing argument.

¶ 57 E. IPI Civil (2011) No. 3.03

¶ 58 We last address plaintiff’s argument that a new trial is required because the trial court refused to tender to the jury an instruction in cases where insurance could play a role in the jury’s decision. The committee notes that this instruction should be given in all cases where insurance could play a role in the jury’s decision. See Instruction, Notes and Comments to IPI Civil (2011) 3.03. The trial court refused the instruction because insurance never came up during the trial.

¶ 59 Plaintiff cites *Calloway v. Bovis Lend Lease, Inc.*, 2013 IL App (1st) 112746, ¶ 135, for the proposition that the instruction is appropriate when the issue does not arise during trial but was raised during *voir dire*. Unlike in *Calloway*, we are unable to consider how this issue presented itself during *voir dire* as the record on appeal does not contain a transcript of the jury selection. Based on the record before us, where insurance never came up during the trial and there is no report of proceedings in the record, no bystanders report, and no agreed statement of facts, we have no way of knowing how the trial court based its decision. Thus, we must assume that the trial court did not abuse its discretion in refusing to tender plaintiff’s instruction.

¶ 60 III. CONCLUSION

¶ 61 For the preceding reasons, we affirm the judgment of the circuit court of McHenry County.

¶ 62 Affirmed.