2015 IL App (1st) 131885-U
No. 1-13-1885

THIRD DIVISION
May 25, 2015

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

DAWN G. KOSTAL,	)	Appeal from the Circuit Court
	)	of Cook County.
Plaintiff-Appellee,	)	
	)	
v.	)	No. 09 L 4036
	)	
PINKUS DERMATOPATHOLOGY	)	
LABORATORY,	)	The Honorable
	)	Deborah M. Dooling,
Defendants-Appellants.	)	Judge Presiding.

JUSTICE PUCINSKI delivered the judgment of the court.
Justice Fitzgerald Smith concurred in the judgment.
Presiding Justice Mason specially concurred.

ORDER

¶ 1 *Held:* jury verdict against defendants in medical malpractice trial upheld where the circuit court did not abuse its discretion in admitting or excluding evidence and provided the jury with a proper set of jury instructions.

¶ 2 Plaintiff Dawn Kostal filed a medical malpractice action against defendants, Pinkus Dermatopathology Laboratory, P.C. (Pinkus Laboratory) and Darius Mehregan, M.D., alleging that defendants negligently interpreted her biopsied skin tissue samples and failed to properly diagnose her skin lesions. Instead of rendering the correct diagnosis of blastomycosis, a fungal

infection, defendants diagnosed her with keratoacanthoma, a type of tumor. The cause proceeded to trial, where the jury returned with a verdict finding defendants guilty of negligence. Defendants challenge the verdict on appeal, arguing that the circuit court: (1) improperly barred them from referencing a former defendant's failure to also properly diagnose plaintiff's skin condition; (2) allowed one of plaintiff's witnesses to provide a "hindsight" diagnosis; and (3) provided the jury with an erroneous set of jury instructions. For the reasons set forth herein, we affirm the judgment of the circuit court.

¶ 3 BACKGROUND

¶ 4 Events Preceding the Lawsuit

¶ 5 Beginning in August 2001, Kostal started to experience respiratory issues and cold-like symptoms. She sought out treatment from Doctor Raymond DiPasquo, her primary care physician, who diagnosed her with an upper respiratory infection and prescribed antibiotics. Thereafter, in November 2001, Kostal began to develop several lesions on her skin. Following another appointment with her primary care physician, Kostal sought out treatment from Doctor Robert Signore, a dermatologist, who biopsied Kostal's lesions and sent them to defendant Pinkus Laboratory for analysis. On December 10, 2001, defendant Doctor Mehregan, a dermatopathologist specializing in pathology and dermatology and one of the shareholders of Pinkus Laboratory, reviewed Kostal's tissue samples and diagnosed her with keratoacanthoma (K.A.), a low-grade self-healing skin tumor. Typically, a patient with K.A. presents with a dome or crater-shaped, symmetrical elevated nodular lesion. Depending on the location or severity of the lesion, K.A. can be treated by excising the full lesion or by waiting and allowing for a spontaneous resolution.

¶ 6 Following Kostal's initial diagnosis, she was referred to Doctor Jeffrey Melton, a dermatologic surgeon, who excised Kostal's lesions and submitted them to Richfield Laboratory of Dermatopathology. The lesions were subsequently reviewed by another dermatopathologist, Doctor David Barron, and he also rendered a diagnosis of K.A. Kostal, however, did not have K.A.; rather she was suffering from blastomycosis, a deep fungal infection that requires the use of antifungal medication to treat it. The fungus that causes blastomycosis is endemic to certain regions in the United States, including the Midwest, and is found in moist soil. Individuals usually become infected when they inhale microscopic fungal spores into their lungs. Infected individuals generally exhibit cold-like or flu-like symptoms. Absent prompt diagnosis and treatment, the fungal infection can disseminate to other parts of the patient's body. Kostal was ultimately properly diagnosed with blastomycosis on February 5, 2002, when she arrived at Palos Community Hospital complaining of severe back pain. During her examination, doctors discovered that the fungal infection had disseminated from her lungs to other parts of her body and had begun disintegrating several levels of plaintiff's spinal column. Kostal ultimately required two spinal surgeries to remedy the damage caused by the infection. The affected parts of her spinal column were removed and her column was reconstructed with bone grafts, rods, hooks and screws.

¶ 7 The Lawsuit

¶ 8 Following her surgeries and rehabilitation, Kostal filed a complaint advancing claims of medical negligence against various medical facilities and personnel including Pinkus Laboratory and Doctor Mehregan, alleging that defendants' failure to properly diagnose and treat her proximately caused her to suffer "severe and permanent injuries." In pertinent part, plaintiff

alleged that defendants were "guilty of one or more of the following careless and negligent acts and/or omissions:

a. Negligently examined and interpreted Plaintiff's specimens;

b. Failed to recognize indicia of fungal process when such indicia were present and observable on said specimens;

c. Failed to notify Plaintiff's physician that said indicia of fungal process were present so that appropriate follow-up procedures could be timely done.

d. Failed to properly train and supervise those persons charged with the responsibility of correctly reading and interpreting tissue samples and forwarding the results of such examination to medical care providers; and/or

e. Returned reports to Plaintiff's treating physician which were incorrect."

¶ 9 Kostal's complaint also raised similar claims against Doctor Barron, the second dermatopathologist who also erroneously diagnosed her with K.A. and his place of employ, Richfield Laboratory of Dermatopathology; however, those parties subsequently settled.

¶ 10 Defendants Pinkus Laboratory and Doctor Mehregan, in turn, filed answers to Kostal's complaint. In pertinent part, Doctor Mehregan acknowledged reviewing Kostal's biopsy samples and rendering an incorrect diagnosis, but denied that the misdiagnosis amounted to negligence. The cause then proceeded to a jury trial.

¶ 11 Pre-Trial Proceedings

¶ 12 Prior to trial, Kostal filed several motions *in limine*. In plaintiff's motion *in limine* No. 24, Kostal sought to bar any reference to "former defendants, their alleged deviations from the standard of care, and their failure to diagnose [her] blastomycosis." Specifically, Kostal sought to preclude any reference to Doctor Barron and his misdiagnosis during the trial. Defendants,

however, objected. Although they agreed that Doctor Barron's status as a former defendant was not relevant, they argued that his treatment of Kostal and his analysis of her tissue samples was relevant.

¶ 13 Similarly, in plaintiff's motion *in limine* No. 29, Kostal sought to bar Doctor Barron from testifying at trial. In pertinent part, plaintiff argued that the tissue sample from her right lateral thorax lesion that Doctor Barron reviewed was obtained by a different submitting physician and prepared at a different laboratory. In addition, the lesion had changed in size in the weeks between Doctor Mehregan's K.A. diagnosis in December 2001 and Doctor Barron's diagnosis in January 2002. Defendants, in turn, responded that Doctor Barron's testimony and erroneous diagnosis were relevant to demonstrate the reasonableness of Doctor Mehregan's K.A. diagnosis and to rebut the testimony that would be provided by Kostal's expert that it was a deviation from the standard of care for a dermatopathologist to fail to diagnose Kostal with blastomycosis following a microscopic examination of her tissue samples.

¶ 14 The circuit court initially denied both of Kostal's aforementioned motions *in limine* pertaining to Doctor Barron and his diagnosis. In doing so, the court noted that Doctor Barron's conduct was "relevant if he did the same thing on the same material;" however, the court later reversed its prior ruling during the trial when Kostal renewed her objections. As such, the defendants were precluded from calling Doctor Barron to testify and from making any reference to him and his erroneous diagnosis.

¶ 15 Trial

¶ 16 At trial, Plaintiff Dawn Kostal testified that in the Fall of 2001, she developed "chills, a fever, and a continuous relentless cough." After experiencing these symptoms for a while, Kostal sought treatment from Doctor DiPasquo, her primary care physician. She saw him on

August 31, 2001, and October 8, 2001. On both occasions, Doctor DiPasquo prescribed an antibiotic; however, Kostal experienced no relief. Sometime after developing the cold-like symptoms, Kostal noticed a skin lesion on the right side of her rib cage that "looked like a white mosquito bite." It was about the size of a dime and it produced a burning sensation. She returned to Doctor DiPasquo's office on November 20, 2001, to seek treatment for the lesion. Doctor DiPasquo prescribed another antibiotic, but it did not clear up her skin lesion.

¶ 17 As a result, Kostal testified that she sought treatment from Doctor Signore, a dermatologist, on December 3, 2001. By the time she saw Doctor Signore, her right lateral thorax lesion was "bigger and it was brown and red and crusty and it was oozing." It appeared scab-like. She had also developed several other smaller lesions. Doctor Signore recommended a biopsy and he performed one the following day. Kostal returned to Doctor Signore's office on December 15, 2001, and received her biopsy results. Doctor Signore informed her that she had "squamous cell skin cancer" and recommended that she see Doctor Melton, a surgeon, to have the lesions removed. She had surgery on January 8, 2002. Doctor Melton ended up removing three lesions from her body: the one on her right thorax, one on her left hip and one on the right side of her chin. Thereafter, on January 28, 2002, she returned to Doctor DiPasquo's office for a follow-up appointment. She had a chest X-ray and some blood work performed. At that time, she was diagnosed with pneumonia and prescribed another antibiotic.

¶ 18 A few days later, however, Kostal went to the emergency room at Palos Community Hospital because she was suffering from "very, very intense" back pain. She was given pain medication and underwent a CT scan and an MRI. At some point during Kostal's hospitalization, she was diagnosed with blastomycosis and learned that the infection had disseminated to her spine. Doctor Ramakrishna, an infectious disease doctor, immediately put her on an antifungal

medication. She remained in the hospital for 21 days. Despite receiving pain medication, Kostal testified that she continued to experience intense back pain and she was fitted with a back brace. She was ultimately discharged from Palos Community Hospital on February 25, 2002. At the time, she could no longer walk independently and she required the use of a walker. Following her discharge, Kostal continued taking prescribed antifungal and pain medications. She had several follow-up visits with her primary care physician; however, she was ultimately referred to Northwestern Hospital because she continued to experience severe back pain. She was admitted to Northwestern Hospital on May 2, 2002 and remained there until May 30, 2002. During that time, she underwent two spinal surgeries. Following her discharge, Kostal commenced an inpatient stay at the Rehabilitation Institute of Chicago for several weeks where she began physical therapy. She continued physical therapy treatments when she moved back to her home.

¶ 19 Although she made improvements over the years and no longer requires a back brace, Kostal testified that she still experiences "constant discomfort" in her back. She was never able to resume her employ at Dominick's Finer Foods, where she worked for "28 and a half years" because the job was physically demanding and she could no longer fulfill those job requirements. Her current physical condition does not allow her to perform heavy lifting or any bending and twisting motions. She testified that she incurred a total of $519,949.82 in medical bills in connection with her blastomycosis infection and spinal surgeries. She further testified that she is "not the same person [she] used to be" and that her "whole life has changed" as a result of the damage caused by the infection.

¶ 20 Doctor DiPasquo, Kostal's primary care physician, confirmed that Kostal came to his office on August 31, 2001, complaining of a cough, congestion, sore throat, runny nose, and a temperature. He diagnosed with her an upper respiratory infection and prescribed her Biaxin, an

antibiotic. Kostal next returned to his office on October 8, 2001, and complained of chills, sore throat, post nasal drip, and head congestion. He again diagnosed her with an upper respiratory infection and prescribed another antibiotic, Zithromax. Doctor DiPasquo testified that Kostal did not report any musculoskeletal complaints at that time and that no lesions were present on her body on either of her visits. On November 20, 2001, however, Kostal came to his office with a skin lesion on the right side of her abdomen that was oozing and scabbed over and another smaller lesion on her left hip. He thought the lesions were "some type of bacterial infected hair follicle" and prescribed her with Augmentin, another antibiotic.

¶ 21 Doctor DiPasquo testified that he next saw Kostal on January 28, 2002, after her lesions had been biopsied and she had been erroneously diagnosed with K.A. This time, Kostal complained of back muscle spasms and migraine headaches. During his examination, Doctor DiPasquo heard "crackles" or fluid in her lungs and ordered a chest X-ray. The results showed that Kostal did have fluid in her lungs. He diagnosed her with pneumonia and prescribed her another antibiotic. The following day, Kostal's husband called and informed Doctor DiPasquo that his wife was reporting migraine headaches and back spasms. He responded by prescribing a muscle relaxant. He subsequently learned that Kostal was admitted to Palos Community Hospital on February 4, 2002.

¶ 22 Doctor Robert Signore, a physician board certified in dermatology and family practice, testified that he became involved in plaintiff's care for the first time on December 3, 2001, when she came to him complaining about a growth on her right lateral thorax. She reported that her skin lesion appeared around October 31, 2001, and that Augmentin, an antibiotic prescribed by her primary care physician, had not successfully treated it; rather her lesion had only gotten bigger. Kostal also reported that a similar lesion had recently appeared on the left side of her

waist. Doctor Signore conducted a physical examination of plaintiff and recorded his findings. In pertinent part, he noted that Kostal's right lateral thorax lesion was approximately 3.2 centimeters and was oval shaped with a "scaley crust like scab." There was also a "pussy discharge." Based upon its appearance, Doctor Signore's "clinical suspicion" was that Kostal's right lateral thorax lesion was a large K.A. lesion. He advised Kostal that he wanted to do a biopsy to either confirm or rebut his clinical K.A. diagnosis.

¶ 23 Doctor Signore explained that he can "often" diagnose a skin condition simply by conducting a clinical evaluation with the naked eye; however, he testified that sometimes a simple clinical evaluation cannot diagnose a particular problem. For example, neither skin cancer nor fungal organisms can be readily observed by the naked eye. On those occasions, biopsies can assist in making a definitive diagnosis. He explained that in his field, biopsies may be performed to "confirm [his] clinical naked eye opinion of what [he] think[s] [the condition] is" or to obtain a diagnosis when he is unsure and has not formulated a clinical naked eye opinion. Biopsied tissue is then sent to an outside laboratory for analysis and he relies on the laboratory to provide him with an accurate microscopic diagnosis, because that in turn, will affect the conversation that he would have with his patient and the course of treatment that he would recommend. An inaccurate diagnosis could "perhaps" delay the proper care and treatment of his patient and could "conceivably" result in a patient receiving the wrong type of treatment.

¶ 24 In accordance with his advice, Kostal returned to his office the following day for a biopsy. After removing plaintiff's tissue samples, Doctor Signore submitted them to Pinkus Laboratory for microscopic analysis. Pinkus Laboratory, in turn, provided him with a dermatopathology report on December 10, 2001 authored by Doctor Mehregan, which contained a microscopic diagnosis of K.A. Thereafter, on December 15, 2001, Doctor Signore, relying on

the report, met with plaintiff and discussed her K.A. diagnosis. After informing Kostal of her diagnosis, he "advised her to see Dr. Melton who's a skin cancer surgery specialist." Doctor Signore tesitified that if the report from Pinkus Laboratory contained a blastomycosis diagnosis instead of a K.A. diagnosis, he would have "most likely" discussed a different type of treatment with Kostal. Specifically, he would have "probably sen[t] [her] to an infectio[us] disease doctor."

¶ 25 Doctor Signore next saw plaintiff in February 2002 after she had been admitted to Palos Community Hospital. Additional skin samples were sent to the lab and the "findings [we]re consistent with a deep fungal infection." After obtaining that information, Doctor Signore "requested the original skin biopsy, which was originally interpreted as [K.A.] to be specially stained for fungus or fungi." The PAS[1] special stain "showed budding yeast forms which was compatible with blastomycosis."

¶ 26 On cross-examination, Doctor Signore explained that he made his initial K.A. clinical diagnosis for "two key reasons." He explained: "Number one [plaintiff's right lateral thorax lesion] grew extremely rapidly. Within about one month it went from nowhere to being this big. So it moved really fast, which is highly characteristic of a keratoacanthoma, in fact it's one of the few skin cancers that can grow really fast that large. The second reason was because it had a characteristic central crust. Keratoacanthomas clinically look a little different than other[] squamous cells because they have like a central plug or central kind of like a scab or a crust. So for those two reasons it looked very characteristic for keratoacanthoma type of squamous cell cancer." He acknowledged that "most keratoacanthomas are single lesions or spots on the skin," but testified that he believed that plaintiff, who presented with multiple lesions, had a more rare

[1] PAS is the acronym used for a Periodic-acid Schiff stain. It is a type of special staining that can be applied to tissue samples to examine tissue for the presence or absence of fungal organisms.

form of K.A. called "multiple keratoacanthomas." Doctor Signore confirmed that he never asked Doctor Mehregan to do a special staining of plaintiff's biopsied tissue or requested a second opinion from Pinkus Laboratory even though he could have done so. He further confirmed that he relied on the accuracy of Pinkus Laboratory's report to make plaintiff's K.A. diagnosis.

¶ 27 Doctor Mehregan, called to testify as an adverse witness in plaintiff's case-in-chief, testified that in 2001, he and his brother, David, were the sole stockholders of their company Pinkus Laboratory, a skin pathology laboratory. He acknowledged that back in December 2001, when he observed the tissue sample taken from Kostal's right lateral thorax under a microscope, he rendered a diagnosis of K.A., which is a type of tumor. He further acknowledged that this diagnosis was incorrect and that Kostal was actually suffering from blastomycosis, a deep fungal infection.

¶ 28 Doctor Mehregan testified became acquainted with Kostal's case when he received her biopsy samples and a requisition form from Doctor Signore. In the requisition form, Doctor Signore described the lesion on Kostal's right lateral thorax as a "rapidly growing 3.2-centimeter nodule with central crust growth." Doctor Signore's clinical diagnosis was K.A. Doctor Mehregan acknowledged that Doctor Signore took an adequate biopsy of Kostal's lesion and provided him with a sufficient amount of tissue to put onto slides and ultimately make a proper diagnosis; however, he believed that Doctor Signore "gave [him] clinical information that was somewhat misleading or at least not complete." Specifically, Doctor Mehregan testified that it would have preferable for Doctor Signore to inform him that Kostal "had multiple crusty lesions rather than [providing] a clinical diagnosis of" K.A. In addition, if Doctor Signore had indicated that Kostal had also been experiencing respiratory symptoms, he would have likely changed his approach and thought process. He acknowledged, however, that if he had any questions about

Kostal's clinical presentation, he could have called Doctor Signore for additional information. He confirmed that he never called Doctor Signore or made any additional inquiries regarding Kostal's right lateral thorax lesion. Instead, he relied on what was written on the requisition form.

¶ 29 He admitted, however, the job of a dermatopathologist is not simply to rubber stamp the clinical diagnosis provided by the submitting physician because a closer examination could conceivably show features that modify or reverse his initial first impression. That is because a skin lesion may appear to be "one thing clinically when looking with the naked eye but turn out to be something else when" examined under a microscope." He further acknowledged that the use of a microscope "most often" provides the definitive diagnosis. Generally, a careful microscopic examination of a tissue sample will allow a dermatopathologist to determine the category of major skin conditions to which the sample belongs. He testified that he utilized a basic H&E[2] stain on Kostal's slides in December 2001. H&E stains are not considered to be complete stains because they do not depict certain tissue components. Doctor Mehregan testified other types of special stains may be used to examine tissue and render a diagnosis when a dermatopathologist believes that the use of special stains would be helpful. In particular, PAS staining is used to examine tissue for evidence of fungal organisms. Doctor Mehregan testified that when a fungal infection is suspected, a reasonable dermatopathologist would conduct a special staining on a tissue sample, including a PAS stain, after utilizing a basic H&E stain. That is, "if you suspect on the H&E based on what you see and the clinical information that you have that there's a fungus, then you should do a PAS stain." He agreed that the failure to conduct a PAS stain when a deep fungal is suspected after viewing an H&E slide would amount to a

[2] H&E is an abbreviation for a hematoxylin and ecosin stain, a basic stain frequently used to examine tissue samples.

deviation from the standard of care. Doctor Mehregan acknowledged that if he had performed a PAS stain on Kostal's tissue specimen in December 2001, he would have most likely made the correct diagnosis of blastomycosis at that time. He conceded that it is not difficult to conduct special staining on tissue samples.

¶ 30 Doctor Mehregan testified that when he viewed Kostal's specimen in December 2001, he observed mixed granulomatous infiltrates, psuedopithiliomatous hyperplasia, and multinucleated giant cells, all of which are outstanding histologic features of blastomycosis. However, he explained that "those features may [also] be seen in other settings" including K.A. Because blastomycosis is rare, Mehregan stated that if he saw the aforementioned features, he would be likely to suspect a more common ailment that shared those features rather than a more rare presentation like blastomycosis. He emphasized that dermatopathologists "take the features that [they] see and [they] put them into clinical context." In this case, Mehregan put the features that he observed in Kostal's specimen "in the clinical context of a single lesion in a middle-aged patient with a clinical presentation of [K.A.]." He admitted that he did not consider blastomycosis when he reviewed Kostal's slides because it is so rare. This is true even though he observed the four hallmark features of blastomycosis and even though he was aware that blastomycosis could appear clinically similar to K.A.

¶ 31 Doctor Jeffrey Melton, a dermatologic surgeon, testified that Kostal was referred to him in January 2002, by Doctor Signore. Based upon the referral, Kostal's lesions had been biopsied and a report had been prepared by Doctor Mehregan diagnosing her with K.A. In accordance with the referral, he excised three lesions that were believed to be squamous cell carcinoma of the K.A. type. Based on his own visual examination of the lesions, he believed that they were "most likely" K.A. lesions; however, he believed that Kostal's "presentation was pretty unusual"

and recommended that she follow-up with her primary care physician "to rule out any underlying disease process." He explained that Kostal's presentation was atypical because her lesions were larger than most K.A. lesions and her lesions occurred in multiples. Doctor Melton testified that he had "never" seen multiple K.A. lesions on a patient at one time. He subsequently learned that the reason for Kostal's unusual presentation was that she did not have K.A.; rather, she had blastomycosis.

¶ 32 In accordance with the circuit court's ruling on Kostal's motion *in limine*, Doctor Melton was not allowed to provide any testimony that: he submitted the lesions he excised to Richfield Laboratory of Dermatopathology for additional review; that Doctor Barron reviewed Kostal's excised lesions; that Doctor Barron inquired whether the lesions could possibly contain evidence of fungal disease; or that Doctor Barron diagnosed Kostal with K.A. after he had been told that there was no possibility that Kostal was suffering from a fungal infection.

¶ 33 Doctor Bhagavatula Ramakrishna, an infectious disease specialist, testified that he treated Kostal during her hospitalization at Palos Community Hospital in February 2002. He had received a call from her attending physician, who requested a consult. At the time, Kostal had visible lesions on her face and she was complaining of severe back pain. Doctor Bhagavatula first examined Kostal on February 13, 2002, at approximately 8 a.m. He initially observed a lesion on her chin and another on her forehead. He noted that her chin lesion was "very characteristic" for blastomycosis. Because Kostal's prior biopsy results did not lead to a blastomycosis diagnosis, Doctor Ramakrisha wanted to conduct his own examination of her tissue. Kostal also underwent a bone biopsy and an MRI. Testing confirmed Doctor Ramakrishna's suspicion that Kostal was suffering from blastomycosis and that the infection had spread to her bones. There were lesions on her vertebrae at T9, T10 and L2. In his medical

opinion, Kostal's blastomycosis was an "indolent slowly-moving infection" and that her back pain was caused by the infection, which had begun to destroy her spine. He immediately prescribed Itraconazole, an anti-fungal medication.

¶ 34 Doctor Ramakrishna testified that he continued to monitor Kostal's progress during her hospital stay. On February 16, 2002, he noted that her skin lesions had become stable and no additional lesions had formed. At the time of her discharge on February 25, 2002, her lesions were visibly improving. He attributed the improvement to a correct diagnosis and treatment plan. He had a follow-up visit with Kostal on April 4, 2002. Her skin lesions had healed by that point; however, she still complained of severe back pain even though she was taking pain medication. Due to the continued back pain, Kostal underwent surgery at Northwestern Hospital.

¶ 35 On cross-examination, Doctor Ramakrishna acknowledged that Kostal reported that she had gone to visit her father in Wisconsin in June 2001, had begun coughing in September 2001, and had begun to experience some back pain in October 2001. Based on the information she relayed, Doctor Ramakrishna believed that Kostal was likely infected during her June 2001 visit with her father and that the symptoms she experienced thereafter were caused by the dissemination of the infection. Although prompt diagnosis and treatment is better, he agreed that he could not say with certainty whether Kostal could have avoided surgery if she had been diagnosed with blastomycosis earlier. He explained that patients respond to anti-fungal medication differently, and that some patients who experience bone destruction caused by blastomycosis may not require surgical intervention because the antifungal medication will arrest the progression of the infection and allow the bone to heal.

¶ 36 Doctor Stephen Ruby, a pathologist board certified in anatomic and clinical pathology, testified that back in 2002, he was a pathologist on staff at Palos Community Hospital and was called upon to review tissue slides biopsied from Kostal's right lateral thorax. At the time that he conducted his own microscopic examination of plaintiff's slides, he was aware that an outside institution had diagnosed her with K.A. On February 20, 2002, he issued a pathology report detailing his findings. In pertinent part, Doctor Ruby observed a "heavy, chronic, active inflammatory cell infiltrate consisting of multiple multi-nucleated giant cells." In addition to the granulomatous infiltrates and multi-nucleated giant cells, he also observed micro-abscesses caused by fungal organisms. All of these findings were "compatible with blastomycosis."

¶ 37 On cross-examination, Doctor Ruby acknowledged that a PAS stain had already been performed on one of the slides by the time that he conducted his own examination and authored his own report. He further acknowledged that Doctor Mehregan had already amended his initial diagnosis from K.A. to blastomycosis at the time that he conducted his own analysis and rendered his own diagnosis.

¶ 38 Doctor Matthew Hepler, the orthopedic surgeon that operated on Kostal at Northwestern Hospital, testified that his "role in her treatment was to address spine-related problems, including kyphosis and some neurologic involvement." He testified that Kostal's MRI showed that she suffered "spinal disruption" as a result of her fungal infection. She had damage at her vertebral bodies located at T9 and T10, which had resulted in instability of her spinal cord. After reviewing Kostal's MRI, Doctor Hepler recommended two operations: "an anterior I & D and stabilization followed at a second stage with posterior spinal fusion and instrumentation." The surgeries were complex and lengthy. He first had to make a spinal incision and remove the infected bone. Then, bone grafts were used to "fill [the] hole" caused by the removal of the

infected bone. Rods, screws, and hooks were utilized to hold the bone still until it healed and fused. Because Kostal had some postoperative pulmonary complications, Doctor Hepler testified that she had to be intubated and put on a ventilator for several days after the initial surgery. Although there were no complications with the second surgery, Doctor Hepler testified that patients who undergo such extensive spinal surgery do not return "back to normal." He explained that their recovery time will be lengthy and that their range of motion will be limited. Given Kostal's physically demanding job at Dominick's, he advised her that returning to her employ would "be unrealistic based upon the surgery that she had and the limitations that would be imposed on her afterwards."

¶ 39 On cross-examination, Doctor Hepler opined that it would take a significant period of time for the blastomycosis infection to erode her spine. He estimated that it would likely have taken "a minimum of a month to several months" for the infection to cause the degree of damage that it did to her spine. He agreed, however, that even if the correct diagnosis of blastomycosis had been made in December 2001 rather than February 2002, Kostal may have nonetheless required spinal surgery. Doctor Hepler clarified that if the infection had been caught before there were "structural changes" to her spine then surgery would not have been required; however, because no MRI or CT scan was performed until February 2002, there was no way to tell when Kostal began to sustain structural damage to her spine as a result of the infection.

¶ 40 Doctor Wayne Duke, a dermatopathologist with board certifications in anatomic and clinical pathology, testified as plaintiff's retained dermatopathology expert witness. Throughout the years that he practiced as a dermatopathologist, Doctor Duke testified that he has become "well versed" in the diagnosis of various skin conditions and diseases including skin cancers and

deep fungal infections and the standard of care applicable to other dermatopathologists called upon to make such diagnoses.

¶ 41 Doctor Duke confirmed that when a patient's tissue samples are sent to a dermatopathologist for review, the slides are often accompanied by a clinical or differential diagnosis from the submitting physician. Although a clinical impression can sometimes be "quite helpful," he testified that other times the impression is not really relevant because "the buck stops with the pathologist." It is the dermatopathologist, not the clinician, who is responsible for deciding what the tissue sample reveals. Doctor Duke emphasized, "if the clinician knew what it was with 100 percent certainty," the sample would not have been sent to a dermatopathologist for a diagnosis. He further testified that although the clinical diagnosis provided by the submitting physician "sometimes" matches the microscopic diagnosis made by a dermatopathologist, often times the diagnoses differ explaining: "Every dermatopathologist every day makes a diagnosis that's contrary to what's on a slip of paper." The reason that diagnoses made by clinicians do not always match diagnoses made by dermatopathologists is that "when [dermatopathologists are] looking at a specimen [they are] looking at typically 100 to 400 times the magnification that the clinician is. So the clinicians might have good eyes. They might even use a little magnifying glass," but the dermatopathologist has access to equipment that allows them to analyze a piece of tissue more closely.

¶ 42 Doctor Duke testified that K.A. is a "form of squamos cell carcinoma" and its hallmark feature is a volcano shaped tumor. Blastomycosis, in turn, is a "relatively rare" type of fungal infection that has four hallmark features, including: pseudoepitheliomatous hyperplasia, or a thickening of the skin, which is caused by a reaction to the fungus; "little pockets of puss" known as microabscesses; multinucleated giant cells, which are simply "big cells that have multiple

nuclei"; and mixed granulatomous infiltrates. In addition to these four hallmark features, there will also be evidence of fungal microorganisms. He explained that the circular fungal microorganisms typical of blastomycosis can be seen on a basic H&E slide and that a reasonably well-qualified and careful dermatopathologist could make a blastomycosis diagnosis without conducting a special stain on a tissue sample. He explained that the microorganisms reproduce, and thus, there will be evidence of "broad based budding," which is "two circles [that] are basically touching or ever so slightly overlapping [as] one gives birth to another" that will be visible on a routine H&E slide. Doctor Duke acknowledged, however, that there may be instances in which a dermatopathologist can observe the four main features of blastomycosis but not observe any fungal microorganisms on an H&E slide. He testified that in those instances, the standard of care dictates that the dermatopathologist conduct a special stain on the tissue sample. He explained that special stains are "a bit more sensitive" which makes it "easier to see the bugs."

¶ 43 Doctor Duke confirmed that he reviewed the tissue samples of plaintiff's right lateral thorax lesion that had been biopsied on December 4, 2001. He further confirmed that he reviewed the pathology report authored by Doctor Mehregan on December 10, 2001, that included his microscopic description and diagnosis of Kostal's right lateral thorax lesion as well as the addendum report authored by Doctor Mehregan in February 2002 after he conducted a PAS stain on plaintiff's biopsied tissue. Based on his own review of the slides, Doctor Duke opined that Doctor Mehregan's work on plaintiff's case deviated from the standard of care in two ways: "One, there was a definitive diagnosis of a tumor, a definitive diagnosis of keratoacanthoma. The pictures that you will see do not show the characteristics of keratoacanthoma. So that diagnosis was entirely wrong or incorrect. In addition, he failed to

identify or suspect that there was a serious fungal infection." Based upon his own microscopic analysis of plaintiff's H&E slides, Doctor Duke testified that the "findings were classic for blastomycosis" including pseudoepitheliomatous hyperplasia, "abundant prominent mircrosabscesses," multinucleated giant cells, mixed granulomatous infiltrate, and fungal microorganisms. Doctor Duke emphasized that the large number of microabscesses present on plaintiff's slides was significant because "[t]he most classic typical case of blastomycosis has a lot of microabscesses." In contrast, microabscesses are "not typically part of the disease" of K.A. He confirmed that the standard of care required Doctor Mehregan to recognize and identify the presence of fungal microorganisms on the 2001 H&E slide, stating: "he should have suspected that it was an infection and if he could not identify the organisms using the standard stain, he should have done a fungal stain to identify the organisms." He testified that Doctor Mehregan's failure to perform a special stain on the slides was another way in which he failed to comply with the applicable standard of care. Although Doctor Duke acknowledged that the standard of care did not require Doctor Mehregan to be perfect, he testified that the standard of care did require him to take all of the reasonable steps necessary to render an accurate diagnosis. After considering the records and slides, Doctor Duke testified that he "[did] not believe [Doctor Mehregan] performed his due diligence in his care of [plaintiff]" and that his diagnosis of K.A. was "not [a] reasonable" diagnosis. That is primarily because Kostal's slides contained fungal microorganisms, a feature that is absolutely inconsistent with a diagnosis of K.A.

¶ 44 Doctor Duke acknowledged that prior to evaluating plaintiff's slides, he was aware that she had blastomycosis; however, he explained that he did not know whether the specific biopsy slides that he was given to review depicted blastomycosis and that he did not begin his examination by assuming that blastomycosis was manifested in the slides. He denied that his

knowledge that Kostal had been diagnosed with blastomycosis affected the manner in which he assessed whether or not Doctor Mehregan complied with the requisite standard of care. He explained that "the slides speak for [themselves.] The fact is the fungus was on the biopsy." Doctor Duke testified that as a result of Doctor Mehregan's failure to adhere to the standard of care, Kostal's blastomycosis diagnosis was "delay[ed] [for] approximately two and a half months."

¶ 45 On cross-examination, Doctor Duke acknowledged that he has never published any article on either K.A. or blastomycosis and has never diagnosed any of his own patients with blastomycosis. He explained that the fungus that causes blastomycosis is not endemic to the New England area where he and his patients reside, but instead exists primarily in the Great Lakes region. He further acknowledged that the microscopic analysis of tissue samples involves a certain amount of subjectivity; however, the presence or absence of microfungal organisms is not a determination that involves subjectivity because "they're [either] there or they're not." He testified that there is no specific number of abscesses that must be present on a tissue sample to warrant a diagnosis of blastomycosis and admitted that some of the hallmark features of blastomycosis can be present in a patient with K.A., including abscesses and multi-nucleated giant cells. He emphasized, however, that the presence of fungal microorganisms is not consistent with a K.A. diagnosis.

¶ 46 Doctor John Segretti, an infectious disease professor and physician board certified in internal medicine and infectious diseases, testified as plaintiff's retained infectious disease expert. He confirmed that blastomycosis is a relatively "uncommon" deep fungal infection. It is caused by an organism called blastomyces dermatitidis, a microorganism endemic to areas in the Midwest. Because the microorganism that causes blastomycosis is endemic to this region,

Doctor Segretti testified that the occurrence of blastomycosis, although perhaps uncommon, is "not rare at all" in this locale. He explained that most people become infected with blastomycosis when they inhale the microorganism. Generally, the microorganism will remain confined to the person's lungs and the infected person will evidence symptoms similar to pneumonia. Most of the time, the person will be able to fight off the infection herself and she will not be aware that she ever had blastomycosis. On other occasions, the microorganisms will get into the blood stream and "disseminate" to other places in the body. The most common place for the microorganisms to spread is the skin where they will form lesions. Once blastomycosis has reached the skin, the most common treatment is antifungal medication. He testified that the treatment should be started "as soon as possible."

¶ 47 In other instances, the microorganisms can invade a person's bones, including her spine. When the microorganisms reach the bone, they do not cause immediate destruction; rather bone destruction will only occur if the infection is left untreated for a period of time. Doctor Segretti explained that most of the destruction is not due to the organisms eating away at the bone; rather "a lot of the destruction is related to the inflammatory response to the infection," a process that takes some time. If left undiagnosed and untreated, blastomycosis can eventually result in the "collapse of the bone" and "instability of the spine." As the infection progresses, the patient would typically feel an increased degree of pain. Antifungal medication is also used to treat blastomycosis that has spread to the bone; however, it takes longer to treat the infection when it has spread the bone because "drugs don't penetrate into the bone as well as they do into the skin and the lung." Doctor Segretti estimated that it will usually take somewhere between "six to eight weeks before [he would expect] to see any significant impact of treatment in the bone." He further testified that surgery is not required in all cases in which blastomycosis reaches the

patient's spine, explaining: "if you can stop the progression and decrease the amount of inflammation in the area before you get to the point where you have too much damage, the body will heal that. You will get some fibrosis of the area. You will get a little scar formation inside the bone. But you can effectively heal that without having to do surgery."

¶ 48 After reviewing Kostal's medical records and other relevant evidence, Doctor Segretti opined that Kostal was likely infected with blastomycosis when she "inhaled the organism, and it went to her lungs, and then spread to the skin and the bone." The skin lesions observed by her primary care physician Doctor DiPasquo on November 20, 2001, were likely blastomycosis lesions. Doctor Segretti estimated that the organisms had "seed[ed] the bone six to eight weeks prior" to when she first reported experiencing severe back pain on January 28, 2002. The "severe" back pain she experienced was evidence that the disseminated blastomycosis had begun to cause destruction to her spine at that time. He acknowledged that Kostal's primary care physician prescribed various antibiotics in the months prior to her correct diagnoisis; however, he testified that antibiotics have no impact on fungal organisms and thus, her blastomycosis essentially remained untreated. She did not begin receiving correct treatment for her blastomycosis until her admission to Palos Community Hospital in February 2002, approximately 2 months after her initial skin biopsy. At that time, she was prescribed Sporanox, an anti-fungal medication, and based on her medical records, Doctor Segretti opined that the medication was effective in treating Kostal's blastomycosis because her lesions began to disappear. Although the medication was effective, Kostal "already had significant destruction of some of her vertebrae" before she was properly diagnosed and treated. As a result, she underwent spinal surgery in May 2002. Doctor Segretti opined that if Kostal had been properly diagnosed treated with an anti-fungal medication, at the time of her December 4, 2001, biopsy,

she "more likely than not could have avoided the [spinal] surgery" as well as her prolonged postsurgical rehabilitation and physical therapy. He explained that Kostal was not complaining of back pain at the time of her December 2001 biopsy and he believed that if she had received effective treatment at that time, it would have likely prevented the destruction to her spine that occurred over the next few months until her proper diagnosis. In his opinion, the delay in Kostal's diagnosis "made a huge difference" in the outcome.

¶ 49 On cross-examination, Doctor Segretti acknowledged that the respiratory symptoms that Kostal experienced in September and August 2001 were most likely symptoms of blastomycosis. In addition, because Kostal did not undergo an MRI or CT scan until she was admitted to Palos Community Hospital in February 2002, there is no way to know when exactly the microorganisms disseminated to the bone. On redirect examination, Doctor Segretti testified that even if there was "seeding" of the bone in August or September 2001, it would not change his ultimate opinion in the case. He reiterated that the process from seeding to bone erosion is one that takes a substantial period of time and that correct diagnosis and treatment in December 2001 would have likely prevented Kostal's need for spinal surgery.

¶ 50 After presenting the aforementioned evidence, plaintiff rested her case-in-chief.

¶ 51 Doctor Mehregan provided testimony consistent with the testimony he provided as an adverse witness in plaintiff's case-in-chief. He reiterated that the clinical description of the lesion that Doctor Signore provided was consistent with a K.A. diagnosis. In addition, the features contained in the tissue samples that he observed were also consistent with a diagnosis of K.A. He explained that he did not conduct a special stain because there were "features that were consistent with [K.A.] and a clinical history and clinical description that were both consistent with [K.A.]." Although there are similarities in the features of K.A. and blastomycosis, Doctor

Mehregan testified that a reasonably careful dermatopathologist would not necessarily consider a blastomycosis diagnosis when the lesion is presenting clinically as K.A. He acknowledged that after he was told of the correct diagnosis and he reviewed Kostal's previously prepared H&E slides, he could see the presence of fungal organisms on her slides. He explained: "In retrospect, when you know they're there, it's easy to go back and—especially once you've seen a PAS stain and you know approximately where they are—to go back and find them." In his opinion, he acted as a reasonably careful dermatopathologist when he interpreted Kostal's slides in December 2001 and complied with the requisite standard of care.

¶ 52 On cross-examination, Doctor Mehregan agreed that he would have deviated from the standard of care in this case if he had conducted PAS staining on Kostal's tissue sample and failed to diagnosis her with blastomycosis. He believed that if he had performed a PAS stain on Kostal's tissue samples, he would have seen the fungal organisms and would have diagnosed Kostal with blastomycosis in December 2001. He also acknowledged that if he had diagnosed Kostal with blastomycosis in December 2001, her course of treatment would have been different.

¶ 53 Doctor Timothy McCalmont a practicing dermatopathologist, confirmed that he was retained by defendants and was asked to examine two of the slides that Doctor Mehregan reviewed in connection with Kostal's case. In his opinion, one of the slides "showed a squamous proliferation with features of [K.A.]." He indicated that the clinical diagnosis on Doctor Signore's submission form "matched very well with [his] objective interpretation of the slide." In particular, he observed a combination of features commonly associated with K.A., including: microabscesses, keratinocytes, and mixed infiltrates. He did not view any fungal organisms on the slides nor did he conduct any PAS stain testing.

¶ 54 After providing his initial observations, Doctor McCalmont testified that he subsequently learned that the slides contained tissues of a skin abnormality caused by blastomycosis. He admitted that if Doctor Signore's requisition form had indicated that Kostal had other symptoms including fever or cough or multiple lesions, that information would have led a reasonably careful dermatopathologist to suspect that the cause was a fungal infection. Based upon the information that was actually contained in the requisition form as well as his review of the slides, Doctor McCalmont testified that the report generated by Dr. Mehregan diagnosing Kostal's skin condition as a "squamous cell carcinoma of the keratoacanthoma type" was the report of a "reasonably careful dermatopathologist." He further opined that Doctor Mehregan complied with the requisite standard of care. More specifically, he opined that the applicable standard of care did not require Doctor Mehregan to conduct a special staining on Kostal's tissue sample because "having been presented with the scenario where the slide looks like [K.A.] and the clinical history suggests that the lesion is [K.A.], it wouldn't be the next thought process to [perform] special stains on a case like that." Although in retrospect Doctor Mehregan's diagnosis was incorrect, Doctor McCalmont testified that a dermatopathologist can render an incorrect diagnosis and still comply with the standard of care. He emphasized that "the standard of care requires the reasonable behavior of a reasonably careful physician in performing an activity and Dr. Mehregan was reasonably careful in evaluating the specimen and in coming *** to a diagnosis that was proved incorrect at a later point in time."

¶ 55 On cross-examination, Doctor McCalmont acknowledged that the role of a dermatopathologist was not to simply rubber stamp or endorse the clinical diagnosis made by the submitting physician. He further acknowledged that he considered the possibility that Kostal's tissue sample contained evidence of a deep fungal infection and that he included this possibility

in his list of differential diagnoses when reviewing the slides. Nonetheless, he could not state with certainty that he would have conducted a PAS stain on the sample if he had been in Doctor Mehregan's position; however, he indicated that he "would like to think that [he] would have" done so. He agreed that if a special staining had been performed by Doctor Mehregan in December 2001, Kostal would have likely been correctly diagnosed with blastomycosis. He further agreed that "in a situation where a pathologist has questions regarding a differential diagnosis that can be solved by the use of special staining, then utilization of the stains is going to be the best cause of action under the standard of care."

¶ 56 After hearing the aforementioned evidence and the arguments of the parties, the jury received a series of instructions. The jury then commenced deliberations and ultimately returned with a verdict against defendants, awarding Kostal $3,249,821.82 in damages. The circuit court subsequently modified the judgment amount to $2,649,820.82 as a result of a set-off. Defendants' post-trial motion was denied and this appeal followed.

¶ 57 ANALYSIS

¶ 58 Exclusion of Evidence Pertaining to Doctor Barron's Misdiagnosis

¶ 59 On appeal, defendants challenge various rulings made by the circuit court during the course of the lower court proceedings. Defendants first argue that the court "abused its discretion when it excluded any and all evidence of Dr. David Barron's diagnosis of keratoacanthoma." In pertinent part, defendants maintain that Doctor Barron's diagnosis of K.A. was admissible because it was relevant to the "seminal issue of the reasonableness of Dr. Mehregan's diagnosis." Moreover, they argue that Doctor Barron's testimony was relevant to rebut the credibility of Doctor Duke, plaintiff's proffered dermatopathology expert. Given the

importance and relevance of Doctor Barron's misdiagnosis, defendants maintain they were prejudiced by the circuit court's decision to exclude that evidence.

¶ 60 Kostal responds that the court properly excluded evidence of Doctor Barron's examination of her tissue samples and his misdiagnosis. She argues that Doctor Barron's misdiagnosis five weeks after Doctor Mehregan's misdiagnosis was "irrelevant because the circumstances of [his] review were entirely dissimilar to defendant Doctor Mehregan's review." Specifically, her right lateral thorax lesion changed in size significantly in the intervening five weeks and the doctors viewed different tissue samples removed at different times. Moreover, Doctor Barron only diagnosed Kostal with K.A. after he was specifically told that there was "no way" that her tissue samples contained evidence of a deep fungal infection.

¶ 61 It is well-established that the admissibility of evidence is within the discretion of the circuit court. *Snelson v. Kamm*, 204 Ill. 2d 1, 33 (2003); *Hubbard v. Sherman Hospital*, 292 Ill. App 3d 148, 155 (1997). More specifically, the decision to admit or exclude evidence pursuant to a motion *in limine* is a decision left to the discretion of the circuit court. *Guski v. Raja*, 409 Ill. App. 3d 686, 698 (2011). Generally, evidence is admissible if it is relevant and evidence is considered relevant if it has any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence. *Smith v. Silver Cross Hospital*, 339 Ill. App. 3d 67, 74 (2003). The relevance of evidence is a matter left within the sound discretion of the circuit court and its determination will not be disturbed absent an abuse of that discretion. *Leonardi v. Loyola University of Chicago*, 168 Ill. 2d 83, 92 (1995); *Smith*, 339 Ill. App. 3d at 74. "The threshold for finding an abuse of discretion is high" and will only be found when no reasonable person would take the view of the circuit court. *In re Leona W.*, 228 Ill. 2d 439, 460 (2008). Moreover, the existence of an abuse

of discretion, standing alone, does not require automatic reversal; rather, reversal is only warranted when the record reveals that the circuit court's ruling resulted in substantial prejudice and affected the trial result. *Id*.

¶ 62 In this case, the circuit court initially denied Kostal's motions *in limine* seeking to bar Doctor Barron from testifying and to bar defendants from referencing Doctor Barron's examination of her tissue samples and his subsequent misdiagnosis. During the trial, after presenting some preliminary evidence, however, Kostal's attorney renewed her objections pertaining to Doctor Barron's testimony and diagnosis. In doing so, counsel argued: "I don't think his testimony is relevant. All of the evidence that has gone in to this point has reflected that the lesion changed between December 2001 and January of 2002. So, whatever [Doctor Barron] looked at could not have been the same or even similar to what Doctor Mehregan looked at in 2001. So, I don't see how Doctor Barron coming in here and testifying about what he saw in 2002 bears any relevance whatsoever to the issues that pertain to Doctor Mehregan. *** I [also] think it would be cumulative in light of Doctor McCalmont being called today and also Doctor Mehregan being called again next week."

¶ 63 In response, counsel for defendants argued: "[T]here has been testimony that the lesion did change in size from the time that Doctor Signore took the biopsy to the time that Doctor Melton excised the lesion on the right lateral thorax. But there has been no testimony that the lesion changed insofar as its histologic characteristics under a microscope, what would be seen because of the fact that it's blastomycosis. There's been lots of testimony about what one would expect to see with blastomycosis under the microscope. Because it's blastomycosis, one would expect these features still to be seen. *** Even if it were a concern, the size of the lesion itself and how it appeared, that would go to the weight of the testimony and not the admissibility of the

testimony. *** The reason his testimony is being offered as we've already gone over numerous times is that he looked at the same lesion and concluded it was [K.A.] which is further evidence of the reasonableness of Doctor Mehregan's interpretation of the same lesion in the form of a biopsy approximately one month earlier."

¶ 64 After hearing the arguments of the parties, the court reversed its prior ruling, explaining: "I've listened to four days of testimony that I didn't have the advantage of hearing at the beginning, and I am going to reverse myself. The reason I'm going to reverse myself is no matter how many times [defense counsel] tells me [he's] just putting it on for [Doctor Barron] to say that he found the K.A. and he didn't find the blasto[mycosis], the inference to the [j]ury is then we have three experts, a reasonably qualified dermatopathologist saying this. So, we shouldn't be trying cases on the number of witnesses. We have three experts on the defense side, one on the plaintiff's side. So, it's cumulative *** and [Doctor Barron] is not going to be allowed to testify."

¶ 65 Later, when denying defendants' post-trial motion and their claim that the exclusion of evidence pertaining to Doctor Barron prejudiced them and warranted a new trial, the court stated: "Based on the evidence presented over the first four days of trial, including testimony that different tissue was removed from different parts of [Kostal's] anatomy at different times by two different doctors, one removed by a dermatologist and one by a dermatological surgeon, this Court could not say Doctor Melton and Doctor Barron examined the same or substantially the same tissue specimens [as Doctor Signore and Doctor Mehregan]. Therefore, the Court determined Doctor Barron's testimony concerning his review of [Kostal']s tissue [specimens] would not be relevant to the claims brought against [Doctor Mehregan]."

¶ 66 Following our review of the record, we do not find that the court abused its discretion. There is no dispute that the conditions under which Doctors Barron and Mehregan conducted their review of Kostal's tissue samples and rendered their diagnoses differed in several significant ways. The doctors did not view the same slides. The relevant tissue samples viewed by Doctor Mehregan were removed by Doctor Signore during a biopsy of Kostal's right lateral thorax on December 4, 2001. Doctor Barron, in contrast, viewed tissue samples after Doctor Melton had excised the entire lesion on January 8, 2002. There is similarly no dispute that Kostal's right lateral thorax lesion was a rapidly growing lesion and that it had changed substantially in the intervening weeks in between both diagnoses. At the time Doctor Signore biopsied Kostal's right lateral thorax lesion and sent it to Doctor Mehregan for review, it was 3.2 cm and oval-shaped. In contrast, by the time Doctor Melton excised Kostal's right lateral thorax lesion, it was found to be 5 cm by 4.9 cm by 1.4 cm. Moreover, the record further indicates that Doctor Barron, unlike Doctor Mehregan, considered the possibility that Kostal was suffering from a fungal infection and only rendered his diagnosis of K.A. after he was told by Doctor Melton that there was "no way" that Kostal's tissue had evidence of such an infection. Ultimately, given the different circumstances pertaining to Doctor Mehregan's and Doctor Barron's examination and diagnoses, we are unable to conclude that the circuit court abused its discretion in finding that evidence pertaining to Doctor Barron's diagnosis was not relevant to the specific claims brought against Doctor Mehregan. Therefore, the court properly excluded Doctor Barron's testimony and evidence relating to his misdiagnosis.

¶ 67 In so finding, we are unpersuaded by defendants' reliance on the Third District's decision in *Steele v. Provena Hospitals*, 2013 IL App (3d) 110364. In that case, a wrongful death and medical malpractice action was brought by the family of a woman who died after an emergency

room physician failed to diagnose her with chicken pox. At trial, the defendant doctor sought to introduce evidence that another physician at another hospital examined the decedent one day after he did and also failed to diagnose her with chicken pox; however, the circuit court excluded that evidence. On appeal, the Third District concluded that the circuit court abused its discretion in excluding that evidence, reasoning: "The excluded evidence represents a nearly contemporaneous presentation of the rash with the same failure of doctors*** to recognize chicken pox ***. The reasons for the failure of other doctors to diagnose chicken pox and underlying varicella zoster infection so close in time to [defendant's] treatment of [decedent] is relevant and probative." *Steele*, 2013 IL App 110374, ¶ 64.

¶ 68 Here, in contrast, Doctors Barron and Mehregan did not view a "nearly contemporaneous" presentation of blastomycosis. Doctor Barron viewed tissue from Kostal's right lateral thorax lesion nearly five weeks after Doctor Mehregan did and the specific tissue samples that both doctors viewed were not the same. Moreover, unlike *Steele* where the was no evidence that the patient's presentation changed significantly in the hours between her first and second examinations, the record in this case reveals that Kostal's right lateral thorax lesion had changed significantly in its presentation between December 2001 and January 2002, when the doctors conducted their microscopic examinations and made their respective diagnoses. Therefore, we cannot conclude that the circuit court's decision to exclude Doctor Barron's testimony and evidence of his misdiagnosis amounted to an abuse of discretion.

¶ 69 Even if we could agree that evidence pertaining to Doctor Barron should have been admitted, we do not find that defendants were prejudiced by the exclusion of that evidence such that a new trial is warranted. At trial, the crux of defendants' defense was that Doctor Mehregan's K.A. diagnosis, although incorrect, was reasonable based on the information

available to him at the time, and did not amount to a deviation from the requisite standard of care. In support of that defense, defendants were able to elicit evidence from Doctors Signore, Melton, and McCalmont, that they too, initially believed that Kostal had K.A. Given that Doctor Barron's testimony would essentially be duplicative of the testimony elicited from Doctors Signore, Melton and McCalmont, defendants suffered no prejudice from its exclusion. See generally *Lebrecht v. Tuli*, 130 Ill. App. 3d 457, 483 (1985) (recognizing that any "[e]rror in the admission or exclusion of evidence is harmless if the facts involved are strongly established by other competent evidence").

¶ 70 Moreover, the exclusion of Doctor Barron's diagnosis did not prevent defendants from effectively cross-examining Kostal's dermatopathology expert, Doctor Duke. Although defendants suggest that evidence of Doctor Barron's misdiagnosis would have undermined Doctor Duke's conclusion that Doctor Mehregan deviated from the standard of care, we note that Doctor Duke's opinions pertaining to Doctor Mehregan were solely based upon his examination of the slides prepared by Doctor Mehregan. In pertinent part, Doctor Duke testified that "the slides [prepared by Doctor Mehregan] speak for [themselves]. The fact is the fungus was on the biopsy." In his opinion, the tissue samples viewed by Doctor Mehregan "were classic for blastomycosis" and the large number of microabscesses on the slides should have led Doctor Mehregan to suspect an infection because microabscesses are "not typically part of the disease [of K.A.]" Given that the basis for Doctor Duke's opinion that Doctor Mehregan deviated from the standard of care was based upon his own review of the slides examined by Doctor Mehregan, any discussion of Doctor Barron's examination of different tissue samples on different slides would not have undermined Doctor Duke's expert testimony pertaining to Doctor Mehregan. Similarly any photograph of Kostal's lesions taken following Doctor Mehregan's examination

and diagnosis were also irrelevant and would not have served to undermine Doctor Duke's opinion. We note that the scope of permissible cross-examination is also a matter that is left to the discretion of the circuit court. *Leonardi*, 168 Ill. 2d at 102; *Fragogiannis v. Sisters of St. Francis Health Services, Inc.*, 2015 IL App 141788, ¶ 27. Here, we do not find that the court abused its discretion or prejudiced defendants when it precluded them from discussing any issues pertaining to Doctor Barron during their cross-examination of Doctor Duke.

¶ 71 Defendants, however, point to the timing of the circuit court's decision to bar evidence of Doctor Barron's misdiagnosis as evidence of prejudice. Given that the circuit court initially denied plaintiff's motion to exclude evidence pertaining to Doctor Barron, defendants intended to call Doctor Barron to testify and to highlight his misdiagnosis throughout the trial. Defendants even referenced Doctor Barron during their opening argument. The circuit court, however, reversed its initial ruling after hearing several days of testimony and defendants argue that they were thereby "discredited in the eyes of the jury." We disagree. Motions *in limine* are interlocutory and remain subject to reconsideration by the circuit court because issues evolve and questions are clarified during the course of a trial. *Guski v. Raja*, 409 Ill. App. 3d 686, 695 (2011). In this case, the judge reversed its earlier decision after hearing "four days of testimony that [it] didn't have the advantage of hearing at the beginning," including the fact that the Kostal's right lateral thorax lesion had changed significantly between December 2001 and January 2002, when the doctors conducted their respective examinations and that the doctors had actually viewed different tissue samples. Defendants were well aware that the court's ruling was subject to reconsideration and we cannot agree that the circuit court's exercise of discretion in reversing its prior rulings on Kostal's motions *in limine* after gaining a better understanding of the facts of the case unduly prejudiced them.

¶ 72 Admission of Doctor Ruby's Testimony and Diagnosis

¶ 73 Defendants next argue that the circuit court erred in allowing Kostal to elicit testimony from Doctor Ruby, the hospital pathologist on staff at Palos Community Hospital, that he "diagnosed" Kostal with blastomycosis after reviewing her slides. They argue that at the time that Doctor Ruby had made his "diagnosis" a PAS stain had been performed on Kostal's tissue samples and that Doctor Mehregan had already changed his diagnosis to blastomycosis. They argue that the admission of Doctor Ruby's "hindsight assessment" was improper and prejudicial.

¶ 74 Kostal responds that Doctor Ruby's testimony was properly admitted without any objection by defendants during trial. She emphasizes that Doctor Ruby viewed the same H&E slide that Doctor Mehregan viewed and was able to arrive at a correct diagnosis and thus his testimony was relevant and admissible.

¶ 75 We agree with Kostal. As set forth previously, the admissibility of evidence is within the sound discretion of the circuit court. *Snelson*, 204 Ill. 2d at 33; *Hubbard*, 292 Ill. App 3d at 155. Initially, we note that defendants failed to object to Doctor Ruby's testimony at trial. Even if they had properly objected, the admission of Doctor Ruby's testimony was not an abuse of discretion. Doctor Ruby testified that he viewed two slides, an H&E slide that had been viewed by Doctor Mehregan, and a PAS slide with special staining. He further testified that the slides contained characteristics "compatible with blastomycosis." Although defendants are correct that Doctor Mehregan did not view a PAS slide prior to making his own diagnosis, that is only because Doctor Mehregan failed to conduct a special stain on Kostal's tissue samples even though her samples contained characteristics consistent with blastomycosis and inconsistent with K.A. Moreover, Doctor Ruby's diagnosis was not based solely on his review of the PAS slide; rather, it was based on his review of both slides. As such, his testimony was relevant and

admissible. Defendants' contention that Doctor Ruby's diagnosis was essentially a "hindsight assessment" is similarly without merit. While it is true that Doctor Mehregan authored an addendum report dated February 14, 2002, in which he changed his diagnosis to blastomycosis, Doctor Ruby did not actually obtain the addendum report until April 12, 2002. Doctor Ruby thus authored his own report on February 20, 2002, without knowledge of Doctor Mehregan's change in diagnosis. As such, Doctor Ruby did not make a hindsight diagnosis.

¶ 76 Jury Instruction Errors

¶ 77 Defendants next argue that the circuit court erred in refusing to provide the jury with the long form of Illinois Pattern Instruction Civil (2012) No. 12.05 (IPI Civil No. 12.05) pertaining to the issue of sole proximate cause. Specifically, defendants argue that they "introduced competent evidence" that blastomycosis, not Doctor Mehregan's misdiagnosis, was the sole proximate cause of Kostal's bone destruction. As such, defendants contend that the jury should have been specifically instructed that it should find in their favor if the jury believed that the sole proximate cause of Kostal's injuries was something "other than the conduct of defendant[s]," language contained in the long version of IPI Civil 12.05.

¶ 78 Kostal responds that the circuit court did not abuse its discretion when it tendered the short form of IPI Civil 12.05 to the jury rather than the long form. Kostal notes that defendants did not call a causation expert and thus did not present any evidence that blastomycosis was the sole proximate cause of her injuries. As such, defendants were not entitled to have the jury instructed in accordance with the long form of IPI Civil 12.05.

¶ 79 The purpose of jury instructions is to convey to the jury the correct principles of law applicable to the submitted evidence. *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 507 (2002). Litigants are entitled to have the jury instructed on any theory that is supported by the evidence.

Leonardi v. Loyola University of Chicago, 168 Ill. 2d 83, 100 (1995); *Mack v. Anderson*, 371 Ill. App. 3d 36, 56 (2006). "A jury instruction is justified if it is supported by some evidence in the record, and the trial court has discretion in deciding which issues are raised by the evidence." *Clarke v. Medley Moving and Storage, Inc*., 381 Ill. App. 3d 82, 91 (2008). To determine the propriety of a set of jury instructions, the relevant inquiry is whether the tendered instructions, taken as a whole, fairly, fully and comprehensively apprised the jury of the appropriate legal principles and theories applicable to the case. *Snelson*, 204 Ill. 2d at 28; *Leonardi*, 168 Ill. 2d at 100. The trial court's instructions to the jury will not be deemed improper absent an abuse of discretion. *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 505 (2002). An abuse of discretion will only be found where the instructions tendered to the jury are unclear, misleading or they do not fairly and accurately state the law. *Dillon*, 199 Ill. 2d at 505; *Johnson v. Johnson*, 386 Ill. App. 3d 522, 542 (2008). Even where the circuit court errs and provides the jury with an improper instruction, the error does not require reversal unless a reviewing court can conclude that the error prejudiced the appellant. *Johnson*, 386 Ill. App. 3d at 542.

¶ 80 The long form of IPI Civil 12.05 provides:

> "If you decide that a defendant was negligent and that its negligence was a proximate cause of injury to the plaintiff, it is not a defense that something else may have also been a cause of the injury.
>
> *However, if you decide that the sole proximate cause of injury to the plaintiff was something other than the conduct of the defendant, then your verdict should be for the defendant*." (Emphasis added.) IPI Civil No. 12.05.

¶ 81 The second paragraph of IPI Civil 12.05 references sole proximate cause, which is a valid defense in a medical negligence case and may be utilized if evidence exists that tends to establish

that the conduct of something or somebody other than the defendant was solely responsible for the plaintiff's injuries. *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 105 (1997); *Jones v. Beck*, 2014 IL App (1st) 131124, ¶ 28. Accordingly, a defendant may endeavor to prove that some other cause was the sole proximate cause of the plaintiff's injury and tender a jury instruction pertaining to that theory if the theory is supported by competent evidence. *McDonnell v. McPartlin*, 192 Ill. 2d 505, 521 (2000). The notes accompanying IPI Civil No. 12.05 specifically state that "the second paragraph should be used only where there is evidence tending to show that the sole proximate cause of the occurrence was something other than the conduct of the defendant." IPI Civil No. 12.05, Notes for Use.

¶ 82 In this case, at the jury instruction conference, Kostal's attorney offered the short form of IPI Civil No. 12.05, which simply contained the first sentence of the instruction and omitted the second sentence that referenced sole proximate cause. Defense counsel, however, objected and argued that the long form of the instruction was more appropriate. In pertinent part, defense counsel argued: "I believe that there's been plenty of evidence that suggests that blastomycosis, as a thing, is the sole proximate cause or was the sole proximate cause of her injury rather than any delay in diagnosis or misdiagnosis by Doctor Mehregan or the conduct of anyone else for that matter. So I think there's been enough evidence to suggest or support an argument that the disease itself was the sole proximate cause." The circuit court disagreed, stating: "I just have a hard time understanding how the disease that [Kostal] is saying [Doctor Mehregan] didn't diagnose could be the sole proximate cause." Accordingly, the circuit court denied defendants' request to provide the jury with the long form of IPI Civil 12.05 and instead provided the short form of that instruction.

¶ 83 After reviewing the record, we disagree with the defendants that the court's ruling constituted an abuse of discretion. Although defendants called Doctor McCalmont to testify as its dermatopathology expert, they did not call a causation expert. Defendants, however, suggest that the responses that they elicited during their cross-examinations of Doctors Segretti, Ramakrishna, and Hepler provided some evidence that Kostal's blastomycosis infection was the sole proximate cause of her injuries. In pertinent part, defendants highlight the fact that Kostal's infectious disease expert, Doctor Segretti, testified that it was "possible" that the seeding of Kostal's spine had begun to occur as early as August or September 2001; however, defendants ignore the fact that Doctor Segretti clarified that the process from seeding to actual bone erosion is one that takes a substantial period of time and that even if seeding had begun that early, it did not change his ultimate conclusion that correct diagnosis by Doctor Mehregan in December 2001 would have likely eliminated Kostal's need for spinal surgery. Defendants also emphasize that Doctor Ramakrishna acknowledged that Kostal's initial complaint of back pain in October 2001 could be evidence that the infection had already disseminated to her spine and that he could not say with certainty whether she could have avoided surgery had she been properly diagnosed by Doctor Mehregan in December 2001. Similarly, defendants emphasize that Doctor Hepler testified under cross-examination that there was no way to tell when Kostal began to sustain structural damage to her spine because no MRI or CT scan was performed until February 2002. Moreover, Doctor Hepler admitted that it was possible that Kostal might have nonetheless required surgery even if she had been properly diagnosed in December 2001 if structural damage had been occurring at that time. Such testimony regarding possibilities, however, is not a basis upon which to establish proximate causation. See generally *Johnson v. Ingalls Memorial Hospital*, 402 Ill. App. 830, 843 (2010), (quoting *Ayala v. Murad*, 367 Ill. App. 3d 591, 601

(2006)) (recognizing that proximate causation is not established where the causal connection " 'contingent, speculative, or merely possible' "). Ultimately, based on our review of the record, we do not find that the record contains evidence tending to show that the sole proximate cause of Kostal's injuries was something other than defendants' own conduct. Accordingly, the court did not err omitting the second sentence of IPI Civil No. 12.05.

¶ 84 Even if we were to find error, we do not find that reversal would be warranted. During closing argument, defense counsel was able to make his argument that Kostal's blastomycosis infection was the sole proximate cause of her injuries. Specifically, counsel argued that Kostal's "injuries and illness was caused by one villain—blastomycosis." Accordingly, the jury did hear defendants sole proximate cause argument, and thus defendants suffered no prejudice as a result of the court's ruling. See generally *Brooks v. City of Chicago*, 106 Ill. App. 3d 459, 466 (1982) ("A liberal application of the harmless error doctrine to jury instruction issues is favored when it appears that the rights of the complaining party have in no way been prejudiced").[3]

¶ 85 Finally, defendants argue that the circuit court erred in providing the jury with Kostal's version of the issues instruction for this case. They argue that Kostal's issues instruction "unduly emphasized the allegations of negligence and endowed them with prejudicial significance."

¶ 86 Kostal responds that the circuit court did not abuse its discretion when it provided the jury with her version of the relevant issues instruction. She notes that the version of the issues instruction tendered by defendants "omitted[ed] what everyone agreed was the key—the failure to diagnose blastomycosis."

[3] In defendants' appellate brief, they raised a related claim that the circuit court also erred in failing to provide the jury with the long form of Illinois Pattern Instruction Civil (2012) No. 12.04 (IPI Civil 12.04). In their reply brief, however, defendants withdrew their argument pertaining to that instruction. Therefore, we need not address it on appeal.

¶ 87 An issues instruction is one that informs the jury the specific points in controversy between the parties and thereby simplifies their application of law to the facts. *E.J. McKernan Co. v. Gregory*, 252 Ill. App. 3d 514, 541-42 (1993); *Lewis v. Cotton Belt Route—Saint Lewis Southwestern Railway Co.*, 217 Ill. App. 3d 94, 112 (1991). A proper issues instruction should inform the jury of the issues raised by the pleadings in a clear and concise manner and avoid undue repetition and emphasis. *E.J. McKernan Co.*, 252 Ill. App. 3d at 542; *Lewis*, 217 Ill. App. 3d at 112; *Signa v. Alluri*, 351 Ill. App. 11, 19 (1953).

¶ 88 In this case, Kostal tendered the following issues instruction:

"The Plaintiff, Dawn Kostal, claims that she was injured and sustained damage, and that the Defendants, Darius Mehregan, M.D. and Pinkus Dermatopathology Laboratory, P.C., were negligent in one or more of the following respects:

a. Failed to consider a deep fungal infection in the differential diagnosis; and/or

b. Failed to perform special staining to rule out an infectious process; and/or

c. Incorrectly diagnosed the December 2001 biopsy specimen as keratoacanthoma; and/or

d. Failed to diagnose the December 2001 biopsy specimen as blastomycosis.

The Plaintiff, Dawn Kostal, further claims that one or more of the foregoing was a proximate cause of her injuries.

The Defendants, Darius Mehregan, M.D. and Pinkus Dermatopathology Laboratory, P.C., deny that they did any of the things claimed by the Plaintiff, Dawn Kostal; deny that they were negligent in doing any of the things claimed by the Plaintiff, Dawn Kostal; and deny that any claimed act or omission on the part of the Defendants, Darius Mehregan,

M.D. and Pinkus Dermatopathology Laboratory, P.C., was a proximate cause of the Plaintiff's claimed injuries.

The Defendants, Darius Mehregan, M.D. and Pinkus Dermatopathology Laboratory, P.C., further deny that Plaintiff, Dawn Kostal, was injured or sustained damages to the extent claimed."

¶ 89 Defendants, in turn, tendered a shorter issues instruction. Defendants version provided:

"The plaintiff claims she was injured and sustained damage and that the defendants, Darius Mehregan, M.D. and Pinkus Dermatopathology Laboratory, P.C., were negligent in the following respects:

a. Made a definitive diagnosis of keratocanthoma; and/or

b. Failed to suspect fungal infection and to order special stains to rule it out.

The plaintiff further claims that the foregoing was a proximate cause of her injuries.

The defendants deny they were negligent and deny that the claimed acts or omissions on the part of the defendants were a proximate cause of the plaintiff's injuries."

¶ 90 The circuit court ultimately elected to utilize the issues instruction proffered by Kostal. On review, we find no abuse of discretion. Kostal's instruction, although a bit lengthier than the version offered by defendants, accurately set forth the pertinent issues for the jury's consideration. We do not find it to be overly repetitive or prejudicial. Moreover, we note that defendants' version of the issues instruction failed to instruct the jury that Doctor Mehregan's failure to diagnosis Kostal with blastomycosis was a pertinent consideration.

¶ 91 CONCLUSION

¶ 92 The judgment of the circuit court is affirmed.

¶ 93 Affirmed.

¶ 94 PRESIDING JUSTICE MASON, specially concurring.

¶ 95 I concur in the result only in this case in which the reply brief was filed on August 19, 2014, and which was first circulated by the author to the panel on May 16, 2016. I apologize to the litigants for the delay in resolving this appeal.