SECOND DIVISION
November 29, 2016

No. 1-14-0578

MASON WALKER, a Minor, by his Parents and Next Friends, KELLY WALKER and JOSEPH WALKER, KELLY WALKER, Individually, and JOSEPH WALKER, Individually, Plaintiffs-Appellants, v. DUPAGE NEONATOLOGY ASSOCIATES, S.C., a corporation, ANTHONY BELL, M.D., EVANGELIA ZIKOS, M.D., STAVROS IONIDES, M.D., and VIBHABEN THAKER, M.D., Defendants-Appellees.	)	Appeal from the Circuit Court of Cook County No. 09 L 10941 Honorable Lynn Egan, Judge Presiding.

JUSTICE PIERCE delivered the judgment of the court.
Justices Neville and Mason concurred in the judgment.

ORDER

¶ 1 *Held*: (1) The trial court did not abuse its discretion in denying plaintiffs' posttrial motion for a new trial where the jury's verdict was not against the manifest weight of the evidence; (2) the trial court did not abuse its discretion by refusing to admit as substantive evidence a government publication; (3) the trial court did not abuse its discretion by barring plaintiffs' expert from testifying as to the contents of that government publication; (4) plaintiffs were not deprived of a fair trial by any juror misconduct or the number of testifying witnesses; (5) the trial court abused its discretion by giving a sole proximate cause instruction but the error was harmless; and (6) any error in refusing to give a damages instruction was harmless where the jury found in favor of defendants on the issue of liability.

¶ 2 Plaintiffs Mason Walker, a minor, by his parents and next friends Kelly Walker and

Joseph Walker, Kelly Walker, individually, and Joseph Walker, individually, (collectively, plaintiffs), brought a medical negligence action against several defendants, including DuPage Neonatology Associates, S.C., a corporation, and Anthony Bell, M.D., Evangelia Zikos, M.D., Stavros Ionides, M.D., and Vibhaben Thaker, M.D. (collectively, defendants),[1] seeking damages for injuries that Mason sustained due to defendants' alleged negligent failure to timely remove an umbilical artery catheter, negligent failure to recognize the relationship between the extended use of umbilical catheters and the development of infection, and negligent failure to timely appreciate and treat an E. coli infection, resulting in brain damage and the amputation of Mason's right leg below the knee. A jury found in favor of defendants, and the trial court denied plaintiffs' posttrial motion for a new trial. Plaintiffs appeal, arguing the trial court erred in denying their posttrial motion because: (1) the verdict was against the manifest weight of the evidence; (2) the trial court abused its discretion where the evidence at trial was close and the cumulative effect of the trial court's errors and improper jury conduct resulted in an unfair trial; (3) plaintiffs were denied a fair trial where the trial court refused to admit a government publication into evidence; (4) plaintiffs were denied a fair trial where the trial court refused to allow plaintiffs' expert to testify as to the contents of the government publication; (5) the trial court abused its discretion by giving a sole proximate cause jury instruction; and (6) the trial court abused its discretion by refusing to instruct the jury on the measure of damages for aggravation of preexisting conditions. We find no error warranting a new trial, and therefore affirm.

¶ 3 BACKGROUND

[1] Adventist Hinsdale Hospital, Colleen Malloy, M.D., Sandra Cadichon, M.D., Linda Priban, R.N., Amy Ferrero, R.N., Nancy Gozder, R.N., and R. Hick, R.N., were each named as defendants in the trial court and were dismissed before trial. They are not parties to this appeal.

¶ 4 On January 3, 2004, Mason Walker was born at 26 weeks' gestation. He was intubated, placed on a ventilator, and taken to the neonatal intensive care unit (NICU). An umbilical artery catheter (UAC) was inserted through his belly button and was used to draw blood for various tests. Mason was placed in a temperature-controlled isolette (also known as an incubator), to regulate his body temperature. The isolette controlled the ambient air temperature around him, and would automatically increase or decrease the ambient air temperature in order to regulate Mason's skin temperature. While in the NICU, Mason was variously under the care of Drs. Zikos, Thaker, Ionides, and Bell. For a period of time, Mason's condition was stable, although he eventually developed bacteremia (the presence of bacteria in the bloodstream), which progressed into sepsis. He also developed disseminated intravascular coagulopathy (DIC), which caused widespread intravascular clotting. This resulted in persistent hypotension, persistent thrombocytopenia (a platelet deficiency), renal failure, and peritonitis (an inflammation of the tissue in the abdomen). Mason's kidneys eventually failed and he showed signs of congestive heart failure. Mason was left with permanent neurological disabilities. He also developed an infection in his right leg that eventually required amputating the leg below the knee. Plaintiffs' amended complaint alleged in relevant part that defendants: (1) negligently failed to timely remove the UAC, which allowed bacteria to enter Mason's bloodstream; (2) negligently failed to recognize the relationship between the extended use of the UAC and the development of infection; (3) negligently failed to timely diagnose and treat Mason's infection; and (4) negligently failed to timely diagnose and treat the infection in Mason's leg.

¶ 5 The parties proceeded with discovery and agreed to waive the 60-day disclosure requirement in Illinois Supreme Court Rule 218(c) (eff. Oct. 4, 2002).[2] The trial court set a trial date of May 13, 2013. The deposition of plaintiffs' neonatology expert, Maureen Sims, M.D., was completed on February 11, 2013. The depositions of two of defendants' experts, Daniel Hall, M.D., and Michael S. Caplan, M.D., were completed on April 24, 2013. On April 27, 2013, Dr. Sims supplemented her Illinois Supreme Court Rule 213(f)(3) (eff. Jan. 1, 2007) disclosures to address certain opinions from defendants' experts, and identified two previously undisclosed publications that she said supported the opinions she offered at her deposition regarding the standard of care related to the UAC. One of those publications was the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR) published August 9, 2002, titled "Guidelines for the Prevention of Intravascular Catheter-Related Infections." Dr. Sims stated in her supplemental disclosures that the MMWR supported her opinion that leaving a UAC in for a prolonged period of time increases the risk of infection, and that Mason's UAC should have been removed earlier. Specifically, she quoted two sections of the MMWR, which state:

> "Recommendations for Umbilical Catheters
>
> I. Replacement of catheters
>
> A. Remove and do not replace [UACs] if any signs of [catheter-related bloodstream infection], vascular insufficiency, or thrombosis are present (283). Category II.
>
> * * *

[2] We note, however, that plaintiffs fail to cite to the record in order to establish what the discovery schedule was, and instead cite to an oral argument transcript in which plaintiffs' counsel described the discovery schedule as "abnormal" for the trial judge's courtroom.

II. Catheter-site care

D. Remove umbilical catheters as soon as possible when no longer needed or when any sign of vascular insufficiency to the lower extremities is observed. Optimally, [UACs] should not be left in place > 5 days (283, 289). Category II."[3]

¶ 6 Motions *In Limine*

¶ 7 The parties filed numerous motions *in limine,* only three of which are pertinent to this appeal. Of the three, two are pretrial motions filed by defendants, and the third is plaintiffs' motion made during trial. Plaintiffs' motion is discussed *infra*. Defendants' motion *in limine* No. 3 sought to bar plaintiffs from eliciting testimony from any witness regarding the specifics of any publication that had not been produced in response to defendants' Illinois Supreme Court Rule 237 (eff. July 1, 2005) notice to produce, and specifically mentioned the MMWR. Defendants argued that experts may be cross-examined with literature that they relied on if used to impeach the expert, but that the admission of medical treatises as substantive evidence is prohibited and witnesses on the stand may not read text or data from authoritative articles or learned treatises. Plaintiffs responded that the MMWR was a self-authenticating government publication and

[3] See Centers for Disease Control and Prevention, Guidelines for the Prevention of Intravascular Catheter-Related Infections, MMWR 2002, 51 (No. RR-10). The numbers within the parentheses correspond to references included at the end of the publication. The publication includes a system for categorizing the recommendations and uses five categories to indicate the strength of the CDC's recommendation. Each individual recommendation is categorized, as denoted by the category number placed at the end of the recommendation. "Category II" indicates that the recommendation is "suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale." Other categories include: "Category IA: Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies."; "Category 1B: Strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies, and a strong theoretical rationale."; and "Category 1C: Required by state or federal regulations, rules, or standards."

professional guideline that the jury could consider as substantive evidence of the standard of care in connection with an expert opinion. The trial court took the motion under advisement.

¶ 8 Defendants' motion *in limine* No. 22 sought to bar Dr. Sims' supplemental opinions in their entirety as untimely and prejudicial,[4] since they were disclosed for the first time less than three weeks prior to trial and defendants were not able to depose Dr. Sims as to those opinions. Plaintiffs responded that the defendants' experts were asked about the MMWR in their depositions, and that Dr. Zikos referenced the MMWR in her deposition. The trial court heard oral argument, and plaintiffs' counsel provided no explanation as to why Dr. Sims did not disclose the MMWR earlier. Plaintiffs argued that the supplement was seasonable given the discovery schedule and the short amount of time that passed between the defendants' experts' depositions and Dr. Sims' supplemental opinions. Plaintiffs asserted that they would be prejudiced if Dr. Sims were barred from referring to the MMWR because if she were asked by defendants whether she could cite anything to back up her opinion, she would not be able to refer to the MMWR. Plaintiffs further claimed that there was no prejudice to defendants because their experts were questioned about the MMWR, and defendants waited to object to the supplemental disclosures through a motion *in limine*. Defendants' countered that Dr. Sims referred generally to literature at her deposition that supported her opinion regarding the time in which a UAC should be removed,[5] but never identified sources until her supplemental disclosures.

¶ 9 The trial court granted defendants' motion *in limine* No. 22 and barred Dr. Sims from giving foundational opinions regarding the MMWR as a reliable publication. The trial court relied on *People v. Anderson*, 113 Ill. 2d 1 (1986), for the proposition that an expert on direct

[4] In addition to disclosing the MMWR and other articles that supported her testimony, Dr. Sims proffered supplemental opinions on other issues that are not at issue in this appeal.

[5] We note that the record does not contain a transcript of Dr. Sims' discovery deposition, although it is undisputed that Dr. Sims did not identify the MMWR at that time.

examination is not permitted to regurgitate the contents of sources they relied on in forming their opinions. The trial court also found it appropriate to bar the materials where, despite written and oral requests for all articles used to support Dr. Sims' opinions, she never previously identified or produced the MMWR. The trial court stated that other witnesses had been disclosed who had provided the foundational testimony regarding the MMWR's reliability.

¶ 10 The trial court then granted in part and denied in part defendants' motion *in limine* No. 3. The trial court barred plaintiffs from admitting the MMWR as substantive evidence, and barred plaintiffs from eliciting testimony from Dr. Sims on direct examination regarding the substance of the MMWR. The trial court did, however, allow plaintiffs to cross-examine defendants' experts on the substance of the MMWR. Plaintiffs moved to reconsider, arguing that the MMWR should be admitted as a self-authenticating document pursuant to Rule 902(5) of the Illinois Rules of Evidence (Ill. R. Evid. 902(5) (eff. Jan. 1, 2011), and that Illinois Pattern Instruction, Civil, No. 105.01 (2011) (IPI Civil (2011) No. 105.01) instructs the jury that it must rely on opinion testimony from qualified experts and evidence of professional standards. The trial court denied the motion, explaining that the issue was less about admissibility and more about relevance. The trial court observed that Dr. Sims had never offered the opinion that the MMWR was synonymous with the standard of care. The trial court stated that "introducing a complex and highly technical medical bulletin without any explanation to the jury would, in this Court's discretion, be inappropriate."

¶ 11 *Relevant Expert Trial Testimony*

¶ 12 Neither party sets forth a sufficiently complete description of the trial testimony in this case that is relevant to the issues raised on appeal. In order to understand the issues on appeal and the related arguments, we set forth that testimony in some detail.

¶ 13 *Maureen Sims, M.D.*

¶ 14 Plaintiffs called Maureen Sims, M.D., a board-certified pediatrician and neonatologist, as an expert witness. She testified that Drs. Zikos, Thaker, Ionides, and Bell, each deviated from the standard of care by failing to remove the UAC after it was no longer needed. Dr. Sims opined that the standard of care requires that a UAC be removed as soon as possible, and should not be in place for longer than five days. She explained that the UAC sits in the aorta and "roughs up" the inner lining of the vessel causing blood product deposits to form, which in turn can collect bacteria. As the deposits accumulate, they can separate and circulate in the blood stream, lodging in other locations such as the extremities, and can cause sepsis and infection. She acknowledged that a UAC is used to collect blood for testing purposes, but described other methods that could be used to obtain blood gas information after a UAC is removed. She opined that Mason's UAC should have been removed on January 7 due to his stable condition and minimal ventilator settings. She explained that although Mason had patent ductus arteriosus (PDA) (an opening between two blood vessels leading from the heart) on his fifth day of life, there was no reason to leave in the UAC. She further stated that it was not necessary to have the UAC in place while Mason was being weaned from the ventilator because, again, there were other available methods of obtaining the blood gas information. She opined that the PDA did not cause or contribute to Mason's eventual Escherichia coli (E. coli) infection.

¶ 15 Dr. Sims testified that Drs. Zikos and Bell further deviated from the standard of care by failing to remove the UAC when Mason showed signs of vascular insufficiency. She stated that on January 15, a clot had grown in size, resulting in emboli that "flipped off" from the end of the UAC and lodged in Mason's right leg, causing it to become pale, dusky, and cool. Dr. Sims testified that the standard of care required Dr. Zikos to immediately remove the UAC in order to

prevent further embolization and to examine the leg. Although the observed leg condition did not continue, Dr. Sims attributed the leg "getting better" to the emboli changing position, dissolving, or from blood circulation from other parts of the leg.

¶ 16 Dr. Sims further opined that Drs. Zikos, Ionides, and Bell each deviated from the standard of care by failing to timely appreciate, recognize, and evaluate signs of infection in Mason, and for failing to timely treat that infection. According to Dr. Sims, by January 19, Mason's leg began turning "black, mottled, and cool," which suggested an infection. She stated that the signs of infection include temperature instability, heart rate instability, blood pressure instability, changes in skin color, and profusion issues. She stated that a reasonably careful neonatologist is always thinking about possible infection, and that showing even a single sign of infection requires close attention to the patient. Dr. Sims explained that on January 16, Mason had temperature instability, as evidenced by the ambient temperature in his isolette, and that the instability continued through January 18. She testified that, starting on January 16, Mason's heart rate was abnormally high. She opined that the temperature instability was a "big red flag," and that coupled with the abnormal heart rate, it was a "slam dunk" that Mason was giving off "loud signals" of infection. She opined that Mason was bacteremic on January 16, that he developed sepsis the same day, and that he should have been placed on antibiotics at that time. She opined that the sepsis resulted in Mason's brain damage, since other potential causes were not present: Mason did not have a collapsed lung, had no pulmonary hemorrhaging, had no signs of necrotizing enterocolitis (a complication from air in the bowel wall), and no ischemic gut problem (which is essentially decreased blood flow to the gut). Dr. Sims testified that Mason developed bronchopulmonary dysplasia (a chronic lung disease) as a result of being on a ventilator for a prolonged period, and developed osteomyelitis in his right leg as a result of the

infection. She stated that her opinions regarding deviations from the standard of care would not change if the source of Mason's bacteremia was from bacteria in his gut or bowel.

¶ 17 On cross-examination, Dr. Sims acknowledged that there were studies from various institutions in which UACs were left in patients for up to 22 days. She acknowledged that a premature infant such as Mason who has PDA and is on the drug Indomethacin (which is used to treat PDA in premature infants) is at an increased risk for decreased blood flow to the gut, which can lead to bacteria from the intestines getting into the bloodstream. She acknowledged that an ultrasound of Mason's head after he was born showed no signs of brain damage from sepsis. She acknowledged that neither the interdisciplinary progress record for January 19 nor the January 19 flow sheet referred to Mason's leg as being "black," she acknowledged that she did not know where she heard or read any reference to Mason's leg being "black."

¶ 18 Before redirect examination, the trial court ruled that defendants had opened the door for Dr. Sims to be examined regarding whether there were other publications available in 2002 that discussed the length of time a UAC should be left in place. On redirect examination, Dr. Sims testified that there were CDC guidelines that said "get that catheter out as a soon as possible not to exceed five days and to take it out under any circumstances where there's vascular insufficiency." She also stated that whether the leg was bluish or "black" made no difference, since anything other than pink was "bad," and that there was a clear indication of vascular insufficiency.

¶ 19 On re-cross examination, Dr. Sims acknowledged that the CDC guideline actually says "optimally [UACs] should not be left in place for more than five days." She further acknowledged that various other types of catheters and lines used on Mason also carry the risk of infection.

¶ 20 After Dr. Sims' testimony was complete, plaintiffs filed plaintiffs' motion *in limine* No. 43, again seeking to admit the MMWR as substantive evidence to be considered by the jury when determining the applicable standard of care. Plaintiffs argued that defendants' cross-examination of Dr. Sims opened the door for a redirect examination regarding whether there were other publications at the time of the events in question that related to how long a UAC should be left in, and that on re-direct examination, Dr. Sims had stated that the CDC came out with "very good guidelines, very good standards," and that "when they do it, we pay attention." Plaintiffs argued that the MMWR could be admitted as evidence of a professional standard of care to be considered along with the expert testimony. The trial court heard oral argument on plaintiffs' motion *in limine* No. 43, and denied the motion.

¶ 21 *Daniel Hall, M.D.*

¶ 22 Defendants called Daniel Hall, M.D., a board-certified neonatologist, as an expert witness. He opined that Drs. Zikos, Thaker, Ionides, and Bell acted as reasonably careful neonatologists when they left Mason's UAC in place from January 7 to January 16. He explained that the UAC was important because it provided information about oxygen and carbon dioxide in the bloodstream. This, in turn, was used to regulate Mason's ventilator settings, which itself was necessary because Mason had premature lung disease. Dr. Hall stated that a ventilator can cause bronchopulmonary dysplasia and the UAC plays a role in addressing that condition. Furthermore, PDA redirects blood from the body to the lungs, exacerbating any lung disease. The UAC allowed for more precise monitoring of other organ systems as well. In Dr. Hall's opinion, the treating doctors complied with the standard of care by leaving the UAC in until January 16, when Mason began entering a more chronic stage of lung disease which required less sampling. Dr. Hall believed that the treating physicians appropriately balanced on a daily basis

the risks of leaving in the UAC against its continued benefits. He testified that there is no rule that says a UAC must be removed at five days. In his view, the description of the condition of Mason's leg on January 15 was more consistent with an arteriospasm (a spasm that decreases the caliber of an artery) than vascular insufficiency, since it was transient and self-limited, and all that was required was continued monitoring. Dr. Hall opined that the January 15 event and Mason's development of sepsis were unrelated. It was his belief that Mason became infected on January 18. He explained that E. coli is not commonly associated with intravascular devices such as UACs, since it is a gram-negative enteric organism that lives in and arises from the intestinal tract. He opined that Mason's E. coli infection was not related to the presence of the UAC, which had been removed by the time Mason became infected. Mason would have been much sicker on January 16 and January 17 if he had been infected with E. coli on those days. Dr. Hall believed that the treating physicians timely diagnosed Mason's infection, and there were no persistent abnormalities that would have suggested infection prior to January 18. He believed that antibiotics were initiated in a timely fashion. Mason had developed purpura fulminans (a consequence of infection where blood clots too excessively or rapidly and interrupts blood flow), which caused injury to Mason's soft tissues and bone. In his view, the fact that there was a "profound reduction" in Mason's platelet count, the presence of increased blood clotting, and the soft tissue and bone injury all suggested purpura fulminans. Dr. Hall did not believe there was any evidence that Mason had osteomyelitis given that soft-tissue injury is not commonly associated with that sort of bone infection.

¶ 23 On cross-examination, Dr. Hall acknowledged that other doctors who subsequently treated Mason, including physicians and orthopedic surgeons, noted that he had osteomyelitis. Dr. Hall acknowledged that premature babies are not born with E. coli infections. He further

acknowledged that E. coli can cause an infection through a line such as the UAC, although it is was not the most common type of infection. A nosocomial infection (an infection acquired from a hospital) can enter a patient through a port of entry such as a UAC. The longer a UAC is in place, the greater the risk of infection. Dr. Hall agreed that the methods for obtaining the blood gas information after the UAC was removed were reliable. He acknowledged that the presenting signs of sepsis in a neonate such as Mason can be nonspecific, and that E. coli sepsis in a premature infant can have a gradual onset, but he did not believe that to be the case here. He agreed that diagnosing sepsis in a neonate requires appreciating the risk of infection and that there must be vigilance in monitoring for signs of infection. Both tachycardia and temperature instability are clinical manifestations of sepsis. Based on a chart that transcribed the flow sheet of the environmental temperature in Mason's isolette on January 16, 17, and 18, he stated that some of the charted temperatures were "extraordinarily low," which suggested that Mason's body temperature would have been higher, and that Mason possibly could have had a fever. The environmental temperature was fluctuating, suggesting that there was some disruption of Mason's thermoregulation. Dr. Hall acknowledged that there were some readings showing that Mason's heart rate was over 180 starting on January 16, and there were several readings on January 17 over 180, some over 190, and two over 200. Prior to January 16, there were no instances of Mason's heart rate exceeding 190. It was probably true that the sustained tachycardia on January 18 was due to his being bacteremic and septic. Dr. Hall acknowledged that, in general, the MMWR is a reasonably reliable resource that "is certainly well respected."

¶ 24 On redirect examination, Dr. Hall stated that there was no indication in the records that the nursing staff brought any problem regarding temperature instability to a doctor's attention

prior to January 18. Dr. Hall opined that there was no deviation from the standard of care with respect to dealing with temperature instability and tachycardia.

¶ 25 *Michael S. Caplan, M.D.*

¶ 26 Defendants called Michael Caplan, M.D., a board-certified neonatologist and clinical professor of pediatrics, as an expert witness. Based on a progress note written by Dr. Cadichon, Dr. Caplan testified that Mason's condition was stable on January 17 at 10:29 a.m., and that Dr. Cadichon was not required to initiate any type of workup to rule out an infection or order the administration of antibiotics. Neonatologists are not required to always be in the NICU, and they rely on the nursing staff to relay any changes in the condition of the infant from the last time a doctor saw them. There was no documentation that Dr. Cadichon was contacted between January 17 at 10:30 a.m. through January 18 at 9:00 a.m., and Dr. Caplan opined that during that time, Dr. Cadichon complied with the standard of care in her treatment of Mason.

¶ 27 On cross-examination, Dr. Caplan testified that he was aware of the CDC's MMWR, and that it was a reasonably reliable publication. He agreed that a reasonably careful neonatologist would have to have a high index of suspicion to identify and evaluate for sepsis, and that the sooner sepsis is diagnosed, the better the outcome. In response to a hypothetical question, Dr. Caplan opined that had Mason been started on antibiotics on January 16 or January 17, his sepsis probably would have been prevented, and if he had been started on antibiotics earlier on January 18, his sepsis possibly would have been prevented.

¶ 28 On redirect examination, Dr. Caplan testified that starting antibiotics as early as January 14 could have been dangerous, and that the standard of care does not require starting antibiotics based solely on tachycardia or temperature changes, but rather requires evaluating whether the risks outweigh the benefits of starting antibiotics. He stated that a septic workup initiated by Dr.

Zikos on January 18 at 3:00 p.m. was timely and appropriate, and that the standard of care did not require antibiotics to be started earlier than they were. He testified that Mason became septic around January 18 at 3:00 p.m., the same time that the blood culture was performed, meaning that if antibiotics were started on January 17, that would have been before Mason was even bacteremic.

¶ 29 *Julie Stamos, M.D.*

¶ 30 Julie Stamos, M.D., a board-certified pediatric infectious disease specialist, was called as an expert witness for the defendants. She testified that there is a difference between early-onset sepsis and late-onset sepsis. Late-onset sepsis typically develops after a newborn's seventh day of life. Dr. Stamos explained that E. coli is one of the most common gram-negative bacteria in a newborn and is found in the gut. She further explained that a newborn could develop bacteremia from translocation, which is where bacteria migrate from the intestine to the blood due to a newborn's fragile mucous membranes. Dr. Stamos testified that the specific definition of sepsis requires having two of three criteria: (1) a white blood cell abnormality; (2) temperature elevation; (3) and elevated heart rate. In order to have a diagnosis of sepsis, either a white blood cell abnormality or a temperature elevation must be present. Based on graphs made from Mason's nursing flow sheets for January 16 through January 18, she opined that there was no evidence that Mason had temperature instability. Based on recordings of Mason's heart rate from the nursing flow sheets, there was no evidence of persistent tachycardia until late on January 18. In Dr. Stamos' opinion, Mason was bacteremic some time during the day on January 18th, and it progressed to late-onset E. coli sepsis by around 3:30 p.m. on January 18. She opined that the E. coli most likely came from Mason's gut. When Mason was started on antibiotics, he was given the appropriate drugs to treat his infection. When Mason was born, both of his legs were bruised,

with the left leg more bruised than the right leg. Dr. Stamos opined that the bacteria may have seeded in Mason's right leg in part because it was already traumatized. If Dr. Zikos started antibiotics at 9:00 a.m. on January 18, it would not have changed the outcome of Mason's leg. In Dr. Stamos' view, Mason developed septic shock syndrome after January 18, but his sepsis did not cause his brain injury.

¶ 31 On cross-examination, Dr. Stamos acknowledged that the location of the UAC was another "traumatized" place where bacteria could potentially have seeded. She acknowledged that there was some element of speculation as to when Mason became bacteremic and septic because his previous blood culture was performed back on January 12. Dr. Stamos acknowledged that tachycardia is an initial sign or symptom of sepsis, although she did not consider tachycardia be to in the top ten signs. She stated that a UAC could be the source of an infection in a neonate, and that an infection could occur related to that line any time while it is in until the time it is taken out, and that it was "not impossible" that Mason's E. coli infection could have come from his UAC. She testified that it makes perfect sense that one would expect a better outcome if an infection is treated earlier, although it has never been "evidence proven." Hypothetically, if Mason had been given the antibiotics earlier, it would have prevented the bacteremia from developing, which would have prevented Mason from developing an infection in his leg.

¶ 32 On redirect examination, Dr. Stamos stated that Mason became bacteremic late January 17 or early January 18, after the UAC was removed.

¶ 33 In addition to the testimony described above, between May 17 and June 3, 2013, the jury heard testimony from several other witnesses, including the defendant physicians, plaintiffs Kelly and Joseph Walker, and additional experts for both plaintiffs and defendants. The jury also

viewed video evidence depositions of other witnesses.

¶ 34 On June 3, the trial court conducted the jury instruction conference, and made several rulings on the proffered instructions. Only two instructions are at issue in this appeal. Plaintiffs sought to have the jury instructed with "the short form" version of Illinois Pattern Jury Instruction, Civil, No. 12.05 (2011) (IPI Civil No. 12.05), while defendants sought to have the jury instructed with "the long form version." After hearing argument from counsel, the trial court ruled that it would give the long form version of IPI Civil No. 12.05:

> "If you decide that a defendant was professionally negligent and that this professional negligence was a proximate cause of injury to the plaintiff, it is not a defense that something else may also have 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."

Second, the trial court refused to give Illinois Pattern Instruction 30.21 tendered by plaintiff, which read:

> "If you decide for the plaintiff on the question of liability, you may not deny or limit the plaintiff's right to damages resulting from this occurrence because any injury resulted from a pre-existing condition which rendered the plaintiff more susceptible to injury." See Illinois Pattern Jury Instructions, Civil, No. 30.21 (2011) (IPI Civil No. 30.21).

¶ 35 The jury heard closing arguments and was instructed on June 4, 2013. On June 5, 2013, the jury found in favor of the defendants. Plaintiffs moved for a new trial, arguing that: (1) the jury's verdict was against the manifest weight of the evidence; (2) plaintiffs were denied a fair trial where the trial court excluded evidence of the CDC's MMWR; (3) plaintiffs were denied a

fair trial where the trial court barred Dr. Sims from testifying that the CDC's MMWR was evidence of the standard of care; and (4) the jury had been misinstructed as to the significance of Mason's prematurity. The trial court denied the motion, and this timely appeal followed.

¶ 36 ANALYSIS

¶ 37 At the outset, we remind the plaintiffs that Illinois Supreme Court Rule 341(h)(6) requires that the statement of facts set forth in the appellants' brief "contain the facts necessary to an understanding of the case, stated accurately and fairly without argument or comment, and with appropriate reference to the pages of the record on appeal." Ill. S. Ct. Rule 341(h)(6) (eff. Feb.6, 2013). Defendants request that we strike the entirety of plaintiffs' statement of facts for repeatedly mischaracterizing the evidence, using tactics designed to mislead the court as to which experts said what, and several instances of plaintiffs' counsel editorializing on the facts. We agree that plaintiffs' recitation does not set forth all of the facts necessary to understand this case, and we have had to thoroughly review the record in order to understand what testimony was presented to the jury. Plaintiffs' argument section also frequently omits specific citations to the record or to authority in support of their arguments. These inadequacies have made it difficult to discern the timing and significance of certain events in Mason's treatment, the manner in which certain events occurred, and the support in the record for plaintiffs' arguments. Furthermore, plaintiffs frequently cite the opinions of experts as facts, even when those opinions have been disputed by defendants. The hearing transcripts and trial testimony account for ten volumes of the record on appeal, and we have found ourselves repeatedly turning to the record to determine what was said at trial and by whom. This has significantly slowed our ability to review the plaintiffs' arguments. Plaintiffs offer a minimal defense of their statement of facts, asserting that even if their statement of facts contained some errors, this court "is entitled to review the

case on the merits." We are entitled to exercise our discretion to strike plaintiffs' brief and dismiss this appeal (*McCann v. Dart*, 2015 IL App (1st) 141291, ¶ 20), although we decline to do so. That said, we consider plaintiffs' claims after having undertaken our own examination of the record. See *Gehrett v. Chrysler Corp.*, 379 Ill. App. 3d 162, 171 (2008).

¶ 38 We first address whether the trial court abused its discretion in denying plaintiffs' motion for a new trial. Plaintiffs contend that the only "credible," "competent," and "proper," evidence before the jury was plaintiffs' evidence, and that in ruling on the motion for a new trial, the trial court needed to engage in the "disciplined evaluation" of the evidence described in *Williams v. Chicago Osteopathic Health Systems*, 274 Ill. App. 3d 1039 (1995). They argue that if the trial court engaged in a disciplined analysis, it would have seen that the "proper evidence at trial overwhelmingly established" that a verdict in plaintiffs' favor was "clearly apparent." They contend that the "credible evidence" before the jury favored plaintiffs' theory that Mason's infection and injuries were the result of defendants' negligent failure to remove the UAC in a timely fashion. It was undisputed that Mason's UAC was left in for thirteen days. Plaintiffs argue that they presented evidence that a leg that is pale, dusky, and blanched is a sign of vascular insufficiency, and that Dr. Zikos testified that it is "very well known that [a] UAC can cause vascular insufficiency" in newborns' extremities. They argue that Mason's heart rate increased and the ambient temperature in his isolette decreased after the UAC was removed, both of which indicated sepsis, and that defendants did not dispute that the nursing flow sheets indicated these increases. Plaintiffs further argue that the defendants' experts "admitted" that the CDC's MMWR guidelines for removal of UACs were reasonably reliable and contradicted Dr. Caplan's and Dr. Hall's opinion that the defendants complied with the standard of care. They contend that Dr. Sims gave uncontradicted testimony regarding how a UAC can create deposits of blood

product that can break off and cause infection if left in for too long. Plaintiffs argue that Dr. Stamos testified that earlier antibiotic intervention could have prevented Mason's infection, and that it was undisputed that Mason would not have been injured had his infection been prevented or timely treated. Given all of this evidence, plaintiffs believe that the jury's verdict in favor of defendants was against the manifest weight of the evidence, and that plaintiffs were entitled to a new trial.

¶ 39 Defendants observe that the plaintiffs do not contest the expertise of defendants' experts. Defendants argue that both Dr. Caplan and Dr. Hall agreed that the MMWR was a "reasonably reliable publication," but neither testified that the CDC's guidelines for the removal of UAC were reasonably reliable. Defendants argue that their experts explained that defendants' so-called "five day rule" was not a rule at all, and that the standard of care did not require removing Mason's UAC after five days. Defendants also point out that the guideline says that a UAC is "optimally" removed within five days, and "optimally" is not the standard of care in Illinois. Dr. Hall testified the UAC provided the most accurate blood gas information, which was necessary in light of Mason's premature lung disease. He further opined that removal of the UAC on January 15 was not necessary because the condition of Mason's leg was transient, suggesting something other than vascular insufficiency. Dr. Hall testified that the E. coli infection that Mason developed was not normally associated with UACs, and that when Mason did become infected, he received timely and appropriate treatment. Defendants argue that plaintiffs are essentially asking this court to re-weigh the credibility of the experts, all of whom were qualified to present their opinions to the jury. They argue that plaintiffs' argument that it was "undisputed" that Mason would not have been injured if his infection was prevented or timely treated is "preposterous," since the citation in plaintiffs' appellant's brief in support of this claim cites

testimony that says nothing of the sort.[6]

¶ 40 In ruling on a motion for new trial, the trial court must weigh the evidence and set aside the jury's verdict and order a new trial only if the verdict is against the manifest weight of the evidence. *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38. A verdict is against the manifest weight of the evidence only if it is clear from the record that the jury should have reached the opposite conclusion or if the jury's findings are unreasonable, arbitrary, and not based upon any of the evidence presented. *Id*. On appeal, the trial court's ruling on a motion for new trial will not be reversed unless the trial court abused its discretion. *Id*. In determining whether an abuse of discretion has occurred, the reviewing court should consider whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial. *Maple v. Gustafson*, 151 Ill. 2d 445, 455-56 (1992). Conflicting testimony as to the standard of care creates a question of fact for the jury. *LaSalle Bank, N.A. v. C/HCA Development Corp.*, 384 Ill App. 3d 806, 829 (2008). This court will not substitute its judgment for that of the jury and reweigh the credibility of the witnesses. *Id.* (citing *Bergman v. Kelsey*, 375 Ill. App. 3d 612, 622-23 (2007)).

¶ 41 We find that the jury's verdict was supported by the evidence. It is clear that the parties and their experts did not agree as to the standard of care. Dr. Sims opined that that the standard of care required the defendants to remove the UAC at five days because the UAC could cause the development of blood product deposits that in turn could collect bacteria, which could then break off and enter the blood stream, leading to infection and sepsis. She further opined that this

[6] Plaintiffs' reply acknowledges this error. They contend that they meant to cite Dr. Stamos' testimony in which she responded to plaintiffs' counsel's hypothetical question. She was asked whether Mason would have developed bacteremia if he had been started on antibiotics on January 16, to which she responded that he would not have. The question did not ask, however, whether there was any reason to start Mason on antibiotics on January 16.

was how Mason became infected. Additionally, she testified that the standard of care required defendants to remove Mason's UAC at the first signs of vascular insufficiency, and given Mason's increasing heart rate and falling isolette temperature, there were clear signs of infection that went unaddressed until it was too late to avoid Mason's injuries. Dr. Hall, on the other hand, acknowledged that there was an increased risk of infection when a UAC is left in for a prolonged period of time, but he opined that under Mason's circumstances, leaving the UAC in place was important for accurate blood tests, and the standard of care does not require the removal of a UAC after five days. He further opined that there was no "vascular insufficiency," rather there was an arteriospasm that required continued monitoring.

¶ 42 On the issue of whether defendants complied with the standard of care regarding the timely appreciation and treatment of Mason's infection, Dr. Sims opined that a reasonably careful neonatologist is always monitoring for infection, and between January 16 through January 18, Mason's increasing heart rate and the falling ambient temperatures in his isolette were "loud signals" of infection. Dr. Hall, on the other hand, opined that there were no persistent abnormalities that would have suggested infection prior to January 18 and, although there were readings that Mason's heart rate was rising and the ambient temperature in his isolette was declining, nothing in Mason's records suggested that this information was brought to the defendants' attention.

¶ 43 These differences of opinion created questions of fact regarding the standard of care, which needed to be resolved by the jury. See *LaSalle Bank*, 384 Ill App. 3d at 829. Plaintiffs had ample opportunity to examine their expert and cross-examine defendants' experts in order to present the jury with the facts needed to make a decision. Plaintiffs fail to cite any authority in support of their claim that the only "credible," "competent," and "proper," evidence before the

jury was plaintiffs' evidence, and their reliance on *Williams v. Chicago Osteopathic Health Systems*, 274 Ill. App. 3d 1039 (1995) is misplaced.

¶ 44 *Williams* involved allegations of common law fraud against various doctors in connection with the stillborn birth of the plaintiffs' baby. The plaintiffs alleged that their child developed a heart rate at some point after delivery, and that defendants failed to inform the parents of this fact. *Williams*, 274 Ill. App. 3d at 1041. *Williams* is neither factually nor procedurally similar to this case, and thus provides little guidance. *Williams* involved an appeal from a directed verdict in a fraud case, whereas this case involves a jury verdict and the denial of a motion for a new trial. *Williams* involved the plaintiffs' failure to present significant evidence on an element of their claim, whereas here, both parties presented extensive expert testimony regarding the applicable standard of care. *Williams* stands for the important and valid proposition that "no case should be lightly taken from a jury[.]" *Id.* at 1048. But that is not the situation here, and plaintiffs fail to explain how their evidence "overwhelmingly favored" their theory of the case. The jury heard both sides of this case and was tasked with evaluating the credibility of the expert witnesses. And while plaintiffs disagree with defendants' experts' conclusions, plaintiffs fail to identify any "scientific poverty" in the defendants' experts' testimony that might put the jury's verdict in doubt. See *LaSalle Bank*, 384 Ill. App. 3d at 829 (citing *Snelson v. Kamm*, 204 Ill. 2d 1, 36 (2003)). We see nothing in the record that would allow us to second-guess the jury's credibility determinations regarding the qualified experts' opinions presented by both sides. Based on the evidence and arguments before us, we find that the jury's verdict was not against the manifest weight of the evidence.

¶ 45 We next consider plaintiffs' arguments that they were denied a fair trial when the trial court refused to admit the CDC's MMWR as substantive evidence, and barred Dr. Sims from

testifying as to the substance of that guideline. We review a trial court's rulings on whether to admit or exclude evidence for an abuse of discretion. *Leonardi v. Loyola University of Chicago*, 168 Ill. 2d 83, 92 (1995). A trial court abuses its discretion only if it "act[s] arbitrarily without the employment of conscientious judgment, exceed[s] the bounds of reason and ignore[s] recognized principles of law [citation] or if no reasonable person would take the position adopted by the court." *Schmitz v. Binette*, 368 Ill. App. 3d 447, 452 (2006) (citing *Popko v. Continental Casualty Co.*, 355 Ill. App. 3d 257, 266 (2005)).

¶ 46 Plaintiffs contend that they should have been permitted to admit the CDC's MMWR as substantive evidence to bolster Dr. Sims' opinion regarding the standard of care. Plaintiffs argue the trial court's rulings on the motions *in limine* kept the jury "uninformed of the true state of medical knowledge," and added undeserved credibility to defendants' experts. They claim that the government guidelines were self-authenticating, admissible evidence of defendants' negligence, and that trial court's reliance on *People v. Anderson*, 113 Ill. 2d 1 (1986) was misplaced. Plaintiffs rely on a host of cases to suggest that governmental guidelines or standards are admissible as evidence of negligence in a variety of different contexts, and that they are admissible to buttress an expert's opinion in professional negligence cases. See, e.g., *Tenenbaum v. City of Chicago*, 60 Ill. 2d 363 (1975) (finding regulations, standards, and building codes admissible in cases arising under Structural Work Act); *Schultz v. Northeast Illinois Regional Commuter R.R. Corp.*, 201 Ill. 2d 260 (2002) (finding OSHA guidelines admissible in cases arising under Federal Employees Liability Act). Plaintiffs insist that the guidelines were relevant, and that plaintiffs were prejudiced when the jury was left with the impression that Dr. Sims' opinions were hers alone.

¶ 47 Defendants argue that plaintiffs continue to misrepresent the actual contents of the MMWR, and that the jury was repeatedly informed about its contents through testimony elicited on direct and cross-examination of the various experts. Defendants claim that plaintiffs confuse the concept "authentication" with "admissibility," and that government guidelines are not admissible as substantive evidence in medical negligence actions against individual physicians. Defendants also argue that the MMWR, by its own terms, does not establish the standard of care because of its use of the term "optimal."

¶ 48 In *Anderson*, our supreme court addressed the question of whether a psychiatrist could disclose to the jury the contents of the materials he relied on when forming his expert opinions regarding the defendant's sanity. 113 Ill. 2d at 7. The trial court refused to allow the defendant's expert to disclose the contents of the reports he relied on, which included prior evaluations and reports from psychiatrists, doctors, and counselors. *Id.* Our supreme court acknowledged that such materials may be substantively inadmissible, citing its decisions in *People v. Ward*, 61 Ill. 2d 559 (1975) and *Wilson v. Clark*, 84 Ill. 2d 186 (1981), but observed that experts may utilize those materials in forming their opinions so long as experts in the field reasonably rely on them. *Anderson*, 113 Ill. 2d at 7. The court considered *Ward* and *Wilson* along with Rule 703 of the Federal Rules of Evidence (which was adopted prospectively in *Ward*) and cases from other jurisdictions to conclude that "an expert should be allowed to reveal the contents of materials upon which he reasonably relies in order to explain the basis of his opinion." *Id.* at 9. The court stated that the contents of the reports relied on by the expert would be inadmissible hearsay if offered for their truth, but the contents of the reports were being offered for "the limited purpose of explaining the basis for the expert witness' opinion." *Id.* at 12. The court went on to say that a "trial judge, of course, need not allow the expert to recite secondhand information when its

probative value in explaining the expert's opinion pales beside its likely prejudicial impact or its tendency to create confusion." *Id.*

¶ 49 *Anderson* stands for the proposition that experts may testify regarding the content of materials they relied on while forming their opinion in order to explain the bases for the opinion, which is distinct from offering the content of a source for its truth. We disagree with plaintiffs that *Anderson* is wholly inapplicable, since *Anderson* appears to directly bear on the question of whether Dr. Sims could testify as to the contents of the materials she relied on in forming her opinions or whether the MMWR is evidence of the applicable standard of care. Plaintiffs cite to no authority that a medical negligence expert may describe to the jury the content of a source for the purpose of explaining that the source sets forth the standard of care. We also note that plaintiffs gloss over the fact that there was nothing before the trial court to suggest that Dr. Sims relied on the MMWR in forming her opinions, which the trial court observed was related to relevance. When the trial court heard argument on whether to bar Dr. Sims' supplemental disclosures as untimely, plaintiffs' counsel acknowledged that Dr. Sims did not disclose the MMWR prior to or at her discovery deposition, did not identify the MMWR by name at her deposition, and never mentioned the MMWR until her supplemental disclosures. Her supplemental disclosures stated: "As a follow-up to questions asked at her deposition, two written sources support Dr. Sims' opinion that leaving [UACs] in place for prolonged periods increases the risk of infection and thrombosis and that Mason's UAC should have been removed earlier[,]" and identified the MMWR as one of those sources. Finally, Dr. Sims never offered any opinion that the MMWR was synonymous with the standard of care. Here, the trial court appears to have been guided by the observation in *Anderson* that the contents of the reports relied on by an expert are inadmissible hearsay if offered for their truth, which Dr. Sims would effectively be

doing if she were directly examined regarding the contents of the MMWR. Having failed to demonstrate that Dr. Sims relied on the MMWR in forming her opinions, plaintiffs essentially sought to have Dr. Sims testify to the contents of the MMWR, which *Anderson* directly cautions against.

¶ 50 Plaintiffs next assert that evidence of standards or guidelines promulgated by the government aid the trier of fact in determining negligence issues and are admissible. See, e.g., *Ruffiner v. Material Service Corp.*, 116 Ill. 2d 53, 58 (1987) (stating that "[e]vidence of standards promulgated by industry, trade, or regulatory groups or agencies may be admissible to aid the trier of fact in determining the standard of care in a negligence action[,]" even if they do not have the force of law). Plaintiffs argue that evidence of standards or guidelines has been found to be admissible in medical negligence cases. See *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 332 (1965); see also *Advincula v. United Blood Services*, 176 Ill. 2d 1, 37 (1996). Although plaintiffs cite several cases without providing any adequate explanation of why they are relevant, they rely primarily on *Kramer v. Milner*, 265 Ill. App. 3d 875 (1994) and *Studt v. Sherman Health Systems*, 2011 IL 108182 in support of their argument that the trial court should have admitted the MMWR as substantive evidence to be considered along with Dr. Sims' opinions. We find plaintiffs' arguments unpersuasive.

¶ 51 In *Kramer*, plaintiff alleged that defendant was professionally negligent for failing to order a mammogram during the three years that defendant was the decedent's treating physician. 265 Ill. App. 3d at 876. At trial, plaintiff's expert opined that 80% to 90% of doctors followed the screening recommendations of the American Cancer Society, and based his opinion on standards and guidelines set forth in a variety of professional publications regarding breast cancer screening for patients over age 50. *Id.* at 877. Defendant's experts did not agree that those

standards and guidelines established the standard of care. However, both experts had analyzed the same statistical data in forming their standard of care opinions, and both relied on that data extensively in their testimony to the jury. *Id.* at 880. At the time, Illinois Pattern Instruction, Civil, No. 105.01 stated:

> "In providing professional services to (patient's name), a (insert appropriate professional person) must possess and apply the knowledge and use the skill and care ordinarily used by a reasonably well-qualified (insert appropriate professional person) practicing in the same or similar localities under the circumstances similar to those shown by the evidence. A failure to do so is professional negligence.
>
> [The only way in which you may decide whether (a) (any) defendant possessed and applied the knowledge and used the skill and care which the law required of him is from (expert testimony) (and) (or) (evidence of professional standards or conduct) presented in the trial. You must not attempt to determine this question from any knowledge you have.]" (IPI Civil No. 105.01 (3d Ed. 1990).

In giving the instruction, the trial judge excluded the parenthetical "evidence of professional standards or conduct," and the jury returned a verdict in favor of defendant. *Kramer*, 265 Ill. App. 3d at 878-79. We reversed, finding the trial court abused its discretion in refusing to include the parenthetical "evidence of professional standards or conduct." *Id.* at 880. We held that the evidence dealing with the professional standard of care did not need to be uncontested to warrant including the parenthetical as part of the instruction. *Id.* at 880-81. We expressed concern that the trial court's refusal to instruct the jury that it could consider the evidence relied on by both experts "might mislead the jury into believing that it was not entitled to consider the basis of the expert opinion." *Id.* at 881.

¶ 52 In *Studt*, the plaintiff sued a hospital for institutional negligence and vicarious liability for the negligence of the hospital's emergency room doctors. 2011 IL 108182, ¶ 5. The trial court instructed the jury with the 2006 version Illinois Pattern Instruction, Civil, No. 105.01 (IPI Civil (2006) No. 105.01), and the jury returned a verdict in favor of plaintiffs. *Id.* ¶ 2. Defendants appealed and the appellate court affirmed, finding that the IPI Civil (2006) No. 105.01 accurately stated the law for professional negligence. *Id.* Our supreme court allowed defendant's petition for leave to appeal and reversed the appellate court, finding that IPI Civil (2006) No. 105.01 did not accurately state the law in professional negligence cases. The instruction read:

> " 'Professional negligence' by a [specialist/doctor/nurse/therapist/health care provider/accountant/lawyer/other] is the failure to do something that a reasonably careful [specialist/doctor/nurse/therapist/health care provider/accountant/lawyer/other][practicing in the same or similar localities] [specialist/doctor/nurse/therapist/health care provider/accountant/lawyer/other] would do, or the doing of something that a reasonably careful [specialist/doctor/nurse/ therapist/health care provider/accountant/lawyer/ other] would not do, under circumstances similar to those shown by the evidence.
>
> The phrase ['violation of the standard of care'] ['deviation from the standard of practice'] means the same thing as 'professional negligence.'
>
> [To determine what the standard [of care] [of practice] required in this case, you must rely upon (opinion testimony from qualified witnesses) (evidence of professional standards) (evidence of by-laws/rules regulations/policies/procedures) (evidence of community practice) (and other sources). You must not attempt to determine this question from any personal knowledge you have.] The law does not say how a reasonably careful [specialist/doctor/nurse/therapist/health care provider/accountant/lawyer/other]

> would act under these circumstances. That is for you to decide." IPI Civil (2006) No. 105.01.

The court first observed that in a professional negligence case, the plaintiff bears the burden of establishing the standard of care through expert testimony (*Advincula*, 176 Ill. 2d at 24), unless the professional's conduct is so grossly negligent, or the procedure so common, that expert testimony was not necessary to equip the jury to judge the professional's conduct (*Jones v. Chicago HMO Ltd. of Illinois*, 191 Ill. 2d 278, 276 (2000)). But in institutional medical negligence cases, a broader range of evidence, including expert witness testimony and administrative rules and regulations, might be used to establish the applicable standard of care for the institution. *Studt*, 2011 IL 108182, ¶ 21 (citing *Greenberg v. Michael Reese Hospital*, 83 Ill. 2d 282, 293 (1980)). *Studt* held that the 2006 version of IPI Civil No. 105.01 effectively "placed bylaws, rules, regulations, policies and procedures *** on equal footing with expert testimony in judging a professional's conduct." *Studt*, 2011 IL 108182, ¶ 23. The court also observed that although the 2005 version of IPI Civil No. 105.01 permitted the standard of care for a professional to be established through nonexpert testimony, the cases cited in the 2005 version's Notes on Use could only be read as a limited exception the requirement of expert testimony in a professional negligence case. *Id.* ¶¶ 24-26 (discussing *Ohligschlager v. Proctor Community Hospital*, 55 Ill. 2d 411 (1973), *Metz v. Fairbury Hospital*, 118 Ill. App. 3d 1093 (1983), and *Smith v. South Shore Hospital*, 187 Ill. App. 3d 847 (1989)). *Studt* held that the trial court erred by giving the 2006 version of IPI Civil 105.01 because it did not accurately state the law in a professional negligence case. 2011 IL 108182, ¶ 29. But the court found that the rules and regulations admitted into evidence were not held out as establishing the standard of care for the professionals (for which plaintiffs sought to hold the hospital vicariously liable), but instead

had been used to buttress the proffered expert testimony with respect to the standard of care for the hospital on the institutional negligence claims. *Id.* Therefore there was no serious prejudice to the hospital's right to a fair trial with respect to the vicarious liability claims. *Id.* ¶ 29.

¶ 53 Neither *Kramer* nor *Studt* support plaintiffs' argument that the trial court abused its discretion by refusing to admit the MMWR as substantive evidence against the defendant physicians. In *Kramer*, both experts extensively relied on the same professional publications in forming their opinions regarding the standard of care, and both testified as to the contents of those publications, not for their truth, but to explain the bases for their opinions. The issue in that case was not whether the publications should be admitted as substantive evidence, but rather whether the jury was properly instructed as to what evidence they could consider in reaching their verdict. *Kramer*, 265 Ill. App. 3d at 880-81. Here, Dr. Sims never mentioned the MMWR until her supplemental disclosures, in which she stated the guidelines supported her opinions. She never stated that she relied on the MMWR in forming her opinions, or that the guidelines were synonymous with the standard of care. Furthermore, Dr. Sims was ultimately permitted to tell the jury that the MMWR supported her opinion regarding how long the UAC should remain in place.

¶ 54 And in *Studt*, our supreme court observed that in institutional negligence cases, the evidence necessary to prove the standard of care is different from the evidence required in a professional negligence case. Plaintiffs argue that "*Studt* recognized the admissibility of professional standards in physician cases as evidence of [*sic*] standard of care, not as establishing the standard, but as buttressing expert testimony." Plaintiffs' reading of *Studt* is too broad. In evaluating whether the defendant hospital suffered any prejudice from giving an instruction that did not accurately state the law, the supreme court observed that the rules and regulations for the

medical staff, which had been admitted into evidence, were not held out as establishing the standard of care for the physicians, but instead buttressed the expert testimony regarding the alleged institutional negligence by the hospital's failure to assure adequate communication between the physicians. *Studt*, 2011 IL 108182, ¶ 29. The court went on to acknowledge that tendering IPI Civil (2006) No. 105.01 under different circumstances could result in serious prejudice, such as if the jury considered only hospital rules or regulations in finding a physician liable. *Studt* did not say that admitting hospital rules and regulations buttressed the expert testimony regarding the standard of care for the *physicians*, but instead that the admission of those rules and regulations buttressed the expert testimony regarding the standard of care for the *hospital*. We therefore reject plaintiffs' reading of *Studt* that nonexpert evidence of the standard of care for a professional is admissible in a professional medical negligence case.

¶ 55 Plaintiffs also argue that IPI Civil No. 105.01 was amended in light of *Studt*, and now reads in relevant part:

> "A [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other] must possess and use the knowledge, skill, and care ordinarily used by a reasonably careful [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other].The failure to do something that a reasonably careful [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other] [practicing in the same or similar localities] would do, or the doing of something that a reasonably careful [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other] would not do, under circumstances similar to those shown by the evidence, is "professional negligence".

> The phrase "deviation from the standard of [care][practice]" means the same thing as "professional negligence".
>
> The law does not say how a reasonably careful [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other] would act under these circumstances. That is for you to decide. In reaching your decision, you must rely upon opinion testimony from qualified witnesses [and] [evidence of professional standards][evidence of by-laws/rules/regulations/policies/procedures] [or similar evidence]. You must not attempt to determine how a reasonably careful [specialist/doctor/nurse/therapist/health-care provider/accountant/lawyer/other] would act from any personal knowledge you may have." Illinois Pattern Instructions, Civil, No. 105.01 (2011) (IPI Civil (2011) No. 105.01).

In plaintiffs' view, IPI Civil (2011) No. 105.01 makes it clear that the jury should have considered the MMWR along with the expert evidence in this case. But this ignores the Notes on Use for IPI Civil (2011) No. 105.01, which state that "[t]he bracketed language in paragraph three is limited to those cases where the evidence warrants its use and is not to be viewed as an alternative to expert testimony" (IPI Civil (2011) No. 105.01, Notes on Use), and cites those cases discussed by *Studt* as the limited exceptions to the requirement for expert testimony. *Studt*, 2011 IL 108182, ¶¶ 24-26 (citing *Ohligschlager v. Proctor Community Hospital*, 55 Ill. 2d 411 (1973), *Metz v. Fairbury Hospital*, 118 Ill. App. 3d 1093 (1983), and *Smith v. South Shore Hospital*, 187 Ill. App. 3d 847 (1989)). Those cases did not involve a situation analogous to the one presented here. See *Studt*, 2011 IL 108182, ¶ 25. We therefore reject plaintiffs' argument that IPI Civil (2011) No. 105.01 required the trial court to admit the MMWR as substantive evidence.

¶ 56 Next, plaintiffs argue that the MMWR was self-authenticating under Rule 902(5) of the Illinois Rules of Evidence and that under the Federal Rules of Evidence it is "well established" that a party cannot be heard to object to the admission of governmental standards. In support, plaintiffs cite a federal district court order in *Mueller v. First National Bank of Quad Cities*, 797 F. Supp. 656, 657-58 (C.D. Ill. 1992). That citation does not adequately support plaintiffs' claim, as that order merely grants or denies certain motions *in limine* without any discussion of the significance of the evidentiary materials. Plaintiffs here offer no additional argument as to why the fact that the MMWR is a government publication, and thus a self-authenticating official publication pursuant to Rule 902(5) of the Illinois Rules of Evidence, means that it should have been admitted as substantive evidence in this case. We also agree with defendants that plaintiffs appear to conflate the concept of authentication, which is a prerequisite for admissibility, with admissibility itself. We therefore find that plaintiffs' failure to develop any meaningful argument on this point results in forfeiture. Ill. S. Ct. R. 341(h)(7) ("Points not argued are waived[.]").

¶ 57 Plaintiffs next argue that the MMWR was relevant because it tended to support plaintiffs' theory that the UAC should have been removed earlier and that plaintiffs were prejudiced because the jury was left with the impression that removal of the UAC after five days was solely Dr. Sims' unsupported opinion. Plaintiffs cite *Pyatt v. Engel Equipment Co.*, 17 Ill. App. 3d 1070 (1974) and *LePage v. Walsh Construction Co., Ltd.*, 126 Ill. App. 3d 1075 (1984) in support of their argument that a party suffers prejudice and is entitled to a new trial when a trial court refuses to allow the jury to hear that an expert's opinion is supported by a government-published standard. However, both cases are readily distinguishable.

¶ 58 In *Pyatt*, the plaintiff sought damages from the manufacturer of a machine for injuries the plaintiff sustained at work. The trial court barred any reference to or identification of the Health

and Safety Rules of the State of Illinois, although witnesses were allowed to testify as to the substance of the rules. *Id.* at 1071. Plaintiff argued that the rules were admissible as substantive evidence for the limited purpose of establishing standards for machine design. *Id.* After a jury found in favor of the manufacturer, plaintiff appealed. We reversed and remanded for a new trial, finding that the trial court erred by prohibiting any reference to the rules by name, stating that "it would be of substantial relevance in evaluating a standard to know the source of the standard as distinguished from the opinion of a single expert." *Id.* at 1072. We note, however, that this is not different from the underlying principle from *Anderson* discussed above, which says that an expert may disclose the materials and the contents of those materials that form the basis for his or her opinions. Furthermore, the rules at issue in *Pyatt* had been adopted by the Industrial Commission, which the appellate court held in *Clements v. Schless Construction Co., Inc.*, 8 Ill. App. 3d 291, 297 (1972) were admissible in helping to establish the standard of care in cases arising under the Structural Work Act. In *Clements* we relied in part on *Darling v. Charleston Community Memorial Hospital*, 33 Ill. 2d 326 (1965), which was an institutional negligence case against a hospital for failing to adequately staff an emergency room, and failing to enforce hospital procedures for observing and communicating changes in a patient's condition. As discussed above, the range of admissible evidence to establish the standard of care in an institutional negligence case is different than that permitted in a professional negligence case. We therefore do not finding *Pyatt* instructive or helpful in evaluating the issues in this appeal. Nor do we find *LePage* helpful either, where we held that the plaintiff was prejudiced by the trial court's refusal to admit Occupational Health and Safety Rules as evidence of the standard of care in a Structural Work Act case. 126 Ill. App. 3d at 1076-77. *LePage* based its holding on *Pyatt*

and the cases relied upon therein, including *Darling*, and is therefore inapposite for the same reasons we previously discussed.

¶ 59 Simply put, we do not agree with plaintiffs that the jury should have been apprised of the fact that the MMWR came from a government source when evaluating the professional conduct of the individual defendants in this case. Plaintiffs cite no authority in which government standards or guidelines were admitted as substantive evidence in a professional negligence case to establish the standard of care or buttress expert testimony. Regardless, any prejudice plaintiffs might claim was ameliorated by the fact that Dr. Sims did in fact testify that the CDC's guidelines supported her opinion that the UAC should be removed after five days. During closing arguments, plaintiffs argued regarding the UAC, "If you don't need it, take it out as soon as possible. That is something that has been endorsed by the American Academy of Pediatrics, the Infectious Disease Society of America and a whole slew of other professional organizations and published by the United States government." In sum, we hold that the trial court did not abuse its discretion in refusing to admit the CDC's MMWR guidelines as substantive evidence and plaintiffs were not deprived of their right to a fair trial.

¶ 60 Next, plaintiffs argue that they were deprived of a fair trial when the trial court barred Dr. Sims from testifying as to the contents of the MMWR. They argue that the trial court imposed an "extreme and unwarranted sanction," because Dr. Sims' supplemental disclosures were not untimely in light of the "unusual discovery schedule," and the fact that the parties agreed to waive the 60-day disclosure requirement in Illinois Supreme Court Rule 218(c) (eff. Oct. 4, 2002). Plaintiffs claim that they were diligent in supplementing Dr. Sims' disclosures, as they were made just three days after the defendants' experts were deposed. They accuse

defendants of trying to gain a tactical advantage by not objecting to the supplemental disclosures until filing defendants' motion *in limine* No. 3 at the start of trial.

¶ 61 Defendants argue that plaintiffs were the ones engaging in tactical gamesmanship by failing to disclose the MMWR as a basis for Dr. Sims' opinion, failing to produce the MMWR, and then "waiting in the weeds" before supplementing the disclosures 17 days before the scheduled trial date. Defendants again point out that Dr. Sims did in fact testify that the MMWR supported her opinions, as thus plaintiffs suffered no prejudice from the trial court's ruling.

¶ 62 Illinois Supreme Court Rule 219(c) (eff. July 1, 2002) authorizes the trial court to impose sanctions, including barring witnesses from testifying, when a party fails to comply with discovery deadlines. The imposition of sanctions is within the sound discretion of the trial court and will not be disturbed absent a clear abuse of discretion. *Sobczak v. Flaska*, 302 Ill. App. 3d 916, 925-26 (1998). Each case presents a unique factual situation which is to be considered in determining whether a sanction is to be imposed. *Boatmen's National Bank v. Martin*, 155 Ill. 2d 305, 314 (1993). Factors the trial court must use in determining whether exclusion of a witness is an appropriate sanction are: (1) surprise to the adverse party; (2) the prejudicial effect of the witness' testimony; (3) the nature of the witness' testimony; (4) the diligence of the adverse party; (5) whether objection to the witness' testimony was timely; and (6) the good faith of the party calling the witness. *Id.*

¶ 63 Considering the factors described in *Boatman's National*, we find that the trial court did not abuse its discretion in barring Dr. Sims from testifying as to the contents of her supplemental disclosures regarding the MMWR. The facts before the trial court are undisputed. In April 2011, Dr. Zikos stated in her deposition that she was aware of the MMWR and its contents. Dr. Sims was deposed on February 11, 2013, and had not previously disclosed the MMWR as a basis for

her opinion, nor did she reference the MMWR at her deposition. Despite multiple prior requests for the production of sources, Dr. Sims did not disclose the MMWR until April 26, 2013, which was 83 days after her discovery deposition and just 17 days before trial. Furthermore, aside from stating that the MMWR supported the opinions she provided at her discovery deposition, Dr. Sims' supplemental disclosures did not state the MMWR was analogous to the standard of care for the physicians in this case. On May 13, 2013, defendants moved *in limine* to bar the supplemental disclosures of Dr. Sims. Defendants do not argue that the supplemental disclosures altered Dr. Sims' testimony as to the standard of care, but it is clear that she sought to bolster her opinions after defendants' experts had already been deposed. Given all of these facts, we cannot find that the trial court abused its discretion in barring the opinions set forth in the supplemental disclosures regarding the MMWR. After the trial court heard oral argument from the parties, the trial court referenced *Anderson* as a reason why Dr. Sims would not be permitted to simply "regurgitate" the contents of MMWR on direct examination, and then stated:

> "[The Court:] That's really an aside. I think that it is clear there was a request in writing and there was an oral request at the deposition for identification of any articles that support her opinion. She declined to produce them so I think it is appropriately barred at this point.
>
> In terms of prejudice, which of course is a relevant consideration, I do not feel that there is any prejudice to the plaintiff given the fact that there are other witness[es] who have been disclosed as providing the foundational testimony for the MMWR being a reasonably reliable document."

¶ 64 We believe this was an appropriate exercise of the trial court's discretion. Despite the MMWR having been mentioned as early as April 2011, Dr. Sims did not identify it as a source

supporting her opinion until more than two months after her deposition and less than three weeks before trial. It was within the trial court's discretion, after having heard the arguments of the parties and being apprised of the facts, to find the supplemental disclosures untimely and to fashion a remedy for the discovery violation, including barring Dr. Sims from testifying about the contents of the MMWR. Ill. S. Ct. R. 219(c)(iv). Dr. Sims was neither barred as an expert, nor barred from giving her opinions regarding the standard of care, but was merely barred from testifying that the MMWR supported her opinions. Notwithstanding this ruling, after the trial court found that defendants' question about other literature opened the door for Dr. Sims to discuss the MMWR, Dr. Sims did in fact testify on redirect examination that the MMWR supported her opinions. We find that the trial court did not abuse its discretion in barring Dr. Sims from testifying as to her opinions regarding the contents of the MMWR, and even if the trial court erred, plaintiffs suffered no prejudice and were not deprived of a fair trial by the trial court's ruling.

¶ 65 We will briefly address two other arguments plaintiffs raise in support of their claim that they were deprived of a fair trial. First, plaintiffs argue that because the evidence was close and the trial court made alleged evidentiary errors (which we have already addressed above), the presence of jury misconduct in the form of persistent juror inattentiveness warrants giving the jury's verdict less deference and requires a new trial. Plaintiffs point to two instances in the record where the trial court made quips about the wakefulness of the jury members. Defendants point out that plaintiffs never raised an objection at trial, never moved for a mistrial, and never requested additional *voir dire* of the jurors. We see no basis for a new trial. Next, after a juror was late on two consecutive days, defendants suggested that the juror be excused. In response, plaintiffs' counsel stated "I'd rather not excuse her." The trial court stated that "unless there is an

agreement, she'll stay on the jury." There was no agreement, and the juror was not excused. We reject plaintiffs' claim that these few instances of jurors being "inattentive" amounted to the jury being "unqualified" or that the jury "demonstrably failed to do its job." The only other misconduct identified in the parties' appellate briefs is that one juror had to have his cell phone confiscated. Plaintiffs have failed to identify any instances of a juror demonstrating any bias or unwillingness to be impartial, and raise no argument as to how any perceived misconduct affected the jury's verdict. Any misconduct on the part of the jury fell well short of the severe misconduct that might warrant a new trial. See *Ferman v. Estwing Manufacturing Co.*, 31 Ill. App. 3d 229, 231-34 (1975) (finding that the trial court abused its discretion in granting a new trial based solely on one juror's boredom and antipathy towards one of the parties).

¶ 66 Second, plaintiffs complain that they were only "permitted" one expert witness regarding the standard of care, while defendants presented two retained neonatology experts and four testifying defendant-physicians. Plaintiffs offer no citation to the record that might suggest the trial court limited the number of experts that plaintiffs could present, or that the trial court was involved in any way with "permitting" experts. Plaintiffs cite no authority to support their argument that the number of testifying witnesses might affect the fairness of a trial. Plaintiffs raise no argument regarding the timeliness of defendants' experts' disclosures, and claim no surprise at the number of experts the defendants presented. Nor do plaintiffs cite to anything other than their posttrial motion to suggest that any inequity in the number of witnesses was brought to the trial court's attention. We have no basis to conclude that plaintiffs were substantially prejudiced as a result of their decision to present one expert on the standard of care against defendants' two retained experts and four individual defendants that affected the fairness of the trial.

¶ 67 Next, plaintiffs argue that the trial court erred when it gave the sole proximate cause instruction in IPI Civil No. 12.05 as opposed to the short form version, and refused to give IPI Civil No. 30.21, which instructs the jury that a plaintiff's right to damages should not be limited because any injury may have resulted from an aggravation of a pre-existing injury or that a pre-existing condition made the plaintiff more susceptible to injury, such as prematurity. Plaintiffs contend that defendants presented evidence of a multifactorial cause of Mason's injuries such that a sole proximate cause instruction was not warranted, and that there was evidence that Mason's prematurity was a pre-existing condition that made him more susceptible to injury warranting the requested damage instruction. Plaintiffs argue that giving the sole proximate instruction was not supported by the evidence, and that this error was compounded by the trial court's refusal to instruct the jury on plaintiffs' theory that plaintiffs were entitled to a full measure of damages regardless of any aggravation of a preexisting condition or due to a susceptibility to injury pursuant to IPI Civil No. 30.21. Plaintiffs claim that if the jury found Mason's prematurity was not the sole proximate cause of his injuries but his prematurity made him susceptible to injury, the jury was not properly instructed and would be left to speculate on the applicable law.

¶ 68 A litigant has the right to have the jury clearly and fairly instructed upon each theory that is supported by the evidence. *Ervin v. Sears, Roebuck & Co.*, 65 Ill. 2d 140, 145 (1976). However, it is error to give an instruction not based on the evidence. See *Black v. Peoria Marine Construction Co.*, 160 Ill. App. 3d 357, 365 (1987); *Jensen v. Chicago & Western Indiana R.R. Co.*, 94 Ill. App. 3d 915, 929 (1981). While the threshold for permitting an instruction in a civil case is modest, the standard for reversing a judgment based on failure to permit an instruction is high. *Heastie v. Roberts*, 226 Ill. 2d 515, 543 (2007). The question of what issues have been

raised by the evidence is within the discretion of the trial court. *Leonardi v. Loyola University of Chicago*, 168 Ill. 2d 83, 100 (1995). Although the evidence may be slight, a reviewing court may not reweigh the evidence or determine if it should lead to a particular conclusion. See *Burge v. Morton*, 99 Ill. App. 3d 266, 269 (1981).

¶ 69 Defendants objected to the plaintiffs' request for the short form instruction, and proffered the long form version that included the sole proximate cause instruction, arguing that Mason was born prematurely and required a degree of resuscitation, and the condition of his birth was the sole proximate cause of his brain injuries. Defendants pointed to testimony from plaintiffs' expert neurologist Jim Pappas, M.D., that indicated Mason's condition at birth could cause all the deficits related to his brain injuries, that a patient could have sepsis without sustaining a brain injury, and that it was possible that Mason may have had a brain injury even if he never became septic. Also, defendants argued that there was evidence that sepsis was the ultimate cause of Mason's leg injury. Plaintiffs argued that under *Clayton v. County of Cook*, 346 Ill. App. 3d 367 (2003), a sole proximate cause instruction is not proper where the defendant presents evidence of multifactorial causes of injury and that is what defendants did in this case. Defendants presented multiple separate possible proximate causes of Mason's injuries: his resuscitation at birth, his breech presentation and leg bruising at birth, prematurity, infection caused by translocation, and an episode of respiratory distress. The trial court agreed with the defendants and gave the long form version of IPI Civil No. 12.05, instructing the jury: "[H]owever, 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."

¶ 70 On appeal, plaintiffs again argue that giving a sole proximate cause instruction was an abuse of discretion because defendants presented a multifactorial cause of Mason's injuries.

Plaintiffs argue that *Clayton* addressed a similar situation and found that there was no identified sole proximate cause that would justify giving the long form version of IPI Civil No. 12.05. Defendants argue that they only needed to present some evidence of a sole proximate cause, and argue that they "put on ample evidence to support giving the long form of [IPI Civil No.] 12.05."

¶ 71 We find that the trial court abused its discretion in giving the long form version of IPI Civil No. 12.05. Defendants here did not identify a sole proximate cause of Mason's brain injury, but rather they advanced several factors that may have proximately caused Mason's injuries. We find *Clayton* instructive. In *Clayton*, a young woman was discovered unconscious with a cord around her neck. 346 Ill. App. 3d at 371. At the hospital she was intubated and placed on a ventilator in a comatose state. *Id.* She developed acute respiratory distress syndrome (ARDS), two types of pneumonia, and a lung infection. *Id.* Doctors performed a tracheostomy and the woman was eventually discharged, but she returned a few days later and the doctors' attempts to intubate her were unsuccessful due to scarring from the previous tracheostomy. *Id.* at 371-72. An emergency tracheostomy was performed, but there were problems getting oxygen to her lungs because of various obstructions. *Id.* at 372. She suffered brain damage and died a few days later. Defendants requested the long form version of IPI Civil (1995) No. 12.05, arguing that decedent's injury was caused by her attempted hanging and the resulting complications, namely the ARDS, pneumonia, the lung infection, and bronchospasm (a spasm of the muscles around an airway causing the airway to narrow). *Id.* at 387-88. We affirmed the refusal to give the sole proximate cause instruction finding no abuse of discretion because defendants failed to identify a sole proximate cause of decedent's death and instead had presented a multifactorial cause of death. *Id.* at 388.

¶ 72 Here, defendants identified some evidence that all of Mason's brain injuries could have resulted from Mason's condition at birth that put him at risk for neurodevelopmental sequelae, and that a premature birth could be the proximate cause of his brain injuries. Defendants also presented at least some evidence that the injury to Mason's leg was caused by the translocation of E. coli in Mason's gut, which seeded in his leg that was traumatized during his birth. But while defendants attempted to establish the circumstances of Mason's birth as a sole proximate cause for his injuries, we cannot say that defendants identified those circumstances as the sole proximate cause. See *Clayton*, 346 Ill. App. 3d at 388. There were several different factors of Mason's birth that were identified by defendants as possible causes of his injuries, such as his prematurity, the need for resuscitation, translocation of the E. coli, and having been born in a breech position resulting in bruising to his legs. We believe this is the sort of multifactorial cause of injury that *Clayton* described. As such, the trial court abused its discretion in finding that defendants had identified Mason's condition at birth as the sole proximate cause of Mason's brain and leg injuries that would justify giving the long form version of IPI Civil No. 12.05.

¶ 73 We find, however, that although it was error to give the sole proximate cause instruction, we cannot find that the error warrants reversal and a retrial. Plaintiffs have not identified any prejudice that resulted from this error, and our review of the record does not establish demonstrable prejudice sufficient to order a new trial. Plaintiffs did not request a special interrogatory on the question of any defendant's negligence or causation. Thus, we are unable to determine from the record whether the jury returned a defense verdict based on a finding of no professional negligence or no proximate cause. See *Jones v. Beck*, 2014 IL App (1st) 131124, ¶¶ 30-32. As we described above, defendants presented substantial expert testimony that the defendant physicians were not negligent and this was the dominant theme of the defense. If the

jury determined that defendants were not negligent, they would never reach the issue of proximate cause. *Id.* ¶ 30 (citing *Tabe v. Ausman*, 388 Ill. App. 3d 398, 402-403 (2009)). A special interrogatory would have tested the verdict on the issue of liability or causation and assisted in the determination of this issue. "If there was no negligence, then instructing on sole proximate cause did not matter." *Tabe v. Ausman*, 388 Ill. App. 3d 398, 404 (2009). For these reasons, based on this record, we find that the trial court's error in giving the long form version of IPI Civil No. 12.05 was harmless.

¶ 74 Finally, we turn to whether the trial court abused its discretion in refusing to give IPI Civil No. 30.21, which is a damages instruction. Plaintiffs argued that trial testimony supported their theory that Mason's prematurity rendered him more susceptible to injury. In refusing the tendered instruction, the trial court observed that giving IPI Civil No. 30.21 would amount to "instructing the jury they can't consider the defendant's entire defense, which is that his prematurity is what caused or contributed [to] causing all of his injuries." In their appellant's brief, plaintiffs claim that IPI Civil No. 30.21 was necessary to avoid any confusion as to what the law was if the jury found that Mason's prematurity was not the sole cause of his injuries but instead found that his prematurity caused him to be more susceptible to infection. Again, plaintiffs did not request any special interrogatories to the jury. As such, any claim that the jury might have been unsure about what the law would be, or that plaintiffs were somehow prejudiced, is purely speculative. Plaintiffs cite to several cases to suggest that a trial court commits reversible error by refusing to instruct the jury regarding entitlement to a full measure of damages, but those cases either involve reversal of a jury's verdict on other grounds (see *Shvartsman v. Septrain, Inc.*, 304 Ill. App. 3d 900, 904 (1999) (reversing jury verdict in favor of defendant where trial court abused its discretion in giving a "missing witness" instruction), or a

jury finding in favor of the plaintiff (see *Balestri v. Terminal Freight Cooperative Ass'n*, 76 Ill. 2d 451, 456 (1979) (affirming the appellate court's judgment reversing the damages award and remanding for a new trial on damages only). The jury found in favor of the defendants on the issue of liability and plaintiffs have not identified any actual prejudice. Even if the trial court abused its discretion by refusing to give IPI Civil No. 30.21 regarding plaintiffs' measure of damages, that error would be harmless considering that the jury returned a verdict in favor of defendants on the issue of liability. See *Dabros v. Wang*, 243 Ill. App. 3d 259, 270 (1993).

¶ 75 CONCLUSION

¶ 76 The trial court did not abuse its discretion in denying plaintiffs' posttrial motion for a new trial because the jury's verdict was not against the manifest weight of the evidence where the jury heard extensive testimony from qualified plaintiff and defense experts regarding the applicable standard of care. The trial court did not abuse its discretion in refusing to admit the MMWR as substantive evidence to be considered by the jury along with the expert testimony as to the standard of care, or by barring Dr. Sims' testimony related to her supplemental disclosures and therefore plaintiffs were not deprived of their right to a fair trial. Nor were plaintiffs deprived of a fair trial by any juror inattentiveness or misconduct where any inattentiveness was minimal and plaintiffs identify no prejudice. Plaintiffs also fail to demonstrate any error by the trial court stemming from plaintiffs' decision to present only one expert witness regarding the standard of care. Although the trial court abused its discretion by instructing the jury regarding sole proximate cause, because plaintiffs fail to identify any prejudice or proof that this error affected the jury's verdict, we find this error was harmless. Finally, the trial court did not abuse its discretion by refusing to instruct the jury regarding plaintiffs' measure of damages, but even if this was in error it was harmless in light of the jury's verdict regarding liability.

¶ 77 For the foregoing reasons, we affirm the judgment of the trial court.

¶ 78 Affirmed.