THIRD DIVISION
September 11, 2019

No. 1-18-0849

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

ANNA WINDEL f/k/a ANNA PALMISANO,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellant,	)	Cook County
	)	
v.	)	14 L 4750
	)	
RANDALL KAHAN, MD, and WOMANCARE, P.C.,	)	Honorable
	)	Janet Adams Brosnahan,
Defendant-Appellee.	)	Judge Presiding

PRESIDING JUSTICE ELLIS delivered the judgment of the court.
Presiding Justice Fitzgerald Smith and Justice Cobbs concurred in the judgment.

ORDER

¶ 1 *Held*: Affirmed. Trial court did not abuse discretion by denying plaintiff's motion to amend shortly before trial. Trial court did not err in denying plaintiff's post-trial motion for JNOV or new trial. Plaintiff forfeited review of alleged error in closing arguments.

¶ 2 Plaintiff Anna Windel developed serious complications after defendant, Dr. Randall Kahan, attempted surgery to remove her ovaries. Anna filed a complaint alleging that Dr. Kahan negligently performed the operation. At the conclusion of the trial, the jury returned a verdict in favor of defendants. On appeal, Anna first argues that the trial court erred in denying her leave to file an amended complaint. She also claims the trial court should have granted judgment notwithstanding the verdict (JNOV) or a new trial, and that a comment made by defense counsel in closing denied her a fair trial. We disagree with each argument and affirm.

¶ 3 BACKGROUND

¶ 4 In early 2013, Anna made an appointment with Dr. Amy Shapiro, a physician with WomanCare. Based on the information presented, Shapiro ordered two ultrasounds. The ultrasounds showed that Anna had an ovarian cyst. The two discussed Anna's options and agreed that surgery was the best course of action. (Anna disputes *why* she agreed to have the surgery, but ultimately she decided to have both ovaries removed.) Shapiro referred Anna to Dr. Kahan, another physician at WomanCare and an OB/GYN surgeon. According to Anna and her fiancé (now husband) Larry Windel, they were under the impression that it would be a simple, straightforward operation.

¶ 5 The operation was scheduled for March 20, 2013. Dr. Kahan intended to remove the ovaries by performing a laparoscopy (a small incision where tools are inserted to perform surgery) as opposed to a laparotomy (a large incision to "open up" the patient). A laparoscopy is performed by piercing the abdomen wall with a trocar—a small sharp tube. Gas is then pumped into the abdomen through the trocar, which inflates the abdominal cavity. Finally, the surgical instruments are placed through the trocar and, using a camera, the surgeon performs the operation.

¶ 6 In this case, Dr. Kahan's surgical tool of choice was a harmonic scalpel. A harmonic scalpel performs two functions: it cuts and then coagulates to reduce bleeding. The tip of the harmonic scalpel is similar to a small claw and is attached to the tissue that requires cutting. Once the tissue is grasped, the surgeon activates the harmonic scalpel, which causes imperceptible vibrations to generate heat to perform its dual functions. The harmonic scalpel is a recognized and accepted tool for laparoscopies. Because of the way it works, a harmonic scalpel

has the drawback of thermal spread. Thermal spread is heat that radiates beyond the actual instrument. If used too close to another structure, it can cause an unintended burn.

¶ 7 After meeting with Dr. Kahan just before surgery, Anna was taken into the operating room. Immediately, Kahan encountered severe adhesions—scar tissue—that fused Anna's organs together. Kahan testified that he was unable to distinguish Anna's anatomy, so he attempted to lyse—cut—the adhesions to create a vision plane in order to continue with the scheduled surgery. Because of the severity of Anna's adhesions, he deemed the vision planes "unmanageable" and decided to abort the procedure. Before ending the surgery, Kahan spoke with Larry about what he found and why they needed to stop. After waking up, Anna immediately complained of pain. She was the last patient in the surgical center, and the staff indicated that she had to leave because they were closing. On the way home, Larry stopped at a pharmacy to fill Anna's prescription for pain medication. Although she regularly took the medication, her pain remained severe.

¶ 8 The next day, Dr. Kahan called to see how Anna was doing. She told him she was still in pain and had not passed gas. Kahan became concerned about her pain level and told Anna to call him back immediately if things changed, especially if she developed a fever. A day later, Anna's condition had not improved. Kahan considered the possibility that Anna had a bowel injury, but he believed her pain was caused by an ileus—when the normal movement (peristalsis) of the gastrointestinal tract stops. Based on her condition, on the evening of March 22, Dr. Kahan advised her to go the nearest emergency room. He gave Anna his contact information and told her to have the hospital contact him. According to Anna, Dr. Kahan said, "[D]on't let them operate on you."

¶ 9 At the hospital, Anna was seen by a number of doctors. The hospital records indicate these doctors spoke with Dr. Kahan about Anna's case—though the contents of those conversations were highly disputed during trial. Based on the trial testimony, it is uncertain whether Dr. Kahan discussed a possible perforation with the emergency room doctors. We do know the emergency room doctors were not able to conclusively determine the source of Anna's pain. Tests showed an "abnormal finding" of "free air" in the abdominal cavity. It was "uncertain whether or not it is due to the retained air from the laparoscopic procedure or possible bowel perforation." Anna was admitted.

¶ 10 Between March 22 and 25, Anna remained in the hospital, and her condition varied. She reported, at least once, that she felt slightly better, but her pain persisted. The doctors still could not confirm, or rule out, an ileus versus a perforation. On the evening of the 25th, Anna was encouraged to walk around to alleviate some of her discomfort. The first time she tried, she had to stop because of the pain. The pain subsided slightly, so she tried again. As she was walking the second time, Anna started screaming in agony. At this point, the doctors decided it was necessary to perform an exploratory laparotomy.

¶ 11 Dr. Douglas Bryan performed the laparotomy in the very early morning of March 26. He first noticed "a lot of adhesions." He lysed the adhesions and inspected the abdomen. During the inspection, Bryan found a "1.5 centimeter perforation" in the "mid to distal part of the sigmoid colon." While the perforation explained Anna's symptoms, she also had an ileus of "her entire abdominal cavity, her entire GI tract." He used sutures to close the perforation and created a colostomy—a bypass of part of the intestinal tract. Bryan's progress note indicates an official diagnosis of "colonic perforation, iatrogenic, from pelvic laparoscopy for ovarian cyst removal,

and sepsis." "Iatrogenic suggests something that we, as physicians, surgeons, whatever, that we did caused the problem."

¶ 12 After Bryan repaired the perforation, Anna remained in the hospital to recover. After going home, she received in-home medical care to help with her open laparotomy wound and colostomy bag. Eventually, the colostomy was reversed. About a year later, in May 2014, she also suffered a hernia and second perforation. This perforation also required a laparotomy and colostomy to repair. This colostomy was reversed after three months and she developed a "chronic low-output fistula"—an abnormal connection between two organs. In Anna's case, her fistula connected her skin and colon.

¶ 13 In April 2014, Anna filed a complaint alleging that Kahan was negligent when he failed to adequately inspect Anna's bowel, failed to diagnose her perforation, failed to treat the perforation, and "was otherwise negligent in his performance of a laproscopic [*sic*] bilateral oophorectomy"—removal of the ovaries. She also sought to hold WomanCare liable under a theory of agency. Defendants answered and the litigation proceeded. In April 2017, three years after its initiation, the case was set for trial in October.

¶ 14 On August 1, 2017, approximately 60 days before trial, Anna sought leave to file a first amended complaint. This new complaint included her original claims, plus a separate theory of negligence: lack of informed consent. Specifically, Anna now claimed that Dr. Kahan failed to inform her of the actual nature of the surgery and her alternative treatment options. Anna alleged that had Dr. Kahan fully informed her, she would not have elected to have the procedure. Initially, the court did not explicitly rule on plaintiff's motion, but found that the "additional disclosures of Dr. Baggish are logical [corollaries] and are to be decided/rule[d] on an issue by issue basis." The case was certified for trial and assigned to a trial judge for the October trial.

¶ 15 Prior to beginning the trial, the trial judge ruled on a number of pre-trial issues, including plaintiff's motion to amend. In ruling on the motion to amend, the court specifically articulated its analysis of the *Loyola* factors. See *Loyola Academy v. S&S Roof Maintenance, Inc.*, 146 Ill. 2d 263, 273 (1992).

¶ 16 The court found that the amendment was not to cure a defect, but to add an entirely new theory of liability. As to this theory, the initial complaint only alleged that Kahan negligently performed the surgery, while the new claim of lack of informed consent also implicated a non-defendant, Shapiro, for the first time. Because of this shift, the court found that prejudice existed as it was the eve of trial and discovery had closed. The court's prejudice finding was based on the fact that the new theory had not been previously raised and was not fully developed as plaintiff's expert "has not been deposed on these new opinions." The court found that although plaintiff's expert opined that it was a bad decision to go forward with the surgery, this was not expanded on or included in his disclosures.

¶ 17 The court found also found the amendment untimely because at her deposition, in May 2015, Anna "unequivocally testified that she had no meaningful conversations with Shapiro and Kahan with regard to the risks of the recommended surgery. She was advised only that it was a simple procedure and that there was nothing to worry about." Despite this testimony, Anna made no attempt to amend her complaint to add this theory, even though she had plenty of opportunity to do so between May 2015 and August 2017. The court denied the motion to amend.

¶ 18 The evidence at trial consisted mostly of expert testimony about whether Dr. Kahan negligently performed Anna's laparoscopy. For his part, Dr. Kahan was adamant that he did not cause any injury, and that Anna's injury must have been caused by some other disease of the bowel. Besides Dr. Kahan himself, plaintiff's and defendants' retained experts agreed that Dr.

Kahan caused an injury to Anna's bowel that resulted in a perforation. The disagreement between the experts was *what* injury Dr. Kahan caused, and whether that injury was the result of negligence.

¶ 19 Plaintiff's Expert, Dr. Michael Baggish

¶ 20 Dr. Baggish testified that there are three major potential complications to laparoscopic surgery: (1) when placing the trocar, possibly hitting a major blood vessel; (2) "gastrointestinal injuries, injuries to the bowel usually referring to the small intestine or large intestine;" and (3) injuries to the urinary tract. Of these three, the first two can be lethal. As to the second, an injury to the intestines can lead to an infection, because the contents of the bowel will spill into the abdominal cavity. Because injury to the bowel is a known and accepted risk of laparoscopic surgery, an injury can occur absent malpractice. In fact, the surgery can go perfectly, and a perforation can still form. But if an injury occurs, the doctor must take care to recognize it to avoid negligence.

¶ 21 Prior to the laparoscopy, Anna was in good health and had undergone three other procedures, two cesarean sections and a hysterectomy; Dr. Kahan performed the latter in 2004. Dr. Kahan was not aware of Anna's history and did not properly consider the possibility of anatomical distortion due to adhesions from her prior procedures. In particular, Dr. Kahan did not remember the details of the hysterectomy he performed in 2004. That was important because a hysterectomy "creates adhesions consistently." These adhesions significantly raise the risk of injury to the bowel or other organs in subsequent procedures. According to Baggish, the standard of care requires an exam before surgery, so the surgeon can accurately apprise himself or herself of the patient's condition and history. In this case, Dr. Kahan did not meet with Anna until just before the surgery.

¶ 22 Dr. Baggish believed that Dr. Kahan also deviated from the standard of care in the way he handled Anna's adhesions. When Dr. Kahan entered the pelvis, he first noticed that his view was obstructed to the point that he could not see either ovary. "When [Kahan] took a look in there and saw the degree of adhesions and felt this was beyond his skill level, he should have stopped, period, not gone forward." The adhesions that Dr. Kahan described did not allow him to safely perform the surgery. When operating in the abdomen, "you've got to know where [the sigmod] colon is. Otherwise, you're going to damage it." In Baggish's opinion, Kahan perforated the colon by directly contacting it. Dr. Kahan "should have never used an energy device" because it requires that you know the anatomy well and be able to visualize where you are applying the scalpel. The failure to visualize can cause an unintended burn to another structure. As such, the standard of care requires a careful inspection of the colon and surrounding structures, which he believed Dr. Kahan failed to do.

¶ 23 Dr. Baggish believed that Dr. Kahan caused a transmural burn—one that penetrates the wall of the colon. Just because a burn goes through all of the layers of the bowel does not mean there is an immediate perforation. A thermal injury evolves over time. While it begins as a discoloration, because the burn has penetrated each layer, it will inevitably lead to a perforation as it progresses. Eventually there will be a small perforation which will grow depending on the severity of the burn. While a burn does not necessarily have to be transmural, Baggish opined that a serosal injury—an injury that does not penetrate each layer—would not have led to Anna's perforation**.**

¶ 24 Baggish dismissed the notion that Anna merely had an ileus, because "during laparoscopic surgery, it is almost unheard of to have an ileus." An ileus did not explain Anna's symptoms. When she was admitted to the emergency room, there was evidence of an infection.

She had an elevated heart rate, and her white blood cell count was approximately four times normal, which indicated she already had a perforated colon. He acknowledged, however, that by March 24, the doctors assessed her as having an ileus, because her pain and white blood cell count had improved slightly.

¶ 25 Defendant, Dr. Randall Kahan

¶ 26 Dr. Kahan testified that Shapiro recommended that Anna have surgery. He performed the operation because Shapiro did not perform the surgery recommended for Anna. While he did not physically meet with Anna until the day of the surgery, he did review her records and dictate a history prior to the operation. But at the time of the surgery, he did not correctly remember her surgical history. He thought she had undergone one caesarian section (she'd had two) and he thought that he had performed a laparoscopic hysterectomy in 2004 (it was a laparotomy).

¶ 27 During the surgery, it was immediately apparent that Anna's adhesions were blocking his view. He had no reason to believe she would have such severe adhesions, because they were not present when he preformed the hysterectomy in 2004. He scoped around and decided to use the harmonic scalpel to lyse adhesions in an attempt to re-establish Anna's anatomy. He acknowledged that it is important to visualize the areas where you apply the harmonic scalpel and that you have to be conscious of, and check for, collateral injury. He agreed that when someone has adhesions as severe as Anna's, you have to be "exquisitely aware of the anatomy."

¶ 28 After he was unable to re-establish the anatomy, he decided to abort the procedure. Prior to withdrawing, he inspected Anna's colon "as well as [he] could possibly inspect it given her anatomy." Despite his best efforts, he claimed he could only see "a very small portion" of the large intestine—approximately a 6 by 2-to-3 centimeter patch. After speaking with Larry about the procedure, he did not lyse any more adhesions and closed the operation. The same day as the

surgery, Kahan dictated a "rough draft" of his operation notes. This draft indicates: "Findings: Patient had completely blocked frozen pelvis. I could not see." This note made no mention of inspecting the colon.

¶ 29 He began having concerns about a possible bowel injury after speaking with Anna the next day. The second day post-surgery, after sending Anna to the emergency room, he dictated his official, signed report, which now indicated: "the anatomy was unrecognizable ***, I examined her colon and small bowel as meticulously as I could, given the situation." Kahan said that this note was edited two days later because "that's when it came to me to edit."

¶ 30 While he denied causing any injury, he recognized that "there may have been an injury at the time of my surgery. And I believe that it wasn't detected and it wasn't possible to be detected. *** [I]n retrospect, there may quite possibly have been a thermal injury to her bowel that manifested as a perforation."

¶ 31 Treating Physician, Dr. Douglas Bryan

¶ 32 Most of Dr. Bryan's testimony related to his decision to perform the laparotomy, which uncovered Anna's perforated colon. When questioned about why he waited until March 26 to perform the operation, he testified that he "did not believe that she had an obvious intestinal perforation." Although her symptoms were consistent with a perforation, they were also consistent with an ileus.

¶ 33 The surgery was performed on the 26th because of the change that occurred after she tried walking. When Anna was walking, she experienced "extreme diffuse abdominal pain." When they first tested her, she had "positive bowel sounds," and a later test showed "no movement of contrast within the bowel." He decided to figure out what was going on. His plan at

the time was to order more labs and perform an exploratory surgery. This was when he found the perforation.

¶ 34 Bryan could not say exactly when the perforation occurred. But he was adamant that it occurred prior to his surgery on the 26th. According to him, Anna's pain on the 25th "is consistent with the patient's body being overwhelmed by infection from a perforation that could occur a week before, four days before," but it was not consistent with a perforation occurring on the 25th. He testified that it would be "an assumption" that Anna's issues were related to an injury caused on March 20. All he could affirmatively say was that his care "was secondary to a perforation that we identified in the first operation."

¶ 35 Defense Expert, Dr. Frederick Luchette

¶ 36 Luchette testified that Anna had a "frozen pelvis." This is when a patient has adhesions that are serious enough to distort the normal anatomical planes, such that things "are stuck together and it's very difficult to separate them." When encountering a frozen pelvis, "the first goal is to re-establish the anatomy. So you have to free up all the intestines to define the anatomy and then approach the organs that you came to do an operation on." The presence of adhesion can "absolutely not" be predicted ahead of a planned procedure; you cannot determine their presence, location, or extent. When dealing with adhesions, the most common complication is an injury to the outermost layer of the intestines. There is nothing that can be done to completely eliminate this risk of injury.

¶ 37 In his opinion, Anna's radiographs and symptoms are consistent with retained air from the laparoscopy and an ileus. Where there is both a thermal injury to the bowel and an ileus, the increased pressure from the ileus can lead to a further compromise of the intestinal structure and a perforation. He believed that Dr. Kahan caused a thermal burn. However, unlike Baggish, he

believed this was a serosal burn caused by thermal spread. Because of the pressure from her ileus, the burned area perforated on the 25th as she trying to walk around. He acknowledged that the burn ultimately led to the perforation.

¶ 38 Defense Expert, Dr. Peter Weeks

¶ 39 Dr. Weeks testified that bowel injury is a recognized risk of surgery. Nothing in Anna's history required Dr. Kahan to abandon the procedure. Adhesions are unpredictable in both occurrence and severity. Kahan could not have anticipated that Anna would develop significant adhesions, because she did not have any in 2004. Dr. Weeks acknowledged, however, that someone with Anna's surgical history is at a higher risk for adhesions.

¶ 40 Dr. Weeks does not believe that Dr. Kahan perforated the colon at the time of the surgery. While Kahan did cause a thermal injury, the perforation did not occur until Anna was walking around on the 25th. He so testified because when there is a perforation, you can see the intestinal contents spilling into the abdominal cavity. So while an injury may have been hidden, it would be difficult to miss fecal matter.

¶ 41 The fact that a thermal injury occurred does not mean there was a breach of the standard of care. It is possible that "it may well have been invisible, hidden by adhesions perhaps." The type of thermal injury Anna sustained is often not a perforation when it occurs. "Injury to the bowel from thermal spread is not a deviation of the standard of care. Not looking for it or not recognizing it would be a deviation." While failure to inspect the colon is a deviation of the standard of care, failing to notice one is not necessarily a deviation, because adhesions can prevent even a reasonably careful gynecologist from being able to see a thermal injury.

¶ 42 After closing arguments, the case was submitted to the jury, which returned a verdict in defendants' favor. Anna filed a post-trial motion, which the circuit court denied. She timely filed her notice of appeal.

¶ 43 ANALYSIS

¶ 44 On appeal, Anna raises three arguments: the court erred in denying her leave to file an amended complaint, the court erred by denying her post-trial motions for new trial or JNOV, and defense counsel made prejudicial remarks in closing argument. We take each in turn.

¶ 45 I. Leave to Amend

¶ 46 "The circuit court retains broad discretion in allowing or denying amendment to pleadings prior to the entry of final judgment, and a reviewing court will not reverse the trial court's decision absent a manifest abuse of such discretion." *Richter v. Prairie Farms Dairy, Inc.*, 2016 IL 119518, ¶ 35. The ruling on a motion to amend constitutes an abuse of discretion only when "no reasonable person would agree with the court's decision." *1515 North Wells, L.P. v. 1513 North Wells, L.L.C*, 392 Ill. App. 3d 863, 870 (2009). To determine whether the court abused its discretion, we look at four factors: (1) whether the amendment would cure a pleading defect; (2) whether the opposing parties would be prejudiced or surprised by the amendment; (3) timeliness; and (4) prior opportunities to amend. *Loyola*, 146 Ill. 2d at 273. The parties agree that the first *Loyola* factor is inapplicable to the facts of this case. Anna focuses primarily on prejudice and timeliness.

¶ 47 In considering a motion to amend, prejudice "is the most important of the *Loyola* factors." *Hartzog v. Martinez*, 372 Ill. App. 3d 515, 525 (2007). Prejudice may be shown where delaying the amendment " 'leaves a party unprepared to respond to a new theory at trial.' " *Id.* (quoting *Miller v. Pinnacle Door Co., Inc.*, 301 Ill. App. 3d 257, 261 (1998)).

¶ 48 The trial court found that defendants would be prejudiced by this amendment, in that it sought to hold defendant WomanCare liable for the actions of Dr. Shapiro, who had never been made a defendant or a subject of criticism by any of Anna's disclosed experts. The amendment would also seek to hold Dr. Kahan liable on this new theory. As to each defendant, this new theory of liability, alleged for the first time after the close of discovery and on the "eve of trial," would leave defendants without an adequate opportunity to defend themselves.

¶ 49 In summing up its analysis, the court stated:

> "So I find that [defendants] are, in fact, prejudiced by the late request and would not be allowed a fair opportunity to defend against these theories at trial particularly in light of the fact that all discovery is closed and these theories were not fully developed during the discovery that did take place and there wasn't expert testimony proffered by the plaintiff to support these theories."

¶ 50 Anna disagrees, claiming that defendants would not have been prejudiced or surprised, because the issue of informed consent was adequately raised throughout the litigation. She claims that Dr. Baggish sufficiently disclosed his opinion about lack of informed consent at his deposition and notes defendants' disclosures contain opinions about informed consent.

¶ 51 During his discovery deposition, Baggish was asked "[w]hat's the next criticism, if any, you have, or are we done?" He initially responded, "I think that's it," but quickly followed it up with "Oh, wait. Wait. Bad decision to proceed with laparoscopy. High risk for injury based on prior abdominal surgery, prior laparotomy in 2004." When asked why Anna shouldn't have had the surgery, Baggish answered:

> "Because when he—he and Dr. Shapiro were pushing that the surgery should be done because of these risks, etc., even though they, Dr. Shapiro claims she told the

> patient she could wait for six months and have observations, this didn't seem to be the major tact [*sic*] they were taking relative to the patient in her deposition and also what I see in the record.
>
> So they say, well, you have cancer in your family, probably be wise to get the ovaries taken out. The patient was stunned when he came out and said he couldn't—he gave up the procedure, he couldn't get the ovary, it's okay now to wait six months for a follow-up."

¶ 52 Anna further notes that defendants' own experts disclosed opinions about informed consent. In their Rule 213(f)(3) disclosures, defendants indicated that Drs. Kahan and Weeks would testify that Anna was an appropriate candidate for surgery and that she received proper informed consent.

¶ 53 But as defendants note, there is a fundamental difference between defendants being made aware of a piece of information, and the defendants being notified that they will be required to defend a claim in court based on that information. See *Hartzog*, 372 Ill. App. 3d at 525; *Ahmed v. Pickwick Place Owner's Association*, 385 Ill. App. 3d 874, 884 (2008). Whatever Dr. Baggish may have said briefly in his deposition, defendants were never notified (before the late amendment Anna sought) that Anna would be pursuing a claim based on informed consent. Dr. Baggish's expert disclosures under Illinois Supreme Court Rule 213(f)(3) indicated that Baggish would offer nine opinions regarding a breach of the standard of care as to how Kahan performed and followed up on the scheduled laparoscopy. There was no mention whatsoever of informed consent, a distinct theory of medical malpractice. See *Xeniotis v. Cynthia Satko, D.D.S, M.S., P.C.*, 2014 IL App (1st) 131068, ¶¶ 50-51.

¶ 54 The portion of Dr. Baggish's deposition testimony discussing informed consent might have broached the topic, but little more. It was a brief portion of his testimony and, as the trial court noted, a comment on which he did not elaborate much at all. For example, as the trial court noted, Dr. Baggish "never formally opined based upon his professional expertise as to the standard of care to support a cause of action based upon lack of informed consent," much less that either Dr. Kahan or Dr. Shapiro deviated from that standard of care, even though such testimony is necessary to prove lack of informed consent. See *Xeniotis*, 2014 IL App (1st) 131068, ¶ 51 (in informed-consent malpractice claim, "[t]he failure of the physician to conform to the professional standard of disclosure must be proven by expert medical evidence.").

¶ 55 And nothing defendants may have written in their expert disclosures about the suitability of Anna for surgery and her informed consent changes those facts. For one thing, defendants had no idea that Dr. Shapiro's conduct would be called into question; she'd never been sued and never been criticized in expert disclosures. And defendants' rather *pro forma* reference to suitability for surgery and informed consent in their expert disclosures simply cannot serve as a substitute for being told, in timely fashion, that they would be required to defend a claim based on informed consent.

¶ 56 Most importantly, we reiterate our deferential standard of review. The trial court carefully detailed its findings on prejudice, and by no means could we say its reasoning was so arbitrary or unreasonable that no reasonable person would agree with it. The trial court did not abuse its discretion in finding that the prejudice element of the *Loyola* factors weighed against allowing the amendment.

¶ 57 With regard to timeliness, Anna argues that "the proposed amended complaint did not change the nature of the allegations, and timeliness should not have been a basis for denying

leave to file." We cannot agree that the amendment did not change the nature of the allegations; Anna added an entirely new and distinct theory of negligence. See *Xeniotis*, 2014 IL App (1st) 131068, ¶¶ 50-51. That aside, she then argues this factor from a statute of limitations/relation-back perspective. While the trial court did state that the statute of limitation was "also a legitimate basis" for denying the motion to amend, the *Loyola* timeliness factor is not synonymous with whether the claim would be time-barred. Indeed, in *Loyola*, 146 Ill. 2d at 275, our supreme court focused not on a statute-of-limitations concern but that the motion was filed "within the pleading stage" and not "after an unreasonable length of time." Amendments made "during the trial stage and not during the pleading stage" are more likely to be untimely. See *Taylor v. County of Cook*, 2011 IL App (1st) 093085, ¶ 56; also *Hartzog*, 372 Ill. App. 3d at 525 ("the stage of litigation in which a proposed amendment is brought is certainly a relevant consideration").

¶ 58 The trial court, referring specifically to Anna's "5-22-2015" deposition, noted that she "unequivocally testified that she had no meaningful conversations with Shapiro or Kahan with regard to the risks of the recommended surgery. *** Plaintiff also described Dr. Sharpio's articulated reasons for recommending the surgery, namely the presence of a cyst on her ovary and her family history of cancer."

¶ 59 Despite this "unequivocal[]" testimony, Anna did not seek to amend the complaint to add a claim of lack of conformed consent. Similarly, Baggish's disclosed opinions did not contain any criticism with regard to informed consent, even though he claimed to have reviewed Anna's deposition. And even when Baggish broached the subject briefly in his deposition on "1-27-17," there was *still* no motion to amend until August, just before trial.

¶ 60 Timeliness is closely related to the next factor, Anna's opportunities to amend. As we have just described, and as the circuit court homed in on, the facts that could have given rise to Anna's claim were first uncovered at least as early as March 2015, more than two years before the proposed amendment. (We say *at least* that early because Anna, the plaintiff, certainly has known all along what she and her doctors discussed about the surgery; her deposition testimony was surely not the first time *she* became aware of that information.) The trial court found that the record "showed that the plaintiff had the facts and opinions years ago that would have supported a request to amend, but the plaintiff failed to make any such request until the case was 60 days from trial."

¶ 61 In her brief, Anna argues that she waited until her case "had fully developed" and that her "only reasonable opportunity" to amend was after the informed consent issue was fully developed in discovery. As discussed above, we do not agree. For one thing, as the trial court noted, the informed consent issue was never developed much at all in discovery. And to the extent it was developed at all by Anna's testimony, it was developed years before her attempted amendment. The record amply supports the trial court's finding that Anna possessed the necessary information years before her attempt to amend.

¶ 62 In sum, we cannot find the court erred in its analysis of the *Loyola* factors. We find no abuse of discretion in the denial of leave to amend the complaint.

¶ 63 II. Denial of Post-trial Motion for New Trial or JNOV

¶ 64 Anna next claims the trial court erred by denying her post-trial motion for JNOV or new trial. A new trial is warranted when " 'the verdict is contrary to the manifest weight of the evidence.' " *Maple v. Gustafson*, 151 Ill. 2d 445, 454 (1992) (quoting *Mizowek v. DeFranco*, 64 Ill. 2d 303, 310 (1976)). We will reverse the trial court on this ruling only if "the opposite

conclusion is clearly evident" or the findings are unreasonable, arbitrary, and not based on the evidence. *Id*.

¶ 65 On the other hand, a JNOV is appropriate in the "limited cases where 'all of the evidence, when view in its aspect most favorable to the opponent, so overwhelmingly favors movant that no contrary verdict based on that evidence could ever stand.' " *Id*. at 453 (quoting *Pedrick v. Peroria and Eastern R.R. Co.*, 37 Ill. 2d 494, 510 (1967)). The court does not weigh evidence or judge credibility; rather, "it may only consider the evidence, and any inference therefrom, in the light most favorable to the party resisting the motion." *Id*. "Most importantly, a [JNOV] *may not* be granted *merely* because a verdict is against the manifest weight of the evidence." *Id*. (emphasis added.)

¶ 66 Anna focuses on the fact that the evidence was—essentially—undisputed that Dr. Kahan caused the bowel injury. It's true that, aside from Dr. Kahan himself, each expert agreed that Dr. Kahan caused a thermal burn to Anna's colon that led to the perforation. Where they disagreed is whether the causing of that injury was a breach of the standard of care. All of the experts agreed that an injury to the colon is an accepted and recognized complication of abdominal surgery. Dr. Baggish even testified that the surgery could go "perfectly," and an injury still could occur. The fundamental factual question was not whether the injury occurred, but why and how it did.

¶ 67 Plaintiff's theory was that Dr. Kahan breached the standard of care when he attempted to lyse adhesions even though he had zero visibility; this caused him to make direct contact with the colon, resulting in a perforation. That is an entirely plausible theory, and one supported by the evidence. The experts generally agreed that being able to visualize where you apply the harmonic scalpel is incredibly important. Drs. Baggish and Bryan testified that they believed a perforation injury occurred prior to the 25th.

¶ 68 But this theory was not the *only* viable one. Defendants' experts testified that Dr. Kahan could not have known the adhesions were unmanageable until he attempted to lyse them. In their opinions, Kahan appropriately tried to create manageable vision planes before aborting the procedure. As Dr. Weeks testified, the causing of the injury is not a deviation of the standard of care; failing to look for one is. And even if Dr. Kahan looked, failing to recognize his injury would not have been a deviation if the injury was hidden by adhesions.

¶ 69 Anna argues there was "overwhelming evidence that Dr. Kahan failed to perform an adequate inspection of Anna's bowel" during the operation "and failed to diagnose a perforation." Dr. Baggish was certainly adamant on this point. But Dr. Kahan testified that he inspected the colon as best he could after he decided to abandon the procedure—and Anna's counsel aggressively cross-examined him on this issue. He also testified that Anna's adhesions were so severe that he could not visualize, basically, anything; Bryan's description of the adhesions is consistent with this characterization. The evidence is far from "overwhelming." There is sufficient evidence to support a conclusion that, even though Dr. Kahan caused the injury and failed to recognize it, it was not due to negligence.

¶ 70 Anna also argues that Dr. Kahan was negligent before even beginning the procedure, because he should have "known to expect severe adhesions in a patient such as Anna." But again, there is sufficient evidence to the contrary in the record. The defense experts testified that a patient with Anna's history has an increased risk of adhesions, but their presence and severity are unknowable prior to performing the operation. Defendants also introduced evidence to directly counter Anna's contention. Specifically, the testimony showed that after two caesarian laparotomies, there was no indication that Anna had developed adhesions—let alone severe

ones—prior to the 2004 hysterectomy. Dr. Kahan testified that, given the lack of adhesions after two laparotomies, he had no reason to suspect they would exist after her hysterectomy.

¶ 71 Given the evidence at trial, this was a classic "battle of the experts," where well-qualified experts for both parties presented their opinions. *Guski v. Raja*, 409 Ill. App. 3d 686, 704 (2011). The jury weighed the evidence and found in favor of defendants. Whether we would have reached the same verdict is not the question on appeal; it is not our function to retry the case or reweigh the evidence. *Id*. Our task is to determine only whether the opposite conclusion—a verdict for Anna—was clearly evident from the record. On a balanced case such as this, with competent evidence submitted on each side, we certainly cannot make that finding. The jury's verdict was not against the manifest weight of the evidence.

¶ 72 Nor, for these same reasons, could we find that Anna has satisfied the even higher burden of establishing that a JNOV should have been entered. See *Maple*, 151 Ill. 2d at 453 (standard for JNOV higher than manifest-weight standard for new trial).

¶ 73 We affirm the denial of the motions for new trial and JNOV.

¶ 74 III. Defense Counsel's Comments

¶ 75 Finally, Anna claims defense counsel made an inappropriate and prejudicial statement during closing argument. She points to defense counsel's comment that Anna had to go "all the way to California" to find an OB/GYN, Dr. Baggish, willing to testify for her, further noting that Dr. Baggish was "pretty much retired" from practice and earned a hundred thousand dollars a year testifying in court. We find that Anna has forfeited this issue, as her counsel did not object to this statement, nor did counsel include this issue in Anna's timely-filed post-trial motion.

Vanderhoof v. Berk, 2015 IL App (1st) 132927, ¶ 91; *Jackson v. Seib*, 372 Ill. App. 3d 1061, 1076 (2007); Ill. S. Ct. R. 366(b)(2)(iii).[1]

¶ 76 In the absence of a contemporaneous objection, we may reverse only if we find plain error, which in the civil context is " 'exceedingly rare and limited to circumstances amounting to an affront to the judicial process.' " *Fakes v. Eloy*, 2014 IL App (4th) 121100, ¶ 120 (quoting *Holder v. Caselton*, 275 Ill. App. 3d 950, 959 (1995)). We must find " 'flagrant misconduct or behavior so inflammatory that the jury verdict is a product of biased passion, rather than an impartial consideration of the evidence.' " *Vanderhoof*, 2015 IL App (1st) 132927, ¶ 94 (quoting *Gillespie v. Chrysler Motors Corp.*, 135 Ill.2d 363, 375–76 (1990)). That is, the comments in closing argument must be " 'so egregious that they deprived a litigant of a fair trial and substantially impaired the integrity of the judicial process itself.' " *Id.* (quoting *Spyrka v. County of Cook*, 366 Ill. App. 3d 156, 170 (2006)).

¶ 77 Suffice it to say that, even if we found error in defense counsel's closing argument, we would not find that any such error rose to that exceedingly rare instance of an affront to or impairment of the judicial process itself. For one thing, even Anna concedes that the subject of the expert's compensation was fair game, and the evidence did, indeed, show that Dr. Baggish hailed from California and was spending the vast majority of his time testifying and not practicing. So much of what defense counsel said was, in fact, supported by the evidence. We would add that this comment was part of a lengthy closing argument spanning over 40 pages in the record, a relative blip on the screen even if improper.

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[1] Anna did seek leave to file an amended posttrial motion that added this argument. But the trial court denied the motion, because it believed that Anna was circumventing the time limit for filing post-trial motions. Anna makes no argument about this denial on appeal, and thus any claim of error on this point is also forfeited. See Ill. S. Ct. R. 341(h)(7) (eff. May 25, 2018).

¶ 78 We would also note that Anna's counsel, while not objecting to this comment, responded to it in rebuttal, trumpeting the fact that clients from all around the nation have hired Dr. Baggish, at least to some extent turning a criticism into a virtue. And Anna's counsel then inserted a bit of non-record commentary as well, stating that "[t]he truth is that [defense counsel] well knows that in Illinois to get an OB/GYN to testify against another OB/GYN is almost impossible *** because they refuse to testify against their fellow doctors." Indeed, it might well have been plaintiff's counsel's strategy *not* to object to defense counsel's comment, reasoning that a rebuttal argument would be more effective than an objection.

¶ 79 In any event, we do not find any substantial impairment to Anna's right to a fair trial under these circumstances. Thus, even if an error occurred, it would not rise to the level of plain error. We honor the forfeiture of this argument.

¶ 80 CONCLUSION

¶ 81 For these reasons, we affirm the judgment of the circuit court.

¶ 82 Affirmed.