2016 IL App (4th) 150969-U

NO. 4-15-0969

FILED
September 13, 2016
Carla Bender
4th District Appellate
Court, IL

IN THE APPELLATE COURT

OF ILLINOIS

FOURTH DISTRICT

BARBARA L. JACKSON,	)	Appeal from
Plaintiff-Appellee,	)	Circuit Court of
v.	)	Macon County
DECATUR MEMORIAL HOSPITAL and STEVEN E. WEBER, M.D.,	)	No. 14L4
Defendants-Appellants.	)	Honorable
	)	Thomas E. Little,
	)	Judge Presiding.

JUSTICE TURNER delivered the judgment of the court.
Presiding Justice Knecht and Justice Pope concurred in the judgment.

ORDER

¶ 1 *Held*: The appellate court affirmed the trial court's judgment, finding the court did not err in denying (1) a motion for judgment notwithstanding the verdict or a new trial, (2) a new trial on the issue of damages or a judgment of remittitur, (3) a new trial due to prejudicial error, or (4) defendants' application for reduction of the verdict based on plaintiff's insurance.

¶ 2 In October 2014, plaintiff, Barbara L. Jackson, filed an amended complaint against defendants, Decatur Memorial Hospital (Hospital) and Steven E. Weber, M.D., alleging defendants acted negligently in providing medical treatment to her. In June 2015, a jury found in favor of plaintiff and awarded her $2,897,000 in damages. In October 2015, defendants filed a posttrial motion, which the court denied in November 2015.

¶ 3 On appeal, defendants argue the trial court should have (1) entered a judgment notwithstanding the verdict or ordered a new trial, (2) ordered a new trial on the issue of damages or a judgment of remittitur, (3) ordered a new trial due to prejudicial error, and (4)

reduced the verdict by the amount provided by plaintiff's insurance. We affirm.

¶ 4 I. BACKGROUND

¶ 5 In October 2014, plaintiff filed a two-count amended complaint alleging medical negligence. In count I against the Hospital, plaintiff alleged she saw Dr. Weber in July and August 2012 for treatment of a rectal prolapse and he performed a laparoscopic low anterior resection. Plaintiff alleged the Hospital, through its agent Dr. Weber, committed negligent acts or omissions by (1) performing the wrong operation in that he removed too much of her rectum and failed to perform a rectopexy; (2) cutting the rectum in a spot too dark for him to see what he was doing; (3) removing a portion of her colon and rectum, which was contraindicated for her condition; (4) erroneously removing the attachments holding in place the splenic flexure of her colon; and (5) failing to order manometry studies to evaluate her sphincter tone. Count II made similar allegations against Dr. Weber.

¶ 6 In June 2015, a jury heard evidence in plaintiff's case. Plaintiff testified she had her appendix removed in 1959 and a hysterectomy in 1987. She had been in good health as an adult, "worked out all the time," and helped teach exercise classes. In December 2009, plaintiff developed an intermittent rectal prolapse, which is a condition where the rectum protrudes through the anus. In the summer of 2012, the rectal prolapse "would come out" when plaintiff was on her feet for a lengthy amount of time. Plaintiff stated it was "extremely painful" and she would have to go to the restroom "and pop it back in." Plaintiff was referred to Dr. Weber.

¶ 7 Plaintiff stated Dr. Weber explained a procedure performed on people in nursing homes in which the surgeon pulls out the prolapse and cuts it off. He told her he would not perform that procedure on her. Instead, Dr. Weber performed a low anterior resection on August 27, 2012. Plaintiff stated he did not explain what the procedure was. In the operation, Dr.

Weber removed plaintiff's rectum and part of her colon. Dr. Weber did not explain her rectum could be stitched back in place in a procedure known as rectopexy.

¶ 8 Two days after Dr. Weber performed the surgery, plaintiff stated her "bowels just started running constantly." Plaintiff went home on August 30, 2012, but she started vomiting and her stools were running like "hot acid." Plaintiff was readmitted on September 2, 2012, and a drain was inserted through her left buttock. She was discharged after five days but continued having problems with her bowel movements. She returned to the hospital but the problem involved her gallbladder. On September 25, 2012, plaintiff saw Dr. Weber and she complained that her "bowels were just running constantly." Plaintiff returned to work wearing adult diapers but still had bowel accidents.

¶ 9 In December 2012, plaintiff stated she started "vomiting up stool" and had "horrific pain." Plaintiff returned to the hospital and a scan revealed a severe bowel blockage. Dr. Timothy Bailey performed surgery to relieve the blockage, and plaintiff remained hospitalized for two weeks.

¶ 10 In January 2013, plaintiff returned to work with her adult diapers. She continued to have rectal pain, and Dr. Bailey recommended Dr. James Thiele, a colorectal surgeon. Sometime later, Dr. Thiele stated the only procedure that would help would be a colostomy because most of her rectum had been removed. In November 2013, Dr. Thiele performed the colostomy surgery. After she had leakage the next day, she returned for more surgery. After the second surgery, her "lungs collapsed" and she "ended up on a ventilator for a time." Plaintiff returned home in December 2013 but had problems with the ostomy bag used to collect her stools. In the summer of 2014, plaintiff developed a hernia around the bag, and Dr. Theile recommended surgery. However, the surgery was cancelled due to complications.

¶ 11 Plaintiff returned to work but started "vomiting stool again" on October 9, 2014. She returned to the hospital, and a scan revealed another bowel blockage. Emergency surgery was performed, and plaintiff returned home on October 25, 2014. When she returned home, she "started vomiting again and the pain got worse." Plaintiff returned to the hospital and stayed until November 6, 2014. She became "violently ill again" on November 25, 2014. She was admitted to the hospital again for another bowel blockage. She returned home on December 1, 2014, but was extremely weak and unable to cook for herself. Plaintiff lost her job and later sought further employment with little success.

¶ 12 Dr. Thiele testified he reviewed Dr. Weber's operative report and performed a colonoscopy to find the location of Dr. Weber's suture line. He determined Dr. Weber removed all of plaintiff's rectum until two centimeters above the anus. Dr. Thiele stated the rectum is a storage vessel, *i.e.*, a reservoir, and it sends signals that it is filling. At low volume, a person gets a signal that he needs to get to a bathroom. As it continues to fill, a person would feel "more urgency." When it fills to an urgent situation, a person constricts the sphincter muscle and gets to a bathroom, where "it reflexively empties the way it should." Dr. Thiele stated the colon takes feculent debris and moves it from point A to point B. If the rectum is removed and the colon is sewn close to the anus, there is no warning that stool is accumulating. Dr. Thiele opined that Dr. Weber's removal of plaintiff's rectum resulted in "debilitating incontinence."

¶ 13 Dr. Thiele ultimately recommended a colostomy, which "involves bringing the colon through the muscle and the subcutaneous fat in the skin and suturing it to the skin." Thereafter, a plastic bag appliance is worn to collect bowel movements. He performed the surgery, but plaintiff developed complications. He saw plaintiff in June 2014 and found she had developed a hernia. He did not perform hernia surgery because plaintiff had developed a small

bowel obstruction.

¶ 14 Dr. Thiele testified all of the medical bills listed for Springfield Clinic were related to his treatment of plaintiff's rectal prolapse and bowel obstructions. He opined the December 2012 bowel obstruction was most likely caused by Dr. Weber's surgery. Further, he opined plaintiff's hospitalizations from October through November 2014 were related either to complications of Dr. Weber's low anterior resection or from scar tissue that developed from the colostomy surgery in 2013. He also stated plaintiff will need ostomy supplies for life. She will also need surgery to fix her hernia.

¶ 15 Dr. Kyle Mueller, a general surgeon, testified he reviewed Dr. Weber's operative report. He opined Dr .Weber deviated from the standard of care by removing almost all of plaintiff's rectum down to the dentate line. He stated for a patient who has a rectal prolapse and is healthy enough to undergo surgery, the treatment of choice is a rectopexy, "which is just tacking the rectum up to hold it in place." He testified practice parameters state a low anterior operation has significant postoperative morbidity, "which means serious complications," and should not be considered a first-line treatment. Based on the operative report and the fact that almost all of plaintiff's rectum was removed, Dr. Mueller opined this deviated from the standard of care because Dr. Weber performed the wrong operation in removing the rectum. Dr. Mueller also opined Dr. Weber deviated from the standard of care by not performing a rectopexy. He opined the removal of plaintiff's rectum "clearly has led to additional surgery and the fecal incontinence that developed."

¶ 16 Dr. Weber testified he is a general surgeon. He became an employee of the Hospital in 2008 or 2009. In his training, he learned the rectopexy approach and the low anterior resection approach. He stated he discussed the surgery with plaintiff and told her "the recurrence

rate is high and side effects are high." In performing the low anterior resection, Dr. Weber removed plaintiff's rectum and part of her colon. He stated choosing the low anterior resection as opposed to a rectopexy does not increase the chances of incontinence. He also stated there is a risk of incontinence with any surgical procedure to correct a rectal prolapse.

¶ 17 Dr. Robert Jacobson, a colon and rectal surgeon, testified as defendants' expert. He stated he has performed rectal prolapse surgery, including rectopexy and low anterior resection. He also stated there are "probably close to eight to ten different types of procedure that can be performed." With a healthy patient, Dr. Jacobson stated "the low anterior resection really is the one that has the least amount of recurrence on dealing with rectal prolapse." From his review of the medical records, Dr. Jacobson considered plaintiff to be a healthy patient and opined the low anterior resection was appropriate. He stated there is no "gold standard" for treating rectal prolapse. Based on his review of the medical records and depositions, Dr. Jacobson opined Dr. Weber's treatment of plaintiff fell within the standard of care. He also stated Dr. Weber's choice of surgical technique did not cause plaintiff's bowel obstruction but actually decreased the risk. Moreover, it did not cause plaintiff's incontinence.

¶ 18 On cross-examination, Dr. Jacobson disagreed with literature that stated anterior resections are obsolete and "laparoscopic suture rectopexy is preferable because it is simple and easy to perform." He also disagreed with literature that stated "laparoscopic rectopexy has evolved into the gold standard, even for elderly patients." He agreed that taking out a portion of the colon and rectum carries a higher risk than stitching the rectum back in place. He agreed the more extensive the surgery, the more likely the patient will get scar tissue and adhesions. Also, the more surgeries a patient has, the more likely the possibility of bowel obstructions.

¶ 19 Dr. Carl Adams, a cardiovascular, thoracic, and general surgeon, testified as

defendants' expert. Having been trained in general surgery, Dr. Adams stated there are "about six" approaches in rectal prolapse surgery. In his opinion, the procedure performed by Dr. Weber was a "totally acceptable" approach to take and "well within the standard of care." He also opined Dr. Weber's choice of doing the low anterior resection instead of a rectopexy did not increase the chances of bowel obstructions in plaintiff.

¶ 20 Following closing arguments, the trial court instructed the jury, in part, as follows:

> "The Plaintiff Barbara Jackson claims that she was injured and sustained damage, and the Defendants Steven Weber, M.D. and Decatur Hospital were negligent in one or more of the following respects:
>
> (a) The Defendants removed too much of Plaintiff's rectum and failed to perform a rectopexy.
>
> (b) The Defendants erroneously removed the attachments holding in place the splenic flexure of the Plaintiff's colon.
>
> (c) The Defendants cut the Plaintiff's rectum in a spot where it was too dark for Dr. Weber to see what he was doing.
>
> (d) The Defendants failed to review the medical literature before operating or alternatively refer the Plaintiff to a specialist."

¶ 21 Following deliberations, the jury found in favor of plaintiff and against

defendants. The jury awarded plaintiff $2,897,000 in damages, including $250,000 for disfigurement, $500,000 for loss of a normal life, $500,000 for pain and suffering, $500,000 for emotional distress, $37,000 in lost earnings, $110,000 in lost future earnings, and $1,000,000 for necessary medical care, treatment, and services received and in the future.

¶ 22 In July 2015, defendants filed a motion to extend the time for filing posttrial motions. The trial court extended the time for filing a posttrial motion until 30 days after the parties received a written trial transcript. In October 2015, defendants filed a posttrial motion for remittitur, judgment notwithstanding the verdict, reduction of the verdict, and a new trial. In November 2015, the court denied the posttrial motion. This appeal followed.

¶ 23 II. ANALYSIS

¶ 24 A. Judgment Notwithstanding the Verdict or a New Trial

¶ 25 Defendants argue the trial court should have entered a judgment notwithstanding the verdict based on plaintiff's experts failing to prove the elements of her medical negligence case through expert testimony. In the alternative, defendants argue the court should have ordered a new trial on all issues due to the verdict being against the manifest weight of the evidence. We disagree.

¶ 26 "A motion for [judgment notwithstanding the verdict] should be granted only when the evidence and inferences therefrom, viewed in the light most favorable to the nonmoving party, so overwhelmingly favors the movant that no contrary verdict based on that evidence could ever stand." *Ries v. City of Chicago*, 242 Ill. 2d 205, 215, 950 N.E.2d 631, 637 (2011) (citing *Maple v. Gustafson*, 151 Ill. 2d 445, 453, 603 N.E.2d 508, 512 (1992)). "[J]udgment [notwithstanding the verdict] is inappropriate if 'reasonable minds might differ as to inferences or conclusions to be drawn from the facts presented.' " *York v. Rush-Presbyterian-St.*

Luke's Medical Center, 222 Ill. 2d 147, 178, 854 N.E.2d 635, 652 (2006) (quoting *Pasquale v. Speed Products Engineering*, 166 Ill. 2d 337, 351, 654 N.E.2d 1365, 1374 (1995)). Moreover, "[a] reviewing court 'cannot reweigh the evidence and set aside a verdict because different conclusions could have been drawn.' [Citation.]" *Estate of Holmes v. Pneumo Abex, L.L.C.*, 2011 IL App (4th) 100462, ¶ 16, 955 N.E.2d 1173. This court reviews a trial court's decision on a motion for judgment notwithstanding the verdict *de novo*. *Hamilton v. Hastings*, 2014 IL App (4th) 131021, ¶ 24, 14 N.E.3d 1278.

> "In contrast, on a motion for a new trial, the trial court will weigh the evidence and order a new trial if the verdict is contrary to the manifest weight of the evidence. [Citation.] A verdict is against the manifest weight of the evidence only where the opposite result is clearly evident or where the jury's findings are unreasonable, arbitrary and not based upon any of the evidence. [Citation.] This court will not reverse the trial court's ruling on a motion for a new trial unless it is affirmatively shown that the trial court abused its discretion." *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38, 983 N.E.2d 414.

¶ 27 To prove a claim of negligence, "a plaintiff must establish the existence of a duty, a breach of the duty, and an injury to the plaintiff that was proximately caused by the breach." *Vancura v. Katris*, 238 Ill. 2d 352, 373, 939 N.E.2d 328, 342 (2010). The elements of a medical-negligence claim are (1) the standard of care in the medical community by which the medical professional's conduct is measured, (2) that the medical professional deviated from that standard of care, and (3) that a resulting injury was proximately caused by the deviation from the standard

of care. *Neade v. Portes*, 193 Ill. 2d 433, 443-44, 739 N.E.2d 496, 502 (2000). "Unless the medical professional's negligence is so grossly apparent or the treatment at issue is so common that it is considered to be within the common knowledge of a layperson, expert medical testimony is required to establish the applicable standard of care and the medical professional's deviation therefrom." *Gulino v. Zurawski*, 2015 IL App (1st) 131587, ¶ 60, 43 N.E.3d 1102.

¶ 28 Defendants argue plaintiff's experts failed to show the claimed deviation (1) took place, (2) was a breach of the applicable standard of care, and/or (3) caused injury to her. In this case, plaintiff's jury instruction presented several different grounds of recovery, claiming defendants were negligent in the following ways:

> "(a) The Defendants removed too much of Plaintiff's rectum and failed to perform a rectopexy.
>
> (b) The Defendants erroneously removed the attachments holding in place the splenic flexure of the Plaintiff's colon.
>
> (c) The Defendants cut the Plaintiff's rectum in a spot where it was too dark for Dr. Weber to see what he was doing.
>
> (d) The Defendants failed to review the medical literature before operating or alternatively refer the Plaintiff to a specialist."

The jury returned a general verdict and found in plaintiff's favor.

¶ 29 " ' "When there is a general verdict and more than one theory is presented, the verdict will be upheld if there was sufficient evidence to sustain either theory, and the [moving party], having failed to request special interrogatories, cannot complain." [Citations.]' " *Lazenby v. Mark's Construction, Inc.*, 236 Ill. 2d 83, 101, 923 N.E.2d 735, 747 (2010); see also 735 ILCS 5/2-1201(d) (West 2014). Here, defendants did not submit special interrogatories to the jury.

¶ 30 In her first allegation, plaintiff claimed defendants removed too much of her rectum and failed to perform a rectopexy. Dr. Thiele, a colorectal specialist, testified treating rectal prolapse is a basic part of his medical practice. He stated there are several different approaches to treat rectal prolapse, and he uses a sacral rectopexy to preserve the rectum and reattach it to the bony structures in the pelvis. In his practice, Dr. Thiele stated a low anterior resection is for cancer patients and a rectopexy is performed on patients with rectal prolapse.

¶ 31 In looking at Dr. Weber's operative report, Dr. Thiele noted plaintiff had a laparoscopic takedown of the splenic flexure, a low anterior resection, and an end-to-end anastomosis. Dr. Thiele stated a low anterior resection is typically performed to treat rectal cancer. He stated rectopexy is his "procedure of choice for an active otherwise healthy woman." He stated the removal of the rectum cures the prolapse but typically results in incontinence. Thus, if the goal is to fix the prolapse but also remain continent, then "the rectopexy is the standard of care." Dr. Thiele stated he would not have performed the low anterior resection because "removing the storage vessel of the rectum will result in incontinence." Regarding rectopexy as the "gold standard" in treatment of rectal prolapse in otherwise healthy patients, Dr. Thiele believed the low anterior resection was the wrong surgery for plaintiff because it resulted "in debilitating incontinence." On cross-examination, Dr. Thiele agreed anything other than a rectopexy would have been below the standard of care for plaintiff because she desired "the best functional outcome possible."

¶ 32 Dr. Mueller testified "the primary reason for doing a low anterior resection is if there's a rectal cancer in that area." He opined Dr. Weber deviated from the standard of care as plaintiff's "rectum was divided very low." He stated "there are multiple surgeries that you can do for rectal prolapse" and the surgeries depend on the patient. He also stated "[i]t is in every article

I've reviewed and in what my training was, is if a patient's healthy enough to undergo an open surgery or a laparoscopic surgery and they have rectal prolapse, it's indicated to do a rectopexy, which is just tacking the rectum up to hold it in place."

¶ 33 Dr. Mueller reviewed *Practice Parameters for the Management of Rectal Prolapse*, prepared by the Standards Practice Task Force for the American Society of Colon and Rectal Surgeons. The parameters recommend that in patients with acceptable risk, the typical procedure of choice for the treatment of rectal prolapse is rectopexy. The parameters state an anterior resection has a higher recurrence rate, significant operative and postoperative morbidity, and "should not be considered a first line treatment."

¶ 34 Dr. Mueller opined Dr. Weber deviated from the standard of care because "almost the entire rectum was removed," and if the rectum is removed, "you're going to have these problems." He stated the removal of plaintiff's rectum "created the problem of incontinence, because she no longer has her rectal reservoir, or pouch, there to hold stool."

¶ 35 The evidence indicated Dr. Weber deviated from the standard of care in this case by failing to perform a rectopexy. While defendants are correct that there are multiple surgical approaches to treat rectal prolapse, including a low anterior resection, the testimony from Dr. Thiele and Dr. Mueller indicates a rectopexy was the procedure of choice considering plaintiff's circumstances. The evidence also indicated plaintiff's fecal incontinence was foreseeable. As plaintiff's evidence showed Dr. Weber breached the standard of care and caused injury to her, the trial court did not err in refusing to grant a judgment notwithstanding the verdict. Moreover, as the jury's verdict was not against the manifest weight of the evidence, the court did not err in refusing to order a new trial.

¶ 36 B. Damages

¶ 37 Defendants argue the trial court should have ordered a new trial on the issue of damages or, in the alternative, a judgment of remittitur, due to the damage award being against the manifest weight of the evidence as well as excessive. We disagree.

¶ 38 The purpose of a remittitur is to correct an excessive jury verdict in limited and appropriate circumstances. *Best v. Taylor Machine Works*, 179 Ill. 2d 367, 411, 689 N.E.2d 1057, 1079 (1997). "The very nature of personal injury cases makes it impossible to establish a precise formula to determine whether a particular award is excessive or not." *Snelson v. Kamm*, 204 Ill. 2d 1, 37, 787 N.E.2d 796, 816 (2003).

> "The trier of fact determines the amount of damages, and reviewing courts give great deference to a jury's damage award. [Citation.] An award of damages will be considered excessive only if it exceeds the range of fair and reasonable compensation, results from passion or prejudice, or is so large that it shocks the judicial conscience. [Citation.] A reviewing court will order a new trial on damages only if the amount awarded bears no reasonable relationship to the loss suffered by plaintiff or is unsupported by the manifest weight of the evidence and the opposite conclusion is clearly evident. [Citation.]" *Clarke v. Medley Moving & Storage, Inc.*, 381 Ill. App. 3d 82, 96, 885 N.E.2d 396, 410 (2008).

"Where the jury's award falls within the flexible range of conclusions reasonably supported by the evidence, a remittitur should not be granted." *Young v. Alden Gardens of Waterford, LLC.*, 2015 IL App (1st) 131887, ¶ 80, 30 N.E.3d 631. A court's refusal to grant a motion for remittitur

is reviewed under the abuse-of-discretion standard. *Estate of Oglesby v. Berg*, 408 Ill. App. 3d 655, 661, 946 N.E.2d 414, 419 (2011).

¶ 39 Defendants argue the jury's $1 million award for past and future medical expenses was excessive. However, defendants did not request an itemization of the past and future medical expenses, and any determination as to the excessiveness of the award would be based on speculation. Thus, we find defendants have forfeited review of this claim. See *Florek v. Kennedy*, 249 Ill. App. 3d 221, 236, 618 N.E.2d 760, 770 (1993).

¶ 40 Defendants also take issue with the $110,000 award for lost future earnings. We note defendants do not cite any authority in support of their claim. Thus, they have forfeited their argument. *Elder v. Bryant*, 324 Ill. App. 3d 526, 533, 755 N.E.2d 515, 521-22 (2001). Moreover, even if we were to consider the issue, we would find the jury's verdict was not outside the limits of fair and reasonable compensation. Also, the damages awarded do not appear to be the result of passion or prejudice or so excessive as to shock the judicial conscience. Accordingly, we find the trial court did not abuse its discretion in refusing to grant a remittitur. We also find the jury's award was not excessive.

¶ 41 C. Prejudicial Error

¶ 42 Defendants argue the trial court should have ordered a new trial on all issues due to prejudicial error committed in the course of the trial. We disagree.

¶ 43 "Statements made by counsel in opening statement are improper if they are not in good faith and are prejudicial." *Auten v. Franklin*, 404 Ill. App. 3d 1130, 1153, 942 N.E.2d 500, 519 (2010).

> "The standard of reviewing a claim of improper argument is whether the argument was of such a character as to have

> prevented a fair trial. [Citation.] The trial court is in a unique position to gauge the effects of misconduct, having heard all of the testimony and arguments and having observed the parties and their effect on the jury. [Citation.] The attitude and demeanor of counsel, as well as the atmosphere of the courtroom, cannot be reproduced in the record, and the trial court is in a superior position to assess and determine the effect of improper conduct on the part of counsel. [Citations.] Where the jury hears an improper comment by counsel, the trial court's prompt action in sustaining an objection can cure the possible error. [Citation.]" (Internal quotation marks omitted.) *Wilbourn v. Cavalenes*, 398 Ill. App. 3d 837, 855, 923 N.E.2d 937, 954-55 (2010).

Whether counsel's "allegedly improper remarks were so prejudicial [as] to require a new trial is left to the sound discretion of the trial court and should not be disturbed on appeal absent an abuse of discretion." *Calloway v. Bovis Lend Lease, Inc.*, 2013 IL App (1st) 112746, ¶ 102, 995 N.E.2d 381.

¶ 44 Defendants argue plaintiff's counsel stated in her opening statement that the practice of medicine is governed by "rules" and attempted to point out they were found in medical literature regarding the treatment of rectal prolapse. Defense counsel objected, and the trial court sustained the objection. When plaintiff's counsel mentioned "the rules" on other occasions, the court sustained defense counsel's objections again. "[W]here the trial court sustains an objection to improper argument by counsel, any error is considered cured and, if the trial was fair as a whole and the evidence sufficient to support the verdict, the judgment will not

be reversed on appeal." *Auten*, 404 Ill. App. 3d at 1154, 942 N.E.2d at 521. Here, as the court sustained the objections, we find any error was cured.

¶ 45 Defendants argue plaintiff's counsel made improper arguments regarding Dr. Jacobson's age and residence, speculated that Dr. Weber had financial motives in performing the surgery on plaintiff, and suggested defendants had an obligation to produce evidence that they had met the standard of care. However, we note defense counsel did not object to these arguments. Thus, defendants have forfeited review of this issue on appeal. See *Guski v. Raja*, 409 Ill. App. 3d 686, 695, 949 N.E.2d 695, 704 (2011).

¶ 46 Defendants argue plaintiff's counsel improperly impeached Dr. Adams. Prior to Dr. Adams' testimony, defense counsel filed a motion *in limine* to prevent cross-examination of Dr. Adams on the basis that his testimony had been disallowed in other cases. The trial court denied the motion. During cross-examination of Dr. Adams, plaintiff's counsel questioned him about his testimony being thrown out in other cases. However, defense counsel did not renew an objection during that testimony, and thus, the issue is forfeited on appeal. See *Steele v. Provena Hospitals*, 2013 IL App (3d) 110374, ¶ 40, 996 N.E.2d 711 (stating a party cannot rely on a motion *in limine* ruling to preserve an error for review and the failure to object at the time of the offending testimony results in forfeiture).

¶ 47 Defendants also argue plaintiff's counsel failed to complete her impeachment of Dr. Adams regarding his work history, his history of testifying for doctors or hospitals, the locations where he had testified, limitations on his hospital privileges, and whether he had practiced in areas of medicine regarding which he testified. We note defense counsel did not object in these instances. While counsel may not be in a position to object initially, given that he does not know whether the impeachment will be completed, he can move to strike the testimony

once it is clear the impeachment was improper. Here, counsel did not move to strike the testimony, and thus, defendants have forfeited this claim of error. See *Morris v. Milby*, 301 Ill. App. 3d 224, 231-32, 703 N.E.2d 121, 126 (1998).

¶ 48 D. Insurance Benefits

¶ 49 Defendants argue the trial court should have reduced the verdict pursuant to section 2-1205 of the Code of Civil Procedure (Procedure Code) (735 ILCS 5/2-1205 (West 2014)) by the amount of benefits provided by plaintiff's insurance, other than the amount for which the insurance company retained a right of reimbursement. We disagree.

¶ 50 Section 2-1205 of the Procedure Code (735 ILCS 5/2-1205 (West 2014)) provides as follows:

> "An amount equal to the sum of (i) 50% of the benefits provided for lost wages or private or governmental disability income programs, which have been paid, or which have become payable to the injured person by any other person, corporation, insurance company or fund in relation to a particular injury, and (ii) 100% of the benefits provided for medical charges, hospital charges, or nursing or caretaking charges, which have been paid, or which have become payable to the injured person by any other person, corporation, insurance company or fund in relation to a particular injury, shall be deducted from any judgment in an action to recover for that injury based on an allegation of negligence or other wrongful act, not including intentional torts, on the part of a licensed hospital or physician; provided, however, that:

(1) Application is made within 30 days to reduce the judgment;

(2) Such reduction shall not apply to the extent that there is a right of recoupment through subrogation, trust agreement, lien, or otherwise;

(3) The reduction shall not reduce the judgment by more than 50% of the total amount of the judgment entered on the verdict;

(4) The damages awarded shall be increased by the amount of any insurance premiums or the direct costs paid by the plaintiff for such benefits in the 2 years prior to plaintiff's injury or death or to be paid by the plaintiff in the future for such benefits; and

(5) There shall be no reduction for charges paid for medical expenses which were directly attributable to the adjudged negligent acts or omissions of the defendants found liable."

¶ 51 In the case *sub judice*, the trial court entered its judgment order on June 24, 2015. On July 7, 2015, defendants filed a motion to extend the time for filing posttrial motions. On July 22, 2015, the court extended the time for filing a posttrial motion until 30 days after the parties received a trial transcript. On October 2, 2015, defendants filed their posttrial motion, which prayed, in part, for a reduction in the jury verdict by the amount of any lien rights of

plaintiff's insurer, if any.

¶ 52 Plaintiff argues defendants did not file their section 2-1205 application for a reduction in the amount of recovery within 30 days as required. Moreover, plaintiff argues defendants' request for an extension of time to file their posttrial motion under section 2-1202(c) of the Procedure Code (735 ILCS 5/2-1202(c) (West 2014)) did not apply to a section 2-1205 application. We note plaintiff cites no authority for the position that the court could not extend the time for filing an application under section 2-1205. The Second District has found the very similar section 2-1205.1 motion (735 ILCS 5/2-1205.1 (West 1992)), like a section 2-1205 motion, must be made within the time for filing a posttrial motion. *Flavell v. Ripley*, 247 Ill. App. 3d 842, 846-47, 617 N.E.2d 1342, 1345 (1993) (citing *Richter v. Northwestern Memorial Hospital*, 177 Ill. App. 3d 247, 257-58, 532 N.E.2d 269, 276 (1988)). We find the same ruling applicable to section 2-1205. As the court extended the time for filing posttrial motions in this case, we find defendants' section 2-1205 application was not untimely.

¶ 53 Plaintiff argues that, even if defendants timely filed their application, they failed to meet their burden of proving any expenses paid by Blue Cross/Blue Shield were not subject to a right of recoupment. Under section 2-1205, "to receive a setoff, the burden is on a defendant to prove that a plaintiff's insurer does not have a right of recoupment against the benefits it has paid." *York v. El-Ganzouri*, 353 Ill. App. 3d 1, 22, 817 N.E.2d 1179, 1197 (2004). Here, defendants did not show plaintiff's insurer had no right of recoupment in their application for reduction. In fact, in attempting to prove their case, defendants sought discovery after the trial court had already denied their posttrial motion. We find defendants failed to show they were entitled to a reduction of the judgment as provided in section 2-1205.

¶ 54 III. CONCLUSION

¶ 55 For the reasons stated, we affirm the trial court's judgment.

¶ 56 Affirmed.