No. 1-10-0595

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FIFTH DIVISION
June 30, 2011

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

THERESA DIXON, Individually and as Special Administrator of the Estate of Loretta Buckner, Deceased, Plaintiff-Appellant,	)	Appeal from the Circuit Court of Cook County, Illinois, County Department, Law Division.
v.	)	No. 09 L 4340
ROSELAND COMMUNITY HOSPITAL, a not-for-profit Illinois corporation, TAJUDEEN OGBARA, M.D., RICHARD WARREN, M.D., RAKESH SALGIA, M.D., DEVINA SHAH, M.D., and JAYESH MADHANI, M.D., Defendants-Appellees.	)	Honorable Jennifer Duncan-Brice, Judge Presiding.

PRESIDING JUSTICE FITZGERALD SMITH delivered the judgment of the court.
Justices HOWSE and EPSTEIN concurred in the judgment.

ORDER

HELD: The circuit court did not err in dismissing the plaintiff's complaint pursuant to section 2-619(a)(5) of the Code of Civil Procedure (735 ILCS 5/2-619(a)(5) (West 2002)) on the basis of the plaintiff's failure to file her complaint within the prescribed two- year statue of limitations period for medical malpractice claims (735 ILCS 5/13-212(a) (West 2002)). The plaintiff's own undisputed deposition testimony established that she knew or reasonably should have known that her mother had suffered an injury and that the injury was wrongfully caused at the very latest on the date of her mother's death, which was well within the two-year limitations period.

The plaintiff, Theresa Dixon, both individually and as special administrator of her mother, Loretta Buckner's estate, brought an action against the defendants, Roseland Community Hospital,[1] Dr. Tajudeen Ogbara, Dr. Richard Warren, Dr. Rakesh Salgia, Dr. Devina Shah, and Dr. Jayesh Madhani, alleging medical negligence in the treatment of her mother. The defendants filed a motion to dismiss pursuant to section 2-619 of the Illinois Code of Civil Procedure (Code) (see 735 ILCS 5/2-619(6) (West 2002)) contending that the plaintiff failed to: (1) file her claim within the prescribed statute of limitations (see 735 ILCS 5/13-212(a) (West 2002)), and (2) to file a sufficient physician's report as required under section 2-622 of the Code (735 ILCS 5/2-622 (West 2002)). The circuit court granted the defendants motion to dismiss on the basis of the plaintiff's failure to file her claim within the two year statutory period. The plaintiff now appeals, contending that dismissal was inappropriate on either ground. For the reasons that follow, we affirm the judgment of the circuit court.

I. BACKGROUND

The record reveals the following pertinent facts and procedural history. The parties do not dispute that on April 6, 2002, the plaintiff's 69-year-old mother, Loretta Buckner, was admitted to Roseland Community Hospital (hereinafter Roseland Hospital), where an

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[1]Although the plaintiff initially named the University of Chicago Hospital as a defendant in her medical negligence action, on September 18, 2009, the circuit court granted the parties' joint (and agreed to) motion to voluntarily dismiss with prejudice the University of Chicago Hospital as a defendant in this cause (see 735 ILCS 5/2-1009 (West 2002)).

intravenous (hereinafter an IV) line was placed in her left hand. Loretta complained that the IV felt like "fire burning through her veins." On April 10, 2002, Loretta was moved to the University of Chicago Hospital, where she died sixteen days later, on April 26, 2002. The autopsy which was completed on July 30, 2002, revealed that Loretta had extensive dry gangrene of the left hand extending to the wrist, "secondary to heparin-induced platelet antibody thromboembolism." The autopsy further revealed that Loretta died from cardiopulmonary failure, "likely secondary to septic shock."

The plaintiff filed her initial complaint on May 13, 2004, pursuant to the Illinois Survival and Wrongful Death Acts (see 755 ILCS 5/27-6 (West 2002); 740 ILCS 180/1 (West 2002)), alleging that the defendants had committed medical negligence in their treatment of Loretta. The plaintiff specifically alleged that the defendants failed: (1) to supervise their agents and employees in the diagnosis, care and treatment of Loretta; (2) to use the degree of care or standard of skill which is ordinarily exercised by professionals in their field; (3) to adequately monitor and observe Loretta's condition; (4) to perform timely and adequate laboratory and other diagnostic tests; (5) to timely diagnose thrombosis (*i.e.*, the formation of a blood clot); (6) to timely administer anticoagulants; (7) to timely discontinue Heparin therapy; and (8) to adequately and timely perform and monitor Loretta's platelet count. The plaintiff alleged that as a proximate result of these negligent acts or omissions, Loretta suffered severe injuries that directly resulted in her death on April 26, 2002.

During discovery, the plaintiff was deposed[2] and testified to the following. The plaintiff is a high school graduate, with no medical training, knowledge or experience. In 2002, she had

[2]The plaintiff's deposition was taken on August 29, 2006.

just been married and therefore lived "back and forth" between Loretta's house, and her new home.

According to the plaintiff, prior to her hospitalization, Loretta appeared to be a healthy and active 69-year-old. She was an artist, who painted, cooked and cleaned for herself on a daily basis. The plaintiff was not aware of any chronic ailments that Loretta suffered from, aside from thyroid disease.[3] The plaintiff stated that Loretta had been taking Heparin, a blood thinning medication, but did not know for what condition that medication had been prescribed for, or for how long her mother had been taking it. According to the plaintiff, Loretta had also undergone gallbladder surgery approximately five years prior to her hospitalization at Roseland Hospital.

During her deposition, the plaintiff testified that about a week before Loretta's hospitalization at Roseland Hospital, Loretta complained that she was not feeling well, and spent the week bed. Since the plaintiff was in and out of Loretta's home, the plaintiff's brother visited Loretta regularly and took care of her. On April 6, 2002, the plaintiff's brother determined that Loretta "did not look well" and he called for an ambulance, which transported Loretta to Roseland Hospital. According to the plaintiff, his decision to call an ambulance had nothing to do with Loretta's hand, but rather had to do with her general state of health, which he deemed to be deteriorating.

The plaintiff visited Loretta at Roseland Hospital in the afternoon of April 6, 2002. There, Loretta complained to her about her left hand, telling the plaintiff that once the IV line was placed into her hand, it began to burn like it was "on fire." Loretta told the plaintiff that it

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[3]The record reveals that Loretta also had a history of ischemic cardiomyopathy, and hypertension.

felt like “liquid fire going through her veins,” or like being “shocked to life with your eyes wide open.”

The plaintiff testified that she did not visit her mother on the following day, April 7, 2002, but that she spoke to her brother and sisters who had visited Loretta at Roseland Hospital, and who informed her that Loretta was still in the emergency room. The plaintiff told her brother about Loretta’s arm and that she wanted him to take Loretta out of Roseland Hospital and transfer her somewhere else.

The plaintiff testified that from April 8, 2002, onward she visited her mother in the hospital every day. Loretta continued to complain about the pain in her hand and the plaintiff observed that the hand had swollen and had begun to change colors. According to the plaintiff, her brother was also concerned with the care that Loretta was receiving at Roseland Hospital and told the plaintiff, “We’ve got to get her out of here.”

On April 10, 2002, Loretta was transferred to the University of Chicago Hospital (hereinafter UC Hospital). When the plaintiff visited her mother at the UC Hospital that evening, Loretta showed her left hand and told her, “Look what they’ve done to me over there. Look what they did to my hand.” Referring to “that awful emergency room,” Loretta said “look what they did to me at Roseland. Just look.” She also told the plaintiff that she was “getting a lawyer when I get out of here.” The plaintiff stated that when she visited her mother at the UC Hospital she immediately noticed a drastic change in the color of Loretta’s hand, from her regular complexion to “jet black.” She stated that the condition of the hand was so “alarming” that when she first saw it she “nearly went into shock.”

According to the plaintiff, the staff at the UC Hospital took photographs of Loretta’s hand

and told the plaintiff they had "never seen anything like it," and that they wanted to use that photograph in the UC medical school journal. Loretta herself told the plaintiff that when she was admitted to the UC Hospital, the emergency room doctors asked her "what in the hell did they do to you over there," referring to her hand. According to the plaintiff, Loretta told her that the doctors at the UC Hospital attempted to treat Loretta's hand with leeches, antibiotics, and with little incisions to help the infection "pour out." However, Loretta's hand did not improve, but, according to the plaintiff, got worse, swelling up with the fingernails growing longer.

According to the plaintiff, at 1 a.m. on April 26, 2002, the family received a telephone call from the UC Hospital asking them to come to the hospital because Loretta had taken a turn for the worse. In that telephone conversation, the family was informed that "parts of the hand had broken off and into her bloodstream *** and that she wouldn't make it. She's been given *** antibiotics *** and its not going to save her. She's going into cardiac arrest until she leaves." The plaintiff stated that she understood this to mean that "the hand was dead and that parts of whatever this gangrene or whatever it was, was going to take her life and into her blood stream." The plaintiff further testified that when her mother died later that morning, she knew that the condition of her mother's hand had been responsible for her mother's death.

The plaintiff was asked when she first decided to hire an attorney and file her lawsuit, and she replied that she decided to do so "right after her mother died." She explained that this decision was based upon what Loretta's hand looked like as well as what Loretta had told her while she was in the two hospitals. According to the plaintiff, Loretta blamed the IV for the condition of her hand. As the plaintiff explained: "I don't think she fully understood what they did, but all she knew is whatever they did, her hand with that IV did that to her hand." When

asked whether this was when she first decided to investigate whether her mother had received appropriate care, the plaintiff responded in the affirmative. The plaintiff elaborated that in order to investigate whether Loretta had in fact received proper care, she obtained a copy of Loretta's medical records, looked them over and then hired an attorney.

During her deposition, the plaintiff further explained that even before her mother passed away, based upon what she had observed of Loretta's hand, she believed something was done wrong with respect to Loretta's treatment. Specifically, upon being asked when exactly she first became aware that negligence may have played a part in her mother's death, she answered "by [simply] looking at that hand, told me that." "Just looking at that told me something was terribly wrong." As she reiterated later in her deposition, "Looking at that hand. Looking at that hand. You go to the hospital to get well, not to get–for something like that to happen."

Although the plaintiff testified that she did not speak to any physicians regarding her mother's hand during her mother's hospitalization, she stated that a physician had confirmed her understanding that negligence in the treatment of Loretta's hand had caused Loretta's death. When asked to explain, the plaintiff averred that she was referring to the statement made by UC hospital emergency room physicians to Loretta upon Loretta's admission to the UC Hospital, pointing to her hand and asking her "what in the hell did they do to you over there." The plaintiff said that she understood this statement to mean that whoever put that IV in Loretta's hand, "did something wrong," and that a physician from the UC Hospital was telling her that there had been negligence in Loretta's care at Roseland Hospital. As the plaintiff stated, "I felt it and the doctor said it."

After discovery was completed, on April 15, 2008, the plaintiff's complaint was

voluntarily dismissed for want of prosecution.[4] The plaintiff refiled her complaint on April 9, 2010. Therein, she admitted that she did not provide the court with a physician's report (*i.e.*, a qualified expert's review of Loretta's medical records) as was required pursuant to section 2-622 of the Code (735 ILCS 5/2-622 (West 2002)), but requested a 90-day extension in which to file one.

The plaintiff subsequently filed two physicians reports, *i.e.*, each an affidavit by her attorney attesting to the fact that he had contacted and consulted two professionals (one a physician and the other a nurse) to review Loretta's medical records and provide their expert

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[4]The record reveals that after discovery, the defendants filed a motion for summary judgement contending that the plaintiff had failed to file her action within the prescribed two-year statute of limitations for medical malpractice claims (see 735 ILCS 5/13-212(a) (West 2002)). This motion was denied by the circuit court, and the defendants sought certification of the issue pursuant to Illinois Supreme Court Rule 308. A hearing on whether certification was appropriate was held before the circuit court on February 19, 2008. However, the issue remained pending for several months because the plaintiff's counsel indicated that he would be withdrawing from the case. The plaintiff's counsel was eventually allowed to withdraw from the case. On April 15, 2008, the circuit court informed the plaintiff that it would either grant the Rule 308 certification request and permit this matter to proceed to the appellate court, in which case the plaintiff would have to brief the issue without the benefit of an attorney, or that it would permit the plaintiff to dismiss the case for want of prosecution to permit the plaintiff time to obtain new counsel. The plaintiff chose to dismiss the case for want of prosecution, and after retaining new counsel refiled her complaint on April 10, 2009.

opinions with respect to the plausibility of the plaintiff's claims. Both reports concluded that the failure of the physicians and staff at Roseland Hospital to appreciate the importance of coagulopathy (*i.e.*, a blood clotting disorder) in the patient and to diagnose and treat Heparin-induced thrombocytopenia[5] within a timely manner, caused the development of the irreversible ischemia[6] and gangrene of Loretta's hand, which ultimately led to septic shock and premature death. The reports further concluded that it was error on part of the defendants to administer fresh frozen plasma to the patient in the phase of heparin-induced thrombocytopenia, as this generally worsens thrombosis (blood clotting). Rather, the reports opined, the defendants should have started the patient on an alternative anticoagulant for the treatment of heparin-induced thrombocytopenia.

On September 16, 2009, the defendants filed a motion to dismiss pursuant to section 2-619 of the Code (see 735 ILCS 5/2-619 (West 2002)), contending that the plaintiff had failed: (1) to file her claim within the prescribed two-year statute of limitations for medical malpractice actions (see 735 ILCS 5/13-212(a) (West 2002)), and (2) to file a sufficient physician's report as required pursuant to section 2-622 of the Code (735 ILCS 5/2-622 (West 2002)). In support of this motion, the defendants attached the plaintiff's deposition, taken on August 29, 2006, as well as the two physician's reports filed by the plaintiff's attorney on August 17, 2009.

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[5]Thrombocytopenia is the medical term for a low blood platelet count.

[6]Ischemia is a restriction in blood supply, generally due to factors in the blood vessels, with resultant damage or dysfunction of tissue. It can also result from congestion in a blood vessel, such as from thrombosis (*i.e.*, the formation of blood clots).

The circuit court, in a written order, granted the defendants' motion to dismiss on January 10, 2009, on the basis of plaintiff's failure to timely file her complaint within the requisite statutory period. In doing so, the circuit court concluded that the plaintiff's deposition testimony established, as a matter of law, that, she knew or reasonably should have known that Loretta's death was wrongfully caused on or before April 26, 2002. The circuit court therefore concluded that the two-year statute of limitations, which began to run on April 26, 2002, expired on April 26, 2004, 17 days prior to the plaintiff's filing of her complaint on May 13, 2004.

The plaintiff now appeals contending that the trial court erred when it found as a matter of law that the complaint should be dismissed as time barred. The plaintiff further contends that the trial court's dismissal of her complaint cannot be affirmed on the basis of her failure to file a sufficient physician's report as was required pursuant to section 2-622 of the Code (735 ILCS 5/2-622 (West 2002)) in effect at the time she filed her lawsuit. We begin by addressing the statute of limitations question.

II. ANALYSIS

A motion to dismiss pursuant to section 2-619 (735 ILCS 5/2-619 (West 2002) admits the legal sufficiency of the complaint (*i.e.*, all facts well pleaded), but asserts certain defects, defenses or other affirmative matters that appear on the face of the complaint or are established by external submissions that act to defeat the claim. *Wallace v. Smyth*, 203 Ill. 2d 441, 447 (2002). Subsection (a)(5) of section 2-619, pursuant to which defendants' motion was brought, specifically allows dismissal when "the action was not commenced within the time limited by law." 735 ILCS 5/2-619(a)(5) (West 1996). In ruling on a section 2-619 motion, all pleadings and supporting documents must be construed in a light most favorable to the nonmoving party,

and the motion should be granted only where no material facts are in dispute and the defendant is entitled to dismissal as a matter of law. *Mayfield v. ACME Barrel Company*, 258 Ill. App. 3d 32, 34 (1994). The relevant inquiry on appeal is "whether the existence of a genuine issue of material fact should have precluded the dismissal or, absent such an issue of fact, whether dismissal is proper as a matter of law." *Kedzie & 103rd Currency Exchange, Inc. v. Hodge*, 156 Ill.2d 112, 116-17 (1993). Our review the circuit court's grant of a motion to dismiss pursuant to section 2-619 is *de novo*. *Spillyards v. Abboud*, 278 Ill. App. 3d 663, 668 (1996).

In the present case, the parties agree that the plaintiff's medical malpractice claims against the defendants brought pursuant to the Illinois Wrongful Death and Survival Acts are governed by a two-year statue of limitations set forth in section 13-212(a) of the Code (735 ILCS 5/13-212(a) (West 2002)). See *Durham v. Michael Reese Hospital Foundation*, 254 Ill. App. 3d 492, 495 (1993) ("all actions for injury or death predicated upon the alleged negligence of a physician [or hospital] are governed by section 13-212(a)").

Pursuant to section 13-212(a), any claim of malpractice asserted against a physician or hospital must be filed within two years of "the date on which the claimant knew, or through the use of reasonable diligence should have known *** of the existence of the injury or death for which damages are sought ***." 735 ILCS 5/13-212(a) (West 2002). Our cases have interpreted this to mean that the two-year malpractice limitations period begins to run when the party knows or reasonably should have known both that an injury occurred and that it was wrongfully caused. See *Witherell v. Weimber*, 85 Ill. 2d 146, 156 (1981); see also *Nair v. Bloom*, 383 Ill. App. 3d 867, 870 (2008), citing *Knox College v. Celotex Corp.*, 88 Ill. 2d 407, 415 (1981); *Clark v. Galen Hospital Illinois, Inc.*, 322 Ill. App. 3d 64, (2001); *Saunders v. Klungboonkrong*, 150 Ill. App. 3d

56, 59 (1986). "Wrongfully caused" does not mean knowledge of a specific defendant's negligent conduct or knowledge that an actionable wrong was committed. *Castello v. Kalis*, 352 Ill. App. 3d 736, 745; see also *Young v. McKiegue*, 303 Ill. App. 3d 380, 388 (1999). Rather, a plaintiff knows or should know his injury was "wrongfully caused," when he " 'becomes possessed of sufficient information concerning his injury and its cause to put a reasonable person on inquiry to determine whether actionable conduct is involved.' " *Saunders*, 150 Ill. App. 3d at 60, quoting *Knox College*, 88 Ill. 2d at 416; see also *Nair*, 383 Ill. App. 3d at 870. In other words, " '[t]he limitations period begins to run when the plaintiff becomes aware that the cause of [the] problem stems from another's negligence and not from natural causes.'" *Castello*, 352 Ill. App. 3d at 745, quoting *Saunders*, 150 Ill. App. 3d at 60. The law is well-settled that once a party knows or reasonably should have known both of the injury and that it was wrongfully caused "the burden is upon the injured person to inquire further as to the existence of a cause of action." *Castello*, 352 Ill. App. 3d at 745, quoting *Witherell* 85 Ill. 2d 146; see also *Knox College*, 88 Ill. 2d at 171 ("once it reasonably appears that an injury was wrongfully caused, the party may not slumber on his rights.")

In determining when a plaintiff knew or reasonably should have known that his injury was caused by a defendant's wrongful conduct, courts often look to the nature of the injury itself. *Saunders*, 150 Ill. App. 3d at 60. "The more obvious the injury, the more easily a plaintiff should be able to determine its cause." *Clark v. Galena Hospital Illinois, Inc.*, 322 Ill. App. 3d 64, 73 (2001).

In most instances, the time at which a plaintiff knows or reasonably should have known both of the injury and that it was wrongfully caused will be a question of fact. *Nair*, 383 Ill. App.

3d at 870, citing *Witherell*, 85 Ill.2d at 156; see also *Castello*, 352 Ill. App. 3d at 744. However, "[w]here it is apparent from the undisputed facts *** that only one conclusion can be drawn, the question becomes one for the court," (*Witherell*, 85 Ill. 2d at 156), and can be resolved as a matter of law, making a section 2-619 involuntary dismissal on statute of limitations grounds appropriate. See *Castello*, 352 Ill. App. 3d at 744, citing *Witherell*, 85 Ill. 2d at 156; see also *Nair*, 383 Ill. App. 3d at 870; *Saunders*, 150 Ill. App. 3d at 61 ("If only one conclusion can be drawn from the undisputed facts, the question of the timeliness of the plaintiff's complaint is for the court to decide").

In the present case, the plaintiff argues that the circuit court erred when it found that the statute of limitations began to run on April 26, 2002, the date of Loretta's death, thereby barring the plaintiff from filing her complaint on May 13, 2004, 17 days after the expiration of the two-year limitations period on April 26, 2004. The plaintiff specifically contends that the circuit court erred when it found that her deposition testimony established, as a matter of law, that she knew or should have known that her mother's death was wrongfully caused at the latest on April 26, 2002. Instead, the plaintiff claims, her deposition testimony only established that she had a *suspicion* that the death was wrongfully caused. The plaintiff contends that she could not have reasonably known that her mother's injury was caused by medical wrongdoing until she received her mother's autopsy report on July 30, 2002, confirming her suspicions, and that therefore her filing of the complaint on May 13, 2004, fell within the statutory limitations period. For the reasons that follow, we disagree.

In the instant case, the injury complained of was the failure of the defendants to diagnose and adequately treat the thrombosis in Loretta's hand, which ultimately resulted in her premature

death from gangrene and septic shock on April 26, 2002. The plaintiff's undisputed deposition testimony establishes that when Loretta was admitted to Roseland Hospital on April 7, 2002, and an IV was administered into her left hand, Loretta immediately began to complain that her hand felt like "it was on fire," or as if "liquid fire was going through her veins." As a result of her these complaints, the plaintiff spoke to her brother and told him she wanted their mother immediately transferred to another hospital. The plaintiff's brother agreed, stating, "We have to get her out of there." It is further undisputed that Loretta's hand began changing colors, and on April 10, 2002, upon her transfer to the UC Hospital, it took a "drastic" change for the worse, turning "jet black." The plaintiff stated in her deposition that the change in color was so "alarming" that when she first observed it she nearly "went into shock." In addition, it is undisputed that upon Loretta's admission to the UC Hospital, the emergency room physicians checking her hand asked her "what in the hell did they do to you over [at Roseland Hospital]?" The physicians at UC Hospital then took photographs of Loretta's hand to publish in the school's medical journal as "they had never seen anything like this before." The plaintiff testified that despite several efforts at treatment of Loretta's hand, the condition worsened, and the hand swelled up. The undisputed deposition testimony further establishes that a few weeks later, on April 26, 2002, at 1 a.m., someone from the UC Hospital telephoned the family and informed them that parts of Loretta's hand "had broken off into the bloodstream" and that "she was not going to make it." The plaintiff stated that she understood this to mean that the gangrene in Loretta's hand, "or whatever it was," was "going to take her life." When her mother died later that morning, the plaintiff acknowledged that she knew at that moment that the condition of her mother's hand had somehow been responsible for her mother's death. Under these undisputed

facts, there can be little doubt that, on April 26, 2002, even without the benefit of the autopsy report, which was completed on July 30, 2002, the plaintiff knew or reasonably should have known that Loretta had suffered an injury (the improper treatment of her hand) and that this injury was wrongfully caused.

What's more, the plaintiff's deposition establishes that, in the weeks prior to Loretta's death, both the plaintiff and Loretta, knew, *subjectively,* that Loretta had suffered an injury and that the injury was wrongfully caused. The plaintiff unmistakably testified in her deposition that she first knew that her mother's death was due to negligence simply by looking at her mother's hand at Roseland and UC hospitals, both before her mother's death on April 26, 2002, and long before the autopsy report was completed on July 30, 2002. The plaintiff explained that Loretta herself had been aware that the treatment she had received at Roseland Hospital with respect to her hand was, to put it mildly, inadequate. Loretta had blamed the condition of her hand on the IV line that was placed into it at Roseland Hospital and she told the plaintiff that she would hire an attorney once she was released from the hospital. The plaintiff, herself, testified that she first decided to hire an attorney and file a lawsuit "right after her mother died." She explained that she did so on the basis of her observations of Loretta's hand, as well as on what the emergency room physicians had told Loretta when they expressed shock at the state of Loretta's hand when she was first admitted to the UC hospital on April 10, 2002. As the plaintiff explained in her deposition, she understood this statement by the emergency room physicians to mean that whoever put that IV in Loretta's hand, "did something wrong," and that a physician from the UC Hospital was telling her that there had been negligence in Loretta's care at Roseland Hospital. As the plaintiff stated, "I felt it and the doctor said it." From this undisputed testimony, it is

apparent that, at the very latest at the time of Loretta' death, the plaintiff *subjectively* knew that the negligent treatment of Loretta's hand had been responsible for her premature death. See *Nair*, 383 Ill. App. 3d at 873-74 (holding that the plaintiff's undisputed deposition testimony that she knew the injuries to her legs were caused by her abdominal surgery and that she knew the leg symptoms were not a normal outcome from abdominal surgery, established, as a matter of law, that by the time she consulted two attorneys, she knew or reasonably should have known her injuries were wrongfully caused); see also *Castello*, 352 Ill. App. 3d at 748-49 (holding that, *inter alia*, the plaintiff's admission in her interrogatories that she "became aware of the alleged malpractice stated in the complaint" after she was diagnosed with cervical cancer and told she had less than 30 months to live, despite years of negative pap smear tests followed by her complaints of vaginal bleeding, established, as a matter of law, that she knew or reasonably should have known at that time that she had suffered an injury and that the injury was wrongfully caused).

To the extent that the plaintiff attempts to suggest that without the benefit of the autopsy report, she could not have known the extent of her mother's injuries, or that her mother's death was in fact directly caused by the injury in her hand, which resulted from the negligence of the staff and physicians at Roseland Hospital, our case-law has repeatedly held that "there is no requirement that a plaintiff must discover the full extent of her injuries before the statute of limitations begins to run." *Nair*, 383 Ill. App. 3d at 873, citing *Hoffman v. Orthopedic Systems Inc.*, 327 Ill. App. 3d 1004, 1010 (2002); see also *Golla v. General Motors Corp.*, 167 Ill. 2d 353, 367 (1995) (same). Instead, as already elaborated above, the statute begins to run when the plaintiff knows or reasonably should know of the injury and that the injury was wrongfully

caused. *Golla*, 167 Ill. 2d at 367.

Accordingly, because the undisputed facts in the instant case show that the plaintiff knew or should have known at the very latest on April 26, 2002, that her mother's injuries were wrongfully caused, the circuit court properly found that she was time barred from filing her complaint after the two-year statute of limitations period expired on April 26, 2004, and properly dismissed her complaint. See *Witherell*, 85 Ill. 2d at 156 ("Where it is apparent from the undisputed facts *** that only one conclusion can be drawn, the question becomes one for the court.")

In coming to this decision we have considered the cases of *Young*, 303 Ill. App. 3d 380, *Clark*, 322 Ill. App. 3d 64, and *Saunders*, 150 Ill. App. 3d 56, relied on by the plaintiff and find them inapposite. As shall be demonstrated below, in each of these cases, the plaintiffs were given alternative explanations for their injuries and reasonably could have assumed that those injuries arose during the course of medical treatment as a natural consequence of their preexisting illnesses, rather than the result of negligent conduct. To the contrary, here, the plaintiff was never given any explanation inconsistent with a wrongful cause.

In *Young*, the plaintiff's husband was treated for pneumonia and died on the day he was to be discharged from the hospital. *Young*, 303 Ill. App. 3d 380. The plaintiff requested an autopsy because she suspected inappropriate medical care contributed to her husband's death. *Young*, 303 Ill. App. 3d at 383. The autopsy report indicated that the death was from complications of pneumonia. *Young*, 303 Ill. App. 3d at 383. The plaintiff retained an attorney to investigate the nature of her husband's death, and her attorney received two physician's reports, on August 17, 1994, and on February 16, 1995, both concluding that the treating

physicians deviated from the standard of care by failing to recognize decedent's cardiac distress. *Young*, 303 Ill. App. 3d at 384. In her complaint for wrongful death, the plaintiff argued that it was not until her receipt of the second physician's report in February 1995 that she knew her husband's death was possibly caused by a misdiagnosed heart attack. *Young*, 303 Ill. App. 3d at 384. The trial court dismissed the plaintiff's claims against several later-added defendants, finding that the limitations period began in December 1993 when, after being suspicious of the care given to her husband, the plaintiff received the medical records and retained a lawyer. *Young*, 303 Ill. App. 3d at 385.

The appellate court reversed in part, finding that the plaintiff knew or reasonably should have known that her husband's death was wrongfully caused, no later than August 17, 1994, when her attorney received the first physician's report, clearly stating that the physicians caring for her husband deviated from the standard of care. *Young*, 303 Ill. App. 3d at 389. The appellate court held that any claims not filed within two years of that date were time-barred. *Young*, 303 Ill. App. 3d at 389.

The court further held that an issue of fact existed as to whether the plaintiff possessed the requisite knowledge before August 1994. *Young*, 303 Ill. App. 3d at 389. The court specifically found that even if the plaintiff "suspected" that her husband may have received inappropriate care, as evidenced by the fact that she retrieved the medical files from the hospital and retained an attorney prior to August 1994, it was nevertheless impossible to state, as a matter of law, that the statute of limitations had begun to run at that point, since the plaintiff had also been told that her husband had died from natural causes (*i.e.*, complications from pneumonia) and this fact was confirmed by an autopsy report. *Young*, 303 Ill. App. 3d at 390. As the court in

Young explained:

> "[S]uspecting wrongdoing is not the same as knowing that a wrong was probably committed. Furthermore, whether a party possessed the requisite constructive knowledge contemplates an objective analysis of the factual circumstances involved in the case. Thus, the relevant determination rests on what a reasonable person should have known under the circumstances, and not on what the particular party specifically suspected." *Young*, 303 Ill. App. 3d at 390.

In the present case, unlike in *Young*, where the plaintiff was told that her husband died from complications of pneumonia, and she merely suspected that he may have received inappropriate medical care because he died on the day he was supposed to be discharged, the plaintiff here had no reason to believe that Loretta's death was caused by anything other than medical wrongdoing. Moreover, as already detailed above, the plaintiff here, admitted in her deposition that she knew on the night of Loretta's death that Loretta's premature death was caused by the injuries she sustained to her hand, and that she knew long before that, just by "looking at [Loretta's] hand" that negligence had played a part in those injuries.

Clark and *Saunders* are similarly distinguishable. In *Clark*, the mother of a prematurely born baby was told that her baby died from natural causes, namely "complications due to it being premature, having an infection and low birth weight and because his blood was clotting and he couldn't tolerate all the transfusions." *Clark*, 322 Ill. App. 3d at 66. Five months after the baby's death, the mother first sought legal advice and, although she consented to release the baby's medical records to the attorney, the attorney never contacted her again. *Clark*, 322 Ill. App. 3d at 66. Two years after her baby's death, the mother retained new counsel and obtained

the infant's medical records, hired an expert and received a physician's report which revealed that the baby had died as a result of a negligently dislodged venus catheter. *Clark*, 322 Ill. App. 3d at 66. The circuit court dismissed the plaintiff's complaint finding that the plaintiff had failed to file her complaint within the statutory two-year period. *Clark*, 322 Ill. App. 3d at 68. The appellate court reversed, finding that it was reasonable for the plaintiff to believe that her premature baby's death at the hospital was due to nonnegligent causes, since she was initially told that her child died due to complications from its premature status. *Clark*, 322 Ill. App. 3d at 74-75. Thus, the *Clark* court concluded that it could not find, as a matter of law, that the statute of limitations began to run on the date of the child's death. *Clark*, 322 Ill. App. 3d at 74-75.

Similarly, in *Saunders,* the plaintiff claimed that his physicians' negligence in delaying the treatment of a circulatory problem in his arm required the amputation of his hand. *Saunders*, 150 Ill. App. 3d at 58. The plaintiff did not file his suit within the limitations period, contending that he did not know that negligence had played a part in the improper diagnosis, which led to the amputation, until he spoke to another doctor several months after his amputation. *Saunders*, 150 Ill. App. 3d at 58. The circuit court granted summary judgment in favor of the defendants, holding that the plaintiff's claims were barred by the two-year statute of limitations. *Saunders*, 150 Ill. App. 3d at 58. The appellate court reversed, finding that because the plaintiff had experienced several years of numbness and aching in his arm prior to the amputation, he reasonably could have attributed the eventual amputation to the same condition. *Saunders*, 150 Ill. App. 3d at 61. As the court stated, "The plaintiff had no reason to believe the removal of his hand was necessitated by anything other than nonnegligent organic causes." *Saunders*, 150 Ill. App. 3d at 61. In addition, since the plaintiff was initially advised that the amputation might be

necessary "in light of the duration of the signs and symptoms" the appellate court concluded that he could have construed that as a reference to the years he had been experiencing numbness in general, rather than the delay in treatment that caused the injury. *Saunders*, 150 Ill. App. 3d at 61. Since the plaintiff was given no suggestion until several months later that the amputation may have been the result of another's act or omission, and was not put on inquiry to determine whether actionable conduct was involved, the court concluded that there was a question of fact as to when he discovered that his injury was wrongfully caused. *Saunders*, 150 Ill. App. 3d at 61.

In the present case, unlike in *Clark*, or in *Saunders*, there was nothing in the record to indicate that the plaintiff ever believed, or had reason to believe that her mother's death resulted from anything but the condition of her hand. In fact, the family was informed on the night of Loretta's death, that the death was a result of "parts of the hand ha[ving] broken off and into [Loretta's] blood stream." In addition, as already elaborated above, the plaintiff, here, unlike the plaintiffs in *Clark* or *Saunders*, admitted in her deposition that she knew there had been negligence in the treatment of Loretta's hand, long before Loretta's death, just by "looking at [Loretta's] hand," and that on the night of Loretta's death she knew that the condition of Loretta's hand had caused (or somehow been responsible for) Loretta's death. The plaintiff further admitted that as a result of all these factors, she decided to hire an attorney "right after her mother" died.

Accordingly, for all of the aforementioned reasons, we conclude that the circuit court properly dismissed the plaintiff's complaint on the basis the plaintiff's failure to file her claim within the requisite two-year statutory period. Since we find that dismissal was proper on this ground, we need not determine whether the plaintiff filed a sufficient physician's report as was

required by section 2-622 of the Code in effect at the time she filed her complaint (735 ILCS 5/2-622 (West 2002)).

For the foregoing reasons, we affirm the judgment of the circuit court.

Affirmed.