2014 IL App (1st) 131333-U

SECOND DIVISION
September 2, 2014

No. 1-13-1333

IN THE
APPELLATE COURT OF ILLINOIS
FIRST DISTRICT

SHEILA SULLIVAN, Individually and as the Guardian of the Estate of JOHN SULLIVAN, a Disabled Person, Plaintiff-Appellant, v. WALTER J. WOJCIK, M.C., NEUROLOGIC CARE ASSOCIATES, P.C., an Illinois corporation, JOHN H. GONG, M.D., and VHS of ILLINOIS, INC. d/b/a MACNEAL HOSPITAL, an Illinois corporation, Defendants-Appellants.	)	Appeal from the Circuit Court of Cook County No. 08 L 14249 Honorable Elizabeth M. Budzinski, Judge Presiding

PRESIDING JUSTICE SIMON delivered the judgment of the court.
Justice Harris and Justice Pierce concurring in the judgment.

O R D E R

¶ 1 *Held*: Trial court did not abuse its discretion in barring testimony of plaintiff concerning conversations she had with a treating neurologist and internist. Trial court did not abuse its discretion in barring testimony from a neurologist who treated plaintiff during a hospitalization subsequent to the complained of treatment. Trial court did not abuse its discretion by instructing the jury on sole proximate cause where there was evidence presented that plaintiff's physical condition may have been the cause of his injuries.

¶ 2 Plaintiff John Sullivan suffered a cardioembolic stroke on April 27, 2007, and was taken to defendant MacNeal Hospital (MacNeal) for treatment. Following his discharge on May 4, 2007, John suffered a second stroke that rendered him permanently disabled. On December 29, 2008, plaintiff filed a four count complaint alleging medical negligence against defendants Dr. Walter Wojcik, Neurologic Care Associates, P.C. (NCA), Dr. John Gong, and VHS of Illinois, Inc. d/b/a MacNeal Hospital. On October 12, 2012, plaintiff's wife, Sheila Sullivan, filed an amended complaint at law to replace John as plaintiff, individually and as guardian of the estate of John Sullivan.

¶ 3 At the conclusion of trial, the jury returned a verdict in favor of all defendants. Plaintiff now appeals that verdict. Plaintiff argues that the trial court erred in granting three of defendants' motions *in limine* excluding testimony by Sheila Sullivan and Dr. Sreepathy Kannan, John's treating neurologist during his second hospitalization. Plaintiff also argues that the trial court erred in instructing the jury on sole proximate cause. For the following reasons, we affirm the judgment of the trial court.

¶ 4 I. BACKGROUND

¶ 5 Prior to trial, defendants presented numerous motions *in limine*. Defendants sought, *inter alia*, to bar Sheila from testifying that Dr. Susan Nadis informed her that John would not be discharged from the hospital with a nontherapeutic International Normalized Ratio (INR), a measure of the status for a patient's anticoagulation on Coumadin, which is between 2 and 3 for therapeutic patients. Defendants also moved to bar Sheila from testifying that Dr. Gong informed Sheila that he was discharging plaintiff because he had to "answer to bureaucrats." Defendants also moved to bar the testimony of Dr. Kannan concerning John's medical treatment at Silver Cross Hospital after his second stroke.

¶ 6 During her deposition, Sheila testified to conversations she had with Dr. Nadis and Dr. Gong during John's stay at MacNeal. Sheila testified that on either May 1 or May 2, 2007, she had an argument with Dr. Gong. She stated that Dr. Gong informed her that John was going to be released from the hospital on May 1, 2007, but Sheila responded that she was not comfortable with that because John was nontherapeutic. Sheila testified that Dr. Gong responded to her that he "had to answer to the bureaucrats" and John would be released.

¶ 7 Sheila also testified that, after she had the argument with Dr. Gong, she had a conversation with Dr. Nadis, a neurologist and partner of defendant NCA who was treating John. Sheila stated that she told Dr. Nadis that she was concerned because John was nontherapeutic. Sheila testified that Dr. Nadis told her that John would not be discharged with a nontherapeutic INR. Sheila testified that when John was discharged, she assumed that he was therapeutic because of Dr. Nadis's assurances.

¶ 8 In an evidence deposition, Dr. Kannan, a neurologist who treated John at Silver Cross Hospital after John's second stroke on May 4, 2007, testified that he learned that John had atrial fibrillation with a history of rheumatic fever and mitral valve disease as well as a cardioembolic stroke within seven days. Dr. Kannan testified that John was administered Heparin, a more aggressive anticoagulant than Coumadin, to bridge the time until Coumadin could be therapeutic. Dr. Kannan explained that this treatment was directed toward attempts to stop a third stroke from occurring. Dr. Kannan also testified that John did not suffer any bleeding as a result of the use of Heparin.

¶ 9 Following extensive argument on defendants' motions *in limine*, the trial court barred Sheila from testifying that Dr. Nadis told her that John would not be discharged nontherapeutic and that Dr. Gong told her that he would discharge John because he had to answer to

bureaucrats. The court agreed that neither Dr. Nadis nor Dr. Gong was involved with the care of John when he was discharged and the conversations that occurred days before John's discharge would be prejudicial and not probative of the question of the propriety of John's discharge. The court also barred testimony that the administration of Heparin at Silver Cross Hospital did not cause any bleeding. The court agreed this testimony would be unduly prejudicial because it could lead to speculation that John would not have bled if he had been administered Heparin at MacNeal.

¶ 10 At trial, the evidence showed that John suffered a stroke on or about April 27, 2007, and was taken to MacNeal for treatment where he had an immediate CT scan and blood drawn. John was initially treated by Dr. Tim McGonagle, a board certified neurologist employed by defendant NCA, who learned that John had chronic atrial fibrillation and rheumatic heart disease and was taking Coumadin. John presented with paralysis to his left side and an INR of 1.7. The first CT scan indicated that John may have suffered a thrombosed artery or a petechial (*i.e.*, small) hemorrhage. Based on these factors, Dr. McGonagle did not treat John with anticoagulants as he feared the risk of bleeding creating a potentially catastrophic injury was ten times greater than the possible benefit provided by the anticoagulants.

¶ 11 On April 28, 2007, a follow-up CT scan showed a potential petechial hemorrhage and Dr. McGonagle ordered another CT scan for the next day. Dr. McGonagle indicated that John demonstrated only a little facial paralysis and had other marked improvement including the ability to use his left hand and arm. Dr. McGonagle deferred the use of Heparin or Coumadin until after the follow-up scan because if there was a petechial hemorrhage, the increase risk of bleeding was too high. The April 29, 2007, scan was not very diagnostic, but Dr. McGonagle's

impression was that there had been petechial hemorrhaging and he continued to hold off administering any anticoagulation and ordered an MRI of the brain for April 30, 2007.

¶ 12 On April 30, 2007, Dr. McGonagle's partner at NCA, Dr. Nadis, assumed John's care. Dr. Nadis's treatment notes indicated that the MRI showed no evidence of hemorrhaging and that she had discussed treating John with Coumadin on May 1, 2007. Dr. Nadis noted that she was considering administering Lovenox, an artificial form of Heparin that is subtler in its effect with less risk of bleed, after another CT scan on May 2, 2007.

¶ 13 Defendant Dr. Wojcik, also a neurologist employed by NCA, assumed the care of John on May 3, 2007. Dr. Wojcik explained that a stroke occurs approximately 90% of the time when the vascular supply of blood to brain tissue is insufficient due to a blocked artery and the tissue dies. This is an ischemic stroke. The remaining type of strokes is hemorrhagic strokes and are caused by a bleeding vessel. Conditions such as atrial fibrillation and mitral valve stenosis, both of which John suffered, greatly increase the risk of stroke. Coumadin is generally used to treat these conditions to try and avoid stroke and John had been on Coumadin for about 15 years. Dr. Wojcik indicated that the INR of a patient should be between 2 and 3 in order for Coumadin to be therapeutic.

¶ 14 Dr. Wojcik received a call from the neuroradiologist on May 2, 2007, concerning the results of John's CT scan ordered by Dr. Nadis indicating that there was progression of petechial bleed in the right parietal area. In response to John's worsened condition, Dr. Wojcik ordered a hold on the use of Coumadin for John. Dr. Wojcik personally reviewed John's CT scans and charts and examined John on May 3, 2007. Dr. Wojcik agreed with the notes in John's charts to not administer Heparin because of the increased risk of bleeding and continued the plan of slow anticoagulation.

¶ 15 John had been discharged by the therapist, physical therapist, speech therapist, and occupational therapist on May 2, 2007, though Dr. Wojcik noted these therapies would be continued after John would be discharged. Dr. Wojcik noted physical improvement from the stroke by John that continued until John was discharged on May 4, 2007, when Dr. Wojcik recommended John be released home. Dr. Wojcik noted that John's INR continued to be subtherapeutic at 1.1 on the date of release and he remained at risk of further strokes based on this and his overall medical condition. However, he determined that it was safe and appropriate for John to be discharged.

¶ 16 Dr. Wojcik explained that the only thing that could be done for John at the time was to continue administering Coumadin and monitoring his INR levels. This could be accomplished with John at home under nursing care as most patients do not want to stay in the hospital unless necessary. Dr. Wojcik believed that whether or not John was in the hospital, he would have suffered his second stroke.

¶ 17 Dr. Gong, a board certified physician in internal medicine, was employed at MacNeal as a hospitalist and he saw John daily during his treatment at MacNeal. As a hospitalist, Dr. Gong is responsible for treating patients to the point where they can be discharged and resume treatment by their primary care doctor. Additional care can also be provided by the specialists such as neurologists and the cardiologist who examined and treated John.

¶ 18 Dr. Gong had treated numerous stroke patients who also had an atrial fibrillation, but the neurologists would decide the level of Coumadin, or other anticoagulants, to administer. Dr. Gong discussed John's care with the other doctors and concurred with the course of slow anticoagulation that was undertaken. The doctors conferred regarding the use of Heparin but, as in any case, the doctors balanced the risk of causing a hemorrhage with the need to anticoagulate

to prevent another stroke and concluded the slow plan was the best. Dr. Gong understood that John was not yet therapeutic when he approved his discharge with continued use of Coumadin.

¶ 19 Dr. Kannan testified as to John's treatment after the second stroke that included the use of both Coumadin and Heparin as a bridge despite the increased risk of bleeding from Heparin. Sheila testified that she rode with John by ambulance to MacNeal on April 27, 2007. Sheila noted that John steadily improved until he was discharged and she took him home on May 4, 2007. That night, she called for an ambulance and John was admitted to Silver Cross Hospital having suffered his second stroked and he received care at Silver Cross Hospital for one month.

¶ 20 Dr. Rodney Johnson, a board certified neurologist, testified that the standard of care required in this case for Dr. Wojcik was to get John's INR to a therapeutic level, including using Heparin when the Coumadin failed to achieve that goal. Dr. Johnson believed that Dr. Wojcik did not properly anticoagulate John, stating that a petechial bleed did not mean that Heparin could not be administered. Dr. Johnson disagreed that John's CT scans showed evidence of a bleed. Although John had been improving physically, he had a history of atrial fibrillation and rheumatic heart disease and Dr. Johnson opined that there was a greater risk of stroke that required stronger anticoagulation than what was administered.

¶ 21 Dr. Johnson stated that larger doses of anticoagulants increase the risk of bleeding in stroke patients and do not eliminate the risk of stroke. He also admitted that once a patient is properly therapeutically anticoagulated, he may still suffer a stroke. Dr. Johnson conceded that a neurologist could conclude that Dr. Wojcik operated within the standard of care given all of the facts in John's case.

¶ 22 Dr. Hadley Morganstern-Clarren, a board certified physician in internal medicine, testified that Dr. Gong's treatment of John fell below the standard of care because John was not

therapeutically anticoagulated when he was released. Dr. Morganstern-Clarren opined that this failure, as well as deferring to the neurologists on the decision to discharge John, breached the standard of care and exposed John to increased risk of a second stroke. He agreed that it was appropriate to allow the neurologists to diagnose, manage, and treat the stroke, but Dr. Gong had his own duty and responsibility to get John therapeutically anticoagulated in order to reduce the risk of future cardioembolic stroke.

¶ 23 Further, Dr. Morganstern-Clarren opined that this was the proximate cause of the second stroke. He added that if John had remained in the hospital instead of being discharged by Dr. Gong, there would have been earlier recognition of stroke and a better outcome. However, Dr. Morganstern-Clarren admitted that the second stroke would have happened whether or not John was in the hospital and that deferring to the neurologists as to whether there was bleeding on the brain was within the standard of care.

¶ 24 Defendant's expert neurologist, Dr. Phillip Gorelick, testified that John's CT images showed bleeding from the brain. Dr. Gorelick agreed that anticoagulants are the proper treatment for a patient with John's history, but opined that the brain bleed in this case indicated that Heparin was not a treatment option in this case and slow anticoagulation by Coumadin was the proper course of action. He explained that there is always potential for a petechial hemorrhage to expand and grain hemorrhages associated with anticoagulants are often fatal.

¶ 25 Dr. Gorelick also opined that it was reasonable and appropriate for Dr. Wojcik to discharge John even though his INR was not in the therapeutic range because the only things that could be done for John at the hospital could be done in his home where he would be away from increased risk of infection. Dr. Gorelick found all of Dr. Wojcik's actions complied with the relevant standard of care.

¶ 26 Dr. Jeffrey Weinberg, a board certified internist, opined that Dr. Gong properly complied with the standard of care in treating John. Dr. Weinberg stated that deference to consulting specialists is the standard of care for an internist in a situation such as the instant matter. The role of the internist is to communicate with the team of physicians and come to his own conclusions concerning the best treatment plan for the patient. Dr. Weinberg concluded that John would have suffered the second stroke whether he was in the hospital or at home.

¶ 27 The jury entered a general verdict in favor of defendants and against plaintiff on all counts. Only one special interrogatory was presented to the jury concerning the issue of Dr. Wojcik's apparent agency, but that interrogatory was not answered by the jury. This appeal followed.

¶ 28 II. ANALYSIS

¶ 29 A. The Two-Issue Rule

¶ 30 To succeed in a medical negligence action, a plaintiff must prove: (1) the standard of care against which the medial professional's conduct must be measured; (2) the negligent failure to comply with that standard; and (3) that the negligence proximately caused the injuries for which the plaintiff seeks redress. *Wiedenbeck v. Searle*, 385 Ill. App. 3d 289, 292 (2008). Defendants contend that because the jury entered a general verdict in their favor without any specified findings of fact, under the "two-issue rule," it is presumed the jury found in favor of defendants on all defenses and the verdict must be upheld where there is sufficient evidence to support either theory. *Lazenby v. Mark's Construction, Inc.*, 236 Ill. 2d 83, 102 (2010).

¶ 31 The two-issue rule precludes review of a jury's general verdict because "the basis for the verdict" is unknowable in the absence of a special interrogatory. *Strino v. Premier Healthcare Assoc.*, 365 Ill. App. 3d 895, 904 (2006). For the instant matter, the two-issue rule applies

because there were two distinct issues, *i.e.*, whether defendants were negligent in meeting the appropriate standard of care and the proximate cause of plaintiff's second stroke; however, the jury returned only a general verdict. Because the mental processes of the jury were not tested by special interrogatories to indicate which of the two issues was resolved in favor of defendants, defendants assert that plaintiff's claims on appeal cannot support reversal for a new trial. See *Tabe v. Ausman*, 388 Ill. App. 3d 398, 402 (2009), citing *Strino*, 365 Ill. App. 3d at 904.

¶ 32 In particular, the defendants note that plaintiff has challenged three evidentiary rulings by the trial court, all relating to defendants' alleged negligence. Accordingly, even if this court found that the trial court erred and plaintiff should have been allowed to present the challenged evidence, it would not have affected the determination of the issue of the proximate cause of John's injuries. Defendants conclude therefore that the proof against them would remain deficient on that issue and the verdict must be affirmed.

¶ 33 While the *Strino* court specifically applied the two-issue rule to errors in jury instructions, defendants do not specifically argue that the rule requires rejection of plaintiff's claim that the trial court erred in giving the sole proximate cause instruction. Rather, defendants simply state that plaintiff did not demonstrate that defendants' actions were the proximate cause of John's injuries. They conclude only that the two-issue rule applies because of the lack of evidence on this issue.

¶ 34 We are without the benefit of a reply brief from plaintiff to respond to defendants' arguments, including the claim that the two-issue rule requires denial of plaintiff's argument and affirming the jury verdict. Unfortunately, this means that we are deprived of plaintiff's reasoning or argument that the issues raised on appeal should be considered. We will not act as a party's advocate or search the record to support a party's claim. *Smith v. Georgia Pacific Corp.*, 76 Ill.

App. 3d 667, 670 (1979). Based on the record and the parties' arguments to this court, we agree that the two-issue rule forecloses plaintiff's arguments for a new trial. Moreover, considering each asserted issue independently, it is clear from the record that the trial court did not abuse its discretion in its rulings and the jury verdict must stand.

¶ 35 B. Motions *In Limine*

¶ 36 The question of whether the granting of a motion *in limine* was proper is subject to the discretion of the trial court. *Petraski v. Thedos*, 382 Ill. App. 3d 22, 26 (2008). Likewise, a challenge made to the trial court's ruling on the admissibility of evidence is reviewed under an abuse of discretion standard. *Mulloy v. American Eagle Airlines, Inc.*, 358 Ill. App. 706, 711 (2005). The trial court is vested with the discretion to determine the relevance and admissibility of this evidence regardless of whether it is expert or lay testimony. *Id.* at 711-12.

¶ 37 Where relevant evidence has any tendency to make the existence of any material fact more probably or less probable, any testimony grounded in guess, surmise, or conjecture is irrelevant for this purpose. *Petraski*, 382 Ill. App. 3d at 27. A trial court abuses its discretion only when no reasonable person would agree with the trial court. *Dawdy v. Union Pacific R.R. Co.*, 207 Ill. 2d 167, 177 (2003). If we determine the trial court erred in resolving an evidentiary issue, we will remand for a new trial only if the error was substantially prejudicial and affected the outcome of the trial. *Liberty Mutual Ins. Company v. American Home Assurance Company*, 368 Ill. App. 3d 948, 960 (2006).

¶ 38 1. Sheila Sullivan's Testimony

¶ 39 Plaintiff first claims that the trial court abused its discretion in barring Sheila from testifying as to conversations she had with Dr. Nadir and Dr. Gong concerning John's treatment and discharge from the hospital. The trial court barred Sheila from testifying to her conversation

with Dr. Nadis in which Dr. Nadis assured Sheila that she would not allow John to be released nontherapeutic. The court also barred Sheila from testifying that she had an argument with Dr. Gong on either May 1 or 2, 2007, because Sheila did not want John released nontherapeutic but Dr. Gong indicated he was going to release John because he had to answer to the bureaucrats.

¶ 40 Plaintiff argues that granting these motions was prejudicial error because it was relevant evidence to counter defendants' argument that the decision of how to anticoagulate John and to discharge him nontherapeutic was carefully considered decision balancing the risks of a second stroke with increased bleeding on the brain. Plaintiff claims that Dr. Nadis's statement was evidence of the planned course of treatment and that John's nontherapeutic release violated that plan and countered defendants' claims that the plan enacted was only after careful deliberation. Plaintiff also argues that Dr. Gong's statements were relevant to also show this deviation from the standard of care and that John's discharge from the hospital was not based on proper medical considerations.

¶ 41 Both of these barred statements were made to Sheila two to three days before John was discharged form MacLean. Significant evidence from the treating internists and neurologists all counter the claim that John's treatment plan and discharge were based on these comments. Dr. Nadis did not take any role in John's discharge and, contrary to plaintiff's argument, had started John on a plan of slow anticoagulation. Testimony was presented that after continued testing and examination that plan was also carried out by Dr. Wojcik. Dr. Gong continued to consult with the neurologists, examine John, review John's scans, and monitor John's progress for days after his conversation with Sheila.

¶ 42 The testimony indicated that John was discharged from the hospital two or three days later when the doctors determined he could receive the same care home as in the hospital and the

statements are not supported by other actions taken by defendants. If the barred statements were allowed, the jury could have interpreted them to establish a standard of care or a larger plan to discharge John before it was safe. From the record of this case, a reasonable person could agree with the trial court that these statements were not probative of the propriety of John's discharge from the hospital days later and that they were unduly prejudicial to defendants. Accordingly, the trial court did not abuse its discretion in granting the motions *in limine*.

¶ 43 2. Testimony on John's Subsequent Treatment at Silver Cross Hospital

¶ 44 Defendants also successfully moved to bar testimony regarding John's subsequent treatment at Silver Cross Hospital by Dr. Kannan involving the use of Heparin. At his deposition, Dr. Kannan testified that he treated John with Heparin as a bridge to Coumadin and John did not experience bleeding. The trial court agreed with defendants that this subsequent treatment evidence was prejudicial because it would allow the jury to speculate that John would not have bled if treated with Heparin at MacNeal. Plaintiff asserts that this was prejudicial error because the fact John did not bleed in his subsequent treatment is a medical fact, not an opinion, and the jurors were left to speculate why John's injuries resulted from the second stroke and not the first stroke.

¶ 45 We agree with defendants that the trial court did not abuse its discretion in barring testimony on John's subsequent treatment with Heparin. As defendants point out, there was no testimony that John's subsequent treatment caused his permanent injuries. A reasonable person could agree that it would be natural to speculate that if John did not bleed when treated with Heparin after his second stroke, he would not have bled if Heparin was used initially. John's subsequent treatment was irrelevant and there was significant testimony concerning the standard of care for John's treatment by defendants as well as the risks and rewards of treating with

Heparin. Plaintiff's expert testified that Heparin should have been used while defendants' experts opined that the risk of Heparin causing dangerous bleeding was too great. Evidence of John's subsequent treatment would likely have led to improper speculation on this key issue and the trial court did not abuse its discretion in barring Dr. Kannan's testimony that John did not bleed after Heparin was administered in subsequent care.

¶ 46 B. Jury Instructions

¶ 47 A Party has the right to have the jury clearly and fairly instructed on any theory that is supported by evidence at trial. *Snelson v. Kamm*, 205 Ill. 2d 1, 27 (2003). Whether the issues and evidence have been raised at trial is a matter within the sound discretion of the trial court. In fact, the " 'evidence may be slight; a reviewing court may not reweigh it or determine if it should lead to a particular conclusion.' " *Id.*, quoting *Leonardi v. Loyola University*, 168 Ill. 2d 83, 100 (1995).

¶ 48 Plaintiff argues that the trial court erred in instructing the jury on the long form of Illinois Pattern Instruction 12.05 (IPI Civil No. 12.05), which states in full:

> "If you decide that a [the] defendant[s] was [were] negligent and that his [their] negligence was a proximate cause of injury to the plaintiff, it is not a defense that something else may also have been a cause of the injury.
>
> [However, if you decide that the sole proximate cause of injury to the plaintiff was something other than the conduct of the defendant, then your verdict should be for the defendant.]" IPI Civil No. 12.05.

The notes on use for this instruction state that "[t]he second paragraph should be used only where there is evidence tending to show that the sole proximate cause of the occurrence was something other than the conduct of the defendant." IPI Civil No. 12.05, Notes for Use. Plaintiff argues that

there was no evidence of a specific cause or instrumentality of John's injury other than defendants' negligence. As such plaintiff claims that because there was no evidence presented by defendants on a sole proximate cause, it allowed the jury to infer any cause of the second stroke raised could be a complete defense.

¶ 49 Plaintiff's conclusory statements aside, in this case there was evidence presented that John's condition, atrial fibrillation, enhanced his risk of stroke considerably, even if a therapeutic dose of Coumadin had been administered. The experts on both sides explained the nature of strokes, the dangers associated with John's condition and the risks and rewards of using medication to treat a stroke on someone like John. Despite plaintiff's unsupported argument that a defendant must take a plaintiff in the condition received and the mere fact that an individual might be at risk does not mean that stroke will occur or that a treatment will not be effective, that does not require rejecting defendants' instruction where they have presented evidence. As in *Nassar v. County of Cook*, 333 Ill. App. 289, 298 (2002), evidence of a prior condition may warrant instructing the jury on proximate cause. There was evidence that, even if treated with anticoagulants, John's strokes may have occurred, therefore the trial court did not abuse its discretion in instructing the jury.

¶ 50 III. CONCLUSION

¶ 51 For the reasons stated, we affirm the judgment of the circuit court.

¶ 52 Affirmed.