2016 IL App (1st) 160073-U

THIRD DIVISION
November 23, 2016

No. 1-16-0073

IN THE APPELLATE
COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

MIRA RYCE, Special Representative and Special Administrator of the Estate of Dennis Ryce, Deceased, Plaintiff-Appellant, v. COUNTY OF COOK d/b/a COOK COUNTY HEALTH AND HOSPITALS SYSTEM and PROVIDENT HOSPITAL, Defendant-Appellee.	)	Appeal from the Circuit Court of Cook County. No. 12 L 14206 The Honorable Larry G. Axelrood, Judge Presiding.

PRESIDING JUSTICE FITZGERALD SMITH delivered the judgment of the court. Justices Pucinski and Cobbs concurred in the judgment.

ORDER

HELD: Summary judgment was proper where defendant was immune from suit under sections 6-105 and 106(a) of the Tort Immunity Act, as the essence of the allegations in plaintiff's complaint amounted to a claim of failure to diagnose decedent's medical condition which caused his injury, rather than a failure to treat the condition at issue.

¶ 1 Plaintiff-appellant Mira Ryce, special representative and special administrator of the

estate of Dennis Ryce, deceased, (plaintiff) filed a wrongful death and survival action against defendant-appellant County of Cook, d/b/a Cook County Health and Hospitals System and Provident Hospital (defendant) following the death of her husband. Defendant moved for summary judgment, asserting immunity under sections 6-105 and 6-106(a) of the Local Government and Governmental Employees Tort Immunity Act (Tort Immunity Act or Act) (745 ILCS 10/6-105, 106(a) (West 2010)). The trial court granted defendant's motion. Plaintiff appeals, contending that the trial court erred in doing so because she produced sufficient evidence demonstrating that immunity did not apply. She asks that we reverse the trial court's order and remand the cause for trial. For the following reasons, we affirm.

¶ 2 BACKGROUND

¶ 3 On April 20, 2010, Dennis Ryce visited defendant's emergency room/urgent care at Provident Hospital complaining of sore throat pain and difficulty swallowing. Physician's assistant Katherine El examined him and, upon finding redness in his throat, diagnosed him with pharyngitis and prescribed an antibiotic. In her deposition, El testified that Dennis' presentation at that time did not require a throat culture and, had one been done, it would not have changed her treatment plan. In addition to prescribing an antibiotic, El ordered Dennis to report to the sixth floor of the hospital to see a primary care physician within one or two days for a follow-up appointment. Dennis did not see a primary care physician after this visit.

¶ 4 On April 27, 2010, Dennis returned to defendant's emergency room, complaining again of a sore throat, as well as itchy red eyes, a fever and chills. Dr. Julita McPherson examined him, finding redness in his throat but no swollen lymph nodes. She diagnosed Dennis with

pharyngitis and gave him a shot of penicillin. In her deposition, Dr. McPherson stated that she gave Dennis penicillin because she leaned toward a diagnosis of bacterial pharyngitis, which is treatable, as opposed to viral pharyngitis, which is not. She was also asked whether a referral to an ear, nose and throat (ENT) specialist was warranted, and she responded that it was not, based on Dennis' presentation. She explained that an ENT referral would have been warranted if Dennis had swollen lymph nodes, lesions, or a mass in his throat, or if he experienced weight loss, a change in his voice, ear pain or the inability to swallow–something more than just a sore throat. Dr. McPherson further testified that the penicillin shot should have yielded gradual improvement of Dennis' pharyngitis, and she ordered him to go see a primary care physician. Dennis did not visit a primary care physician.

¶ 5 On May 3, 2010, Dennis again went to defendant's emergency room. His chief complaints were throat pain and pain on swallowing lasting more than a month following antibiotics with no significant improvement. Dr. Yacob Gawo examined him, noting an indeterminate amount of weight loss, redness of his throat and thrush (white coating) on his tongue. Dr. Gawo ordered a blood panel, a rapid HIV test and a CT scan of Dennis' neck. When all of these came back negative, Dr. Gawo diagnosed him with "presumptive" throat pain, oropharyngeal candidiasis (an oral yeast infection) or gastroesophageal reflux disease (GERD or acid reflux). Dr. Gawo prescribed two antibiotics and ordered Dennis to go see a primary care physician. He further wrote in Dennis' follow-up instructions to return and see him in one week for reevaluation and that he "may consider ENT referral if throat pain persist[s]." In his deposition, Dr. Gawo testified that he had "some suspicion" of something more than a simple

sore throat and this is why he ordered the tests he did, but that Dennis' pathology could have indicated anything from cancer to other issues or chronic diseases and this is why he told Dennis to see a primary care physician. Dr. Gawo explained that there is a difference between emergency room physicians (such as himself) and primary care physicians, with the former responsible for triaging patients and noting thoughts on care and the latter actually performing thorough follow-up examinations to determine what further treatment or specialty referral is needed. Specifically, with respect to Dennis' CT scan, Dr. Gawo noted that he read it along with a radiologist, and both found it was normal and did not show any acute situation with his throat. However, Dr. Gawo recommended to Dennis that he felt it needed to be followed, which should be done with a primary care physician. When asked why he did not refer Dennis to an ENT, Dr. Gawo stated that an ENT referral is to come from a primary care physician, not an emergency room physician. He further explained that an emergency room or urgent care physician must see an acute situation in a patient before he can refer him to an ENT, such as if he saw something on Dennis' CT scan, if he made an abnormal finding upon examination or if Dennis' airway was compromised. As Dennis presented with none of these conditions or anything similar, Dr. Gawo treated him for his diagnoses of candidiasis and GERD and ordered him to see a primary care physician, referring Dennis upstairs to the sixth floor of the hospital and explaining that there was personnel who could help him obtain an appointment with any of a number of such physicians there at the hospital. Dennis did not see a primary care physician.

¶ 6 On May 12, 2010, Dennis returned to defendant's emergency room, this time with forms for disability. Physician's assistant El saw Dennis again; however, she did not examine him but

instead told him to make an appointment with a primary care physician on the sixth floor to have the forms filled out since this was not done in the emergency room.

¶ 7 On May 20, 2010, Dennis presented in the emergency room again, with his chart indicating he returned for a followup reevaluation for GERD. Dr. Pierre Wakim examined Dennis, who denied throat pain or any other related symptoms. Rather, Dr. Wakim noted that Dennis complained of a radiation of pain from his upper gastrointestinal tract with throat pain. Dr. Wakim diagnosed Dennis with gastritis. When asked during his deposition why he did not refer Dennis to an ENT, Dr. Wakim stated that he only refers emergency room patients to an ENT if they are emergent, *i.e.*, if they have a blocked airway, if they are hemorraging or if they are bleeding from their throat; Dennis was not emergent. Dr. Wakim explained that, instead, for persistent sore throat pain, he would refer a patient to a primary care physician for a follow-up who would then refer him to a specialist (*i.e.*, an ENT) if needed. This is what Dr. Wakim did; upon diagnosing Dennis with gastritis, he ordered him to attend a follow-up appointment he himself scheduled for Dennis with a primary care physician at defendant hospital for June 3, 2010 at 9:30 a.m. Dennis did not attend this appointment.

¶ 8 Dennis returned to defendant's emergency room several weeks later, on July 6, 2010. At this time, his chief complaint was ear pain. Dr. Gawo examined him, finding that he had a double earache, sore throat and toothaches (Dennis had had some teeth pulled, as well as dental caries, or cavities). Dr. Gawo diagnosed Dennis with pharyngitis with dental carries and prescribed a broad-spectrum penicillin. He also ordered Dennis to follow up with a primary care physician within one to two days. Dennis did not follow up with a primary care physician.

¶ 9 Five and a half months later, on December 20, 2010, Dennis returned to defendant's emergency room, complaining of difficulty in swallowing. Upon examination, he had a visible throat mass, resulting in an emergency transfer for an ENT oncology consultation. Following a CT scan and biopsy performed that month, Dr. Urjeet Patel, an ENT at defendant hospital, diagnosed Dennis with stage IV throat cancer. In his deposition, Dr. Patel indicated that there are only three ways to treat throat cancer, namely, resection, radiation and chemotherapy. Dr. Patel noted that in Dennis' case, the positioning of the tumor did not allow for resection as an option, so treatment proceeded via radiation and chemotherapy. When asked if the CT scan Dr. Gawo ordered in May 2010 had any impact on his treatment, Dr. Patel stated he had reviewed that scan and it would not have because "[i]t revealed a normal CT scan of the neck." Dr. Patel further stated that the first CT scan to show any mass in Dennis' neck was the one performed in December 2010, and the first test to diagnose cancer was the biopsy also performed in December 2010. Dr. Patel explained that none of the three treatments for cancer could be initiated until cancer is first diagnosed. He opined that Dennis most likely developed stage I throat cancer sometime between his May 2010 and December 2010 CT scans, and he noted that "[i]t's just awfully rare to find a [s]tage I hypopharynx cancer" as Dennis had.

¶ 10 Dennis died as a result of his throat cancer on December 20, 2011, approximately one year after its diagnosis.

¶ 11 Plaintiff filed a two-count amended complaint against defendant asserting wrongful death and survival claims based on the medical malpractice of defendant's emergency room personnel. The only allegation of negligence she asserted was that defendant "violated the standard of care"

"by merely prescribing medications for the treatment" of Dennis' persistent sore throat and "by not having Dennis Ryce seen by an ENT" during any of his visits between May 3 and December 20, 2010. Plaintiff claimed that defendant's failure to refer Dennis to an ENT during that time led to his throat cancer being undiagnosed until December 2010, when it had already progressed to stage IV.

¶ 12 In support of her cause of action, plaintiff retained two experts. Dr. M. Boyd Gillespie, an ENT, stated that Dennis' cancer was not diagnosed until December 2010. He opined that persistent throat pain, difficulty swallowing, weight loss and throat redness are potential signs and symptoms of throat cancer. He further opined that Dennis, more likely than not, had throat cancer in its early stages during his visits between April and July 2010, and that an ENT would have been able to use special equipment to see his tumor within the lining of his throat. Dr. Gillespie also testified in his deposition, just as Dr. Patel, that there are only three ways to treat throat cancer (resection, radiation and chemotherapy), and that a patient cannot receive any of these treatments until a cancer diagnosis is reached. He also acknowledged that patients "are a partner in their own care, and they have to take some responsibility to make sure that the care plan, as advocated, is carried out," which would include attending appointments, filling prescriptions and seeing other doctors as ordered.

¶ 13 Dr. Peter Brown, plaintiff's other expert, agreed that Dennis' cancer was not diagnosed until December 2010 and offered opinions on defendant's standard of care, noting that because Dennis continuously returned to defendant's emergency room, the doctors who examined him had the obligation to review his past complaints and treat his persistent symptoms, which he

asserted they failed to do. Dr. Brown further opined that following Dennis' May 3, 2010 visit when Dr. Gawo noted that he "may consider ENT referral if throat pain persists," defendant's failure to refer him to an ENT on his subsequent visits equated to a failure to appropriately treat him and, as a result, Dennis' cancer progressed "unnecessarily." However, Dr. Brown also explained that "[p]rimary care physicians and non-emergent care physicians do not diagnose cancer" but, rather, treat patients, recognize when persistent symptoms go beyond their expertise, and then refer these patients to other doctors who diagnose the problem which, in Dennis' case, was throat cancer.

¶ 14 Defendant moved for summary judgment pursuant to sections 6-105 and 6-106(a) of the Tort Immunity Act, asserting it was immune from any alleged failure to diagnose Dennis' cancer. The trial court granted defendant's motion. At the outset of its decision, the court clarified the applicability of the Act's immunity, distinguishing that immunity applies when a defendant does not diagnose and therefore does not treat the condition that ultimately causes injury, but immunity does not apply if the defendant makes a correct diagnosis and then improperly treats the patient. Upon examining plaintiff's complaint, the trial court found that, even though she alleged that defendant's wrongful acts or omission resulted from the failure to properly treat Dennis (thereby placing her claims within section 6-106(d)'s exemptions to immunity), the actual "gravamen" of her cause of action was, contrarily, the "failure to timely diagnose" his cancer (thereby making this a failure to diagnose case). In making this distinction, the court reasoned that plaintiff's claim stated defendant violated the standard of care by merely prescribing medications for Dennis' sore throat and not sending him to an ENT, proximately causing his

death because his throat cancer was not timely discovered and treated. This, noted the court, comprised a failure to diagnose in that defendant did not diagnose, and therefore did not treat, the disease (cancer) which injured Dennis. Accordingly, because the court declared this was not a case where defendant properly diagnosed Dennis and improperly treated him leading to his injury, this was not a failure to treat case but, rather, a failure to diagnose case and, thus, there was "no issue of material fact that" defendant was immune under the Act.

¶ 15 ANALYSIS

¶ 16 On appeal, plaintiff contends that the trial court erred in granting summary judgment in favor of defendant because she presented evidence demonstrating that defendant diagnosed Dennis' cancer and failed to properly treat it, making this a failure to treat case under section 6-106(d)'s exception to the Act and rending any immunity thereunder inapplicable. Based on the record before us, we disagree.

¶ 17 Summary judgment is appropriate when the pleadings, affidavits, depositions and admissions of record, construed strictly against the moving party, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. See *Morris v. Margulis*, 197 Ill. 2d 28, 35 (2001). Thus, the moving party has the initial burdens of proof and production to show that there is no genuine issue of material fact. See *Hawkins v. Capital Fitness, Inc.*, 2015 IL App (1st) 133716, ¶ 10. Once the moving party has met these burdens, the burden then shifts to the nonmoving party. See *Triple R Development, LLC v. Golfview Apartments I, L.P.*, 2012 IL App (4th) 100956, ¶ 12. While she need not prove her case at this preliminary stage, the nonmoving party must, nevertheless, present some factual

basis to support her claim and she is not simply entitled to rely on the allegations in her pleading in order to raise a genuine issue of material fact. See *CitiMortgage, Inc. v. Bukowski*, 2015 IL App (1st) 140780, ¶ 19, and *Rucker v. Rucker*, 2014 IL App (1st) 132834, ¶ 49; see also *Winnetka Bank v. Mandas*, 202 Ill. App. 3d 373, 387-88 (1990) (she must submit affidavits or rely on depositions or other admissions of record which counter the facts; in other words, she has a duty to present a factual basis which would arguably entitled her to judgment in her favor based on the law). This basis must recite facts and not mere conclusions or statements based on information and belief. See *In Interest of E.L.*, 152 Ill. App. 3d 25, 31 (1987); *Cohen v. Washington Mfg. Co., Inc.*, 80 Ill. App. 3d 1, 3 (1979); see also *Morrissey v. Arlington Park Racecourse, LLC*, 404 Ill. App. 3d 711, 724 (2010) ("nonmoving party must present a *bona fide* factual issue and not merely general conclusions of law"). And, if her allegations of fact are lacking, any documents provided will be held insufficient to defeat the motion for summary judgment. See *E.L.*, 152 Ill. App. 3d at 31-32; accord *Cohen*, 80 Ill. App. 3d at 3. Ultimately, although summary judgment has been

¶ 18called a "drastic measure," it is an appropriate tool to employ in the expeditious disposition of a lawsuit in which " 'the right of the moving party is clear and free from doubt.' " *Morris*, 197 Ill. 2d at 35, quoting *Purtill v. Hess*, 111 Ill. 2d 229, 240 (1986). Appellate review of a trial court's grant of summary judgment is *de novo* and reversal will occur only if we find that a genuine issue of material fact exists. See *Outboard Marine Corp. v. Liberty Mutual Insurance Co.*, 154 Ill. 2d 90, 102 (1992); *Addison v. Whittenberg*, 124 Ill. 2d 287, 294 (1988).

¶ 19 In the instant cause, we find that no genuine issue of material fact exists, as defendant

was clearly immunized under the Tort Immunity Act.

¶ 20 The primary issue in this cause is whether defendant is immune from liability under section 6-106 of the Act. That section provides:

> "(a) Neither a local public entity nor a public employee acting within the scope his employment is liable for injury resulting from diagnosing or failing to diagnose that a person is afflicted with mental or physical illness or addiction or from failing to prescribe for mental or physical illness or addiction.
>
> ***
>
> (d) Nothing in this section exonerates a public employee from liability for injury proximately caused by his negligent or wrongful act or omission in administering any treatment prescribed from mental or physical illness or addiction or exonerates a local public entity whose employee, while acting in the scope of his employment, so caused such an injury." 745 ILCS 10/6-106(a), (d) (West 2014).

Clearly, and pertinent to the instant cause, section 6-106 operates in two diametrically opposed ways. Subsection (a) grants immunity to a public entity, like defendant hospital, for diagnosing, or failing to diagnose, that a person is afflicted with a physical illness. See 745 ILCS 10/6-106(a) (West 2014). Subsection (d), however, limits that immunity, and thereby makes defendant liable, for injury proximately caused by its negligent acts or omission in administering treatment prescribed for the illness. See 745 ILCS 10/6-106(d) (West 2014). In its most simplistic terms, section 6-106 immunizes a defendant for a failure to diagnose, but does not

immunize for a failure to treat.

¶ 21 The seminal case regarding this distinction is *Michigan Avenue National Bank v. County of Cook*. Both parties here base their arguments directly on their interpretation of that matter. Interestingly, however, plaintiff relies primarily on the underlying appellate holding (306 Ill. App. 3d 392 (1999)), while defendant examines the holding issued by our state supreme court (191 Ill. 2d 493 (2000)). We will discuss each now.

¶ 22 In the underlying facts of *Michigan Avenue*, a woman visited the defendants' clinic on several occasions from September 1986 to February 1987 concerning lumps and pain in her breast, as well as other gynecological illnesses. See *Michigan Avenue*, 191 Ill. 2d at 496-98. In October 1986, the defendants diagnosed her with fibrocystic breast disease and told her to follow up for appointments to monitor this condition. See *Michigan Avenue*, 191 Ill. 2d at 497. In July 1988, a lump in her breast was diagnosed as cancerous, and she later died as a result. See *Michigan Avenue*, 191 Ill. 2d at 499. The plaintiff filed a medical malpractice action against the defendants, alleging that they had been negligent in failing to order a mammogram, failing to adequately perform examinations and tests, failing to perform a biopsy, failing to diagnose breast cancer and failing to administer proper medical and nursing care. See *Michigan Avenue*, 191 Ill. 2d at 499. Citing sections 6-105 and 106 of the Tort Immunity Act, the defendants moved for summary judgment, which the trial court granted. See *Michigan Avenue*, 191 Ill. 2d at 501.

¶ 23 On appeal, the plaintiff made two separate arguments under the statutory sections. The first, which is not pertinent to the instant cause, was that section 6-105 of the Act conferred immunity only for preventative public health screenings, not individualized care. See *Michigan*

Avenue, 306 Ill. App. 3d at 399-400. The appellate majority[1] rejected this claim, finding instead that the Act is "broad in scope" to immunize local public entities and public employees who fail to make or who make inadequate physical or mental examinations for purposes of determining whether a person suffers from a disease or physical or mental condition. See *Michigan Avenue*, 306 Ill. App. 3d at 401.

¶ 24 More critically with reference to the instant cause, the plaintiff's second argument before the appellate court in *Michigan Avenue* was that the trial court had erred in granting summary judgment based on immunity under section 6-106 of the Act because, according to the plaintiff, subsection (d) means that once treatment of a medical condition has been undertaken, a failure to properly diagnose and treat that medical condition is negligence for which tort immunity under subsection (a) does not apply. See *Michigan Avenue*, 306 Ill. App. 3d at 402. In other words, the plaintiff interpreted subsection (d) to extend liability for diagnostic errors once any treatment is undertaken. See *Michigan Avenue*, 306 Ill. App. 3d at 402. The majority of the appellate court rejected this contention as well, finding that such an interpretation would "irreconcilably conflict" with subsection (a), which grants immunity from liability for injury resulting from diagnosing or failing to diagnose an illness as well as from failing to prescribe medical treatment for that illness. *Michigan Avenue*, 306 Ill. App. 3d at 402. As the court noted, reading subsection (d) the way the plaintiff proposed would be illogical, since "treatment of a medical condition cannot be undertaken unless or until a medical condition is diagnosed and unless the

[1]Cousins, J., dissented from the majority decision. See *Michigan Avenue*, 306 Ill. App. 3d at 406-10.

diagnosed medical condition warrants treatment." *Michigan Avenue*, 306 Ill. App. 3d at 402.

¶ 25 Immediately following this discussion, the *Michigan Avenue* majority posed a hypothetical scenario, which plaintiff in the instant cause cites at length in her brief on appeal and upon which she rests her contention of liability here. As she quotes, that hypothetical begins:

> "Argument could be made, however, that once diagnosis of a medical condition is made and treatment of that condition is prescribed and undertaken, any subsequent diagnosis required to be made as a result of that treatment, such as with respect to complications arising from medications prescribed or medical procedures performed, may not be entitled to the immunity protection of section 6-106(a). For instance, a medication could be therapeutic for a diagnosed illness but toxic to an undiagnosed illness. Treatment of the former would require the medical professional to inquire as to common conditions of pathology that would be aggravated by the intake of medication prescribed for the diagnosed illness. Treatment of the diagnosed illness also might require the medical professional to perform further testing when adverse reactions occur as a result of the treatment prescribed for the diagnosed medical condition and to diagnose and treat any additional medical conditions that result. The making of the subsequent diagnosis would become part of the treatment prescribed for the medical condition initially diagnosed; and there would be no immunity if the subsequent diagnosis was incorrectly made (a negligent or wrongful act) or if the diagnosis was not made at

> all (an act of omission). See 745 ILCS 10/6-106(d) (West 1992) ('[n]othing in this section exonerates *** for injury proximately caused by *** negligent or wrongful act or omission in administering any treatment prescribed')." *Michigan Avenue*, 306 Ill. App. 3d at 402-03.

¶ 26 The *Michigan Avenue* majority was correct in this respect, and we take no issue with this portion of the quotation cited. According to the hypothetical, if a provider diagnoses a condition and provides treatment for that condition, any later diagnosis required as a result of that treatment–say, for example, as the result of an adverse reaction to the treatment or from the aggravation of another illness due to that treatment–may be considered part of the treatment prescribed for the initial, diagnosed, medical condition. See *Michigan Avenue*, 306 Ill. App. 3d at 402-03. In such a case, then, and pursuant to the exception to immunity found in 6-106(d), there could be no immunity as, effectively, this would now become a failure to treat scenario, not a failure to diagnose scenario.

¶ 27 Plaintiff here, however, uses the court's hypothetical to argue that the diagnosis and treatment of a more generic condition should obviate immunity when another or a more specific condition is eventually diagnosed. This is a inherently incorrect. While plaintiff took the time to quote a large portion of the court's hypothetical, she neglected to include the court's ultimate conclusion, which it stated in the last sentence of that same paragraph:

> "If, however, a medical professional diagnoses and treats a medical condition but fails to diagnose an independent but co-existent medical condition, and if treating the diagnosed medical condition does not exacerbate the undiagnosed co-existent

condition, the medical professional would not be liable for the failure to diagnose the latter condition." *Michigan Avenue*, 306 Ill. App. 3d at 403.

¶ 28 It is within this portion of the court's reasoning that the instant cause lies. Defendant herein consistently diagnosed Dennis with pharyngitis and treated him for this condition. In her complaint, as well as in her brief on appeal, plaintiff concedes that defendant's diagnosis of pharyngitis was correct. Dennis, however, as experts Drs. Gillespie and Brown testified, more than likely was also in the early stages of throat cancer when he began his visits to defendant's emergency room–a condition independent of, and co-existent with, his pharyngitis which defendant failed to diagnose until, according to these experts, December 2010. Plaintiff never alleged, nor provided any evidence, that treating Dennis' pharyngitis between April and July 2010 exacerbated his undiagnosed cancer. According to the *Michigan Avenue* majority's conclusion, then, defendant would not be liable for the failure to diagnose Dennis' cancer. See *Michigan Avenue*, 306 Ill. App. 3d at 403.

¶ 29 The applicability of defendant's immunity under the Act here becomes even more clear upon the examination of our supreme court's decision in *Michigan Avenue*. Apart from any hypothetical, our supreme court's primary focus with respect to the issue of whether immunity under section 6-106(a) of the Act applied to the defendant in that case was the plaintiff's complaint and how its allegations fit within the terms "diagnosis" and "treatment" used in the Act. The court began by reiterating the components of section 6-106, with subsection (a) granting immunity for diagnosing, or failing to diagnose, a medical condition, and the remaining subsections limiting that immunity, with subsection (d) imposing liability for injury proximately

caused by negligent acts or omissions in the administration of any treatment prescribed for the medical condition. See *Michigan Avenue*, 191 Ill. 2d at 511. Next, the court found that the term "diagnosis" found in subsection (a) should be given its plain and ordinary meaning, namely, " 'the art or act of identifying a disease from its signs and symptoms,' " as should the term "treatment" found in subsection (d), namely, " 'the action or manner of treating a patient medically or surgically.' " *Michigan Avenue*, 191 Ill. 2d at 510-12, quoting Webster's Third New International Dictionary 622, 2435 (1993).

¶ 30 Having established this, the supreme court then turned to the allegations in the plaintiff's complaint. It noted that the plaintiff insisted its allegations established that its suit revolved around the defendants' repeated failure to properly treat the decedent's breast condition and, therefore, the case came within the meaning of subsection (d) of section 6-106 of the Act, making it a failure to treat case and subjecting the defendants to liability. See *Michigan Avenue*, 191 Ill. 2d at 512. The supreme court, however, disagreed. See *Michigan Avenue*, 191 Ill. 2d at 512. Turning to the actual claims in the plaintiff's complaint, the court found that the allegations therein actually belied the plaintiff's contention that its action against the defendants was based upon the negligent provision of medical treatment to the decedent. See *Michigan Avenue*, 191 Ill. 2d at 512. Rather, it found that the plaintiff's allegations actually related to examination and diagnostic actions–not treatment. See *Michigan Avenue*, 191 Ill. 2d at 512. That is, our supreme court looked at the specific claims; these included the failure to order a mammogram, the failure to properly perform examination and tests, the failure to perform a biopsy, the failure to diagnose breast cancer, and the ultimate conclusion by the plaintiff that, as a result of one or more of these

negligent acts or omissions, the decedent died. See *Michigan Avenue*, 191 Ill. 2d at 512-13. After reviewing these, the supreme court concluded that the clear "import" of the plaintiff's allegations was that the decedent's death was caused by the defendants' failure to perform examinations, failure to adequately perform examinations, and failure to diagnose breast cancer. *Michigan Avenue*, 191 Ill. 2d at 513. This was in direct contradiction to the plaintiff's assertion that its action was premised upon the defendants' negligent treatment of the decedent. As the court found, although the plaintiff may have couched its complaint as a failure to treat case, "the essence of [the] plaintiff's suit is that [the] defendants failed to properly examine [the decedent] and diagnose her breast cancer"–a condition which, the expert evidence presented surmised, coexisted independently with the decedent's fibrocystic breast disease, as diagnosed by the defendant. *Michigan Avenue*, 191 Ill. 2d at 516. Ultimately, our supreme court held that, "[b]ecause the gravamen of [the] plaintiff's action against [the] defendants is that [the] defendants' failure either to perform examinations or to adequately perform examinations led to [the] defendants' failure to diagnose [the decedent's] breast cancer, which, in turn, proximately caused her death," this was a failure to diagnose case qualifying the defendant for immunity under section 6-106(a) of the Act. *Michigan Avenue*, 191 Ill. 2d at 512, 516 (the plaintiff's experts focused upon the failure to perform certain exams which, in turn, led to the failure to diagnose cancer that coexisted with the diagnosed condition; section 6-105 immunizes the defendant for the failure to conduct exams in order to evaluate whether the decedent suffered from cancer in addition to the already diagnosed condition, and section 6-106(a) immunizes the

defendant for the failure to diagnose the cancer, rendering summary judgment appropriate).[2]

¶ 31 Turning our focus to an examination of plaintiff's complaint, just as our supreme court did, it immediately becomes clear that the instant cause mirrors *Michigan Avenue* and merits the same result. The allegations in plaintiff's complaint are few, but she couches each of them as violations of defendant's duty to "treat" Dennis. That is, she begins by alleging that defendant rendered "treatment and advice" to Dennis. She then cites two violations, namely, that defendant "violated the standard of care by merely prescribing medications for the treatment of Dennis Ryce's persistent sore throat, for treatment," and that it "violated the standard of care by not having Dennis Ryce seen by an ENT." She then alleges that, as a proximate result of defendant's actions and omissions in administering proper treatment, defendant caused Dennis to endure pain until his death because his cancer was not discovered and timely treated.

¶ 32 However, although plaintiff consistently attempted to couch her complaint as a failure to treat case, the gravamen of her cause of action is essentially a failure to diagnose case. The evidence is clear that defendant did not diagnose Dennis as having throat cancer until December 2010 and, therefore, did not treat this disease, which was the disease that eventually caused his death, at any time during his visits between April and July 2010. Rather, during that time, defendant diagnosed pharyngitis and treated for that–a coexising, independent disease, which it, in turn, treated and which did not cause Dennis' death. Simply couching one's complaint as a

---

[2]Our appellate court likewise looked at the allegations of the plaintiff's complaint and similarly concluded that these belied the plaintiff's contention that this was a failure to treat case. Albeit in a much more succinct manner, that court, just as our supreme court, also found that the allegations at issue involved a failure to diagnose. See *Michigan Avenue*, 306 Ill. App. 3d at 405.

failure to treat case does not make it so. Rather, and just as in *Michigan Avenue*, plaintiff's allegations here relate directly to examination and diagnostic actions surrounding Dennis' coexisting illnesses–pharyngitis, which defendant diagnosed and treated properly without any objection by plaintiff, and throat cancer, which defendant did not diagnose–and did not treat–during the cited period. The crux of plaintiff's allegations of merely prescribing medications for the treatment of Dennis' sore throat and not having him see an ENT is that Dennis' death was caused by defendant's failure to either perform examinations or its failure to adequately perform examinations that led to defendant's failure to diagnose Dennis' throat cancer which, in turn, proximately caused his death. This falls in direct line with the terms "diagnosis" and "treatment" as defined by our supreme court, with the former as the art of identifying a disease from its signs and symptoms and the latter as the action of treating a patient medically. The key here, as found in plaintiff's very complaint, is her ultimate allegation that defendant failed to identify Dennis' throat cancer–*i.e.*, to diagnose it. Treatment of Dennis' throat cancer could never have been undertaken unless or until it was diagnosed and unless it warranted treatment. As Dennis' throat cancer was not diagnosed until December 2010, plaintiff's cause of action cannot be a failure to treat case. Clearly, the gravamen of plaintiff's complaint is a failure to diagnose, for which defendant is immune under sections 6-105 and 6-106(a) of the Act.

¶ 33 Plaintiff spends much time in her brief analyzing Dennis' May 3, 2010 visit at defendant's emergency room, during which Dr. Gawo gave him a CT scan. Plaintiff claims that, at this point, Dr. Gawo provided a differential diagnosis of cancer and treated Dennis for it by giving him that scan. Citing *American National Bank & Trust Co. v. County of Cook*, 327 Ill. App. 3d

212 (2001), and *Mills v. County of Cook*, 338 Ill. App. 3d 219 (2003), she insists that this differential diagnosis and treatment provided sufficient diagnosis and treatment to satisfy "the *Michigan* test," namely, the hypothetical that if a defendant diagnoses a condition and provides treatment for that condition, any later diagnosis required as a result of the treatment of that condition is not entitled to immunity. However, plaintiff's claim misses the mark here, and the cases she cites are wholly distinguishable. A closer examination of her assertion actually reinforces that this is a failure to diagnose case and not, as she insists, a failure to treat case.

¶ 34 In *American*, a woman received prenatal care at the defendant's medical clinic. After an ultrasound, it was determined that her baby was in a transverse lie position (lying perpendicularly to the mother's body) and could not be delivered vaginally. See *American*, 327 Ill. App. 3d at 213. However, a few weeks before her delivery, a doctor performed a maneuver on the woman and determined that the baby was now positioned head down and was no longer in the transverse lie position. See *American*, 327 Ill. App. 3d at 214. When the woman eventually went into labor, doctors allowed the birth to proceed vaginally; at that time, the fetus was in the transverse lie position and the vaginal delivery caused umbilical cord prolapse, which required an emergency cesarean section and resulted in severe brain damage to the baby. See *American*, 327 Ill. App. 3d at 214-15. The plaintiff brought a medical malpractice action, and the defendant sought to invoke immunity under sections 6-105 and 106 of the Act. See *American*, 327 Ill. App. 3d at 215. The trial court granted summary judgment in favor of the defendant, but the reviewing court reversed. After discussing *Michigan Avenue*, the *American* court noted that the doctor's action of performing the maneuver on the woman a few weeks before her delivery did

not constitute a "diagnosis," which is immunized by the Act, but, rather, "treatment." See *American*, 327 Ill App. 3d at 217. This was because the doctor who performed the maneuver was already aware, having read earlier patient notes, that the baby was in the transverse lie position–the existing diagnosis. See *American*, 327 Ill. App. 3d at 217. The doctor's maneuver, then, amounted to the negligent treatment of a previously diagnosed, known medical condition, as opposed to a failure to diagnose and, thus, section 6-106(a) of the Act did not provide immunity. See *American*, 327 Ill. App. 3d at 217.

¶ 35 Similarly, in *Mills*, the plaintiff brought her son to the defendant's hospital because he was coughing and wheezing. A doctor examined him and determined he had pneumonia; she provided nebulizer treatments of albuterol and nasal saline drops and, upon determining his condition improved after these treatments, she discharged him. See *Mills*, 338 Ill. App. 3d at 220-21. The boy died a few hours later. The plaintiff filed suit alleging negligent treatment and the trial court dismissed her claim, citing immunity under section 6-106 of the Act. However, the *Mills* court reversed. It noted that, while the doctor first stated in her deposition that she did not diagnose the boy with pneumonia, she subsequently admitted she differentially diagnosed him with pneumonia and treated him for it; additionally, a nurse who helped the doctor and an expert reviewing her notes both examined the boy's chart and determined the doctor had diagnosed him with pneumonia. See *Mills*, 338 Ill. App. 3d at 222-23. The *Mills* court found the doctor performed an adequate examination and had properly diagnosed the boy as having pneumonia; the negligence, it concluded, stemmed not from her diagnosis but from her treatment of him, thereby negating immunity under the Act. See *Mills*, 338 Ill. App. 3d at 223.

¶ 36 Contrary to plaintiff's assertion here, the instant cause is not "synonymous" with *American* and *Mills*; rather, it is very different. In both those cases, the defendants provided treatment for the condition that caused injury. Neither case was a failure to diagnose case–the defendant in *American* had already (properly) diagnosed the pregnant woman as having a baby in the transverse lie position, and the defendant in *Mills* had already (properly) diagnosed the boy with pneumonia. Instead, as both courts found, these were failure to treat cases–performing the maneuver on the pregnant woman and allowing the birth to otherwise proceed vaginally, and giving the boy only nebulizer treatments and saline drops before discharging him. It was on these actions (or omissions) of the defendants in the actual treatment of the patients for the conditions that caused their injuries which the reviewing courts found the potential for liability, actions (or omissions) in treatment for which section 6-106 of the Act does not provide immunity.

¶ 37 In contradistinction, defendant in the instant cause did not initiate any sort of treatment for the condition that caused Dennis' death–his throat cancer–during the cited period of April to July 2010. It did not, and logically could not have, because defendant did not diagnose Dennis' throat cancer until December 2010. See, *e.g.*, *Michigan Avenue*, 306 Ill. App. 3d at 402 ("treatment of a medical condition cannot be undertaken unless or until a medical condition is diagnosed and unless the diagnosed medical condition warrants treatment"). More specifically, and again contrary to plaintiff's insistence, that Dr. Gawo ordered a CT scan on May 3, 2010, was not treatment of his throat cancer. First, she provides no evidence to support this claim and, critically, the evidence is directly contrary to this. Dr. Patel, the ENT who actually treated

Dennis' throat cancer, as well as Dr. Gillespie, plaintiff's own expert ENT, both testified in agreement that there are only three ways to treat throat cancer: resection (surgery), radiation, and chemotherapy. They also agreed that none of these treatments may be undertaken unless and until cancer is first diagnosed. Dr. Gawo's CT scan, then, was not a treatment of Dennis' throat cancer. In fact, Dr. Patel specifically noted that the CT scan did not have any impact on treatment since it was normal. Rather, it was a diagnostic tool, a method to diagnose, not treat, cancer which, in this case, came back normal on May 3, 2010, and nonindicative of cancer at that time. As Dr. Patel further described, the first test to show any indication of cancer was the CT scan of Dennis' neck performed in December 2010 when a mass was present, and the first test to actually diagnose cancer was the biopsy, also performed in December 2010.

¶ 38 Moreover, that Dr. Gawo's May 3, 2010 CT scan was not treatment under the exceptions to section 6-106(a)'s immunity is further supported by case law. Several cases, including *Johnson v. Bishof*, 2015 IL App (1st) 131122, *Hemminger v. Nehring*, 399 Ill. App. 3d 1118 (2010), and *Wilkerson v. County of Cook*, 379 Ill. App. 3d 838 (2008), all show this to be true. For example, *Johnson* involved a patient who presented at the defendants' emergency room with back spasms, back pain, numbness in her lower extremity and cramping in her thigh. See *Johnson*, 2015 IL App (1st) 131122, ¶ 4. The defendants performed a CT scan, diagnosed a buttock contusion and muscle spasm and treated the patient for this; in reality, the patient had a spinal cord injury and eventually became paralyzed. See *Johnson*, 2015 IL App (1st) 131122, ¶ 15. The plaintiff brought suit, alleging a failure to treat case, but the trial court granted summary judgment in favor of the defendants based on immunity under section 6-106(a) of the Act. See

Johnson, 2015 IL App (1st) 131122, ¶ 29. Our court affirmed. Noting that all of the plaintiff's claims of negligence were directed to the defendants' improper treatment of her spinal cord injury, we found that this was a failure to diagnose case; the defendants treated the plaintiff for her signs and symptoms but consistently diagnosed those as a buttock contusion and muscle spasm, not a spinal cord injury. See *Johnson*, 2015 IL App (1st) 131122, ¶ 49. Particularly, as to the plaintiff's insistence that the CT scan and resulting treatment made this a failure to treat case, we noted that this was incorrect. Instead, we reasoned that the diagnosis here was always buttock contusion and muscle spasm; this did not change and, as the CT scan came back normal, was actually confirmed by defendants, who ruled out a spinal cord injury and consistently treated the plaintiff for what they believed she had, treatment that no one alleged was negligent for that diagnosis. See *Johnson*, 2015 IL App (1st) 131122, ¶ 55. The defendants were wrong in that they had misdiagnosed the plaintiff, but a misdiagnosis invokes immunity under section 6-106(a). See *Johnson*, 2015 IL App (1st) 131122, ¶ 50. See also *Johnson*, 2015 IL App (1st) 131122, ¶ 51 ("[t]he fact that the muscle spasm diagnosis was incorrect or inadequate does not, without more, make [the] defendants' treatment for that diagnosis negligent. The fact that the treatment was the wrong treatment for spinal cord injury would be relevant only if [the] defendants had diagnosed [the] plaintiff with a spinal cord injury. They had not").

¶ 39 Likewise, in *Hemminger*, the defendants performed a Pap smear on the patient and read it to be within normal limits. See *Hemminger*, 399 Ill. App. 3d at 1119. Several months later, the patient was diagnosed with cervical cancer and died. See *Hemminger*, 399 Ill. App. 3d at 1119. The plaintiff filed an action and the defendants, claiming immunity under the Act, moved for

summary judgment, which was granted. On appeal, the *Hemminger* court affirmed the lower court's finding of immunity under section 6-106(a). The plaintiff argued that this was not a failure to diagnose case, since he was asserting that the Pap smear test was merely a screening tool, not a diagnosis of cancer, and that his allegations amounted to a failure to correctly interpret that test, which would invoke a failure to treat. See *Hemminger*, 399 Ill. App. 3d at 1123. The *Hemminger* court, however, disagreed, finding that the essence of his cause was that the defendants failed to adequately examine and/or diagnose the cancer. See *Hemminger*, 399 Ill. App. 3d at 1125. The Pap smear, it explained, was a screening test "that is clearly part of the diagnostic process and precisely the conduct that both sections 6-105 and 6-106 immunize." *Hemminger*, 399 Ill. App. 3d at 1126.

¶ 40 And, *Wilkerson* further follows suit. In that case, the patient presented with abdominal pain and vaginal discharge. See *Wilkerson*, 379 Ill. App. 3d at 840. Following a Pap smear which was abnormal, the defendants diagnosed her with pregnancy and a vaginal infection; it was later discovered that she had cervical cancer and died. See *Wilkerson*, 379 Ill. App. 3d at 840. The plaintiff asserted that the defendants were negligent in the treatment of the patient because of their failure to perform an additional Pap smear and biopsy which, the plaintiff asserted, would have led to a cancer diagnosis. See *Wilkerson*, 379 Ill. App. 3d at 840-41. The trial court granted summary judgment in favor of the defendants based on immunity under section 6-106(a) of the Act, and we affirmed. See *Wilkerson*, 379 Ill. App. 3d at 843. In our decision, we found *American* and *Mills* to be distinguishable because in those cases, the defendants properly examined and diagnosed the patients, thereby making the central issue

improper treatment for which there is no immunity. See *Wilkerson*, 379 Ill. App. 3d at 845-46. Contrarily, we found that in *Wilkerson*, just as in *Johnson* and *Hemminger*, there was no evidence presented that the treatment was rendered pursuant to a diagnosis or even a differential diagnosis of cancer. See *Wilkerson*, 379 Ill. App. 3d at 847. Rather, the patient in *Wilkerson* was diagnosed with a pregnancy and a vaginal infection and treated for those conditions–she was never treated based on a diagnosis of cervical cancer. See *Wilkerson*, 379 Ill. App. 3d at 847. In other words, "[t]he alleged negligence in this case *** was not based on the treatment [the patient] received, but on the treatment that she should have received had the defendants correctly examined and diagnosed all of her medical conditions." See *Wilkerson*, 379 Ill. App. 3d at 847. Accordingly, because this was not a failure to treat case but, rather, a failure to diagnose case, immunity applied. See also *Mabry v. County of Cook*, 315 Ill. App. 3d 42, 55, 58-59 (2000) (where claim of negligence was based on failure to conduct test or scan that could have identified pulmonary embolism had it been suspected, immunity applied since this claim was not the negligent prescription of treatment but the failure to diagnose and prescribe treatment; "[n]egligent prescription of treatment is different from failure to prescribe treatment as a result of a failure to diagnose"); accord *Willis v. Khatkhate*, 373 Ill. App. 3d 495, 505-06 (2007) (even though the plaintiff asserted that the defendants made a differential diagnosis of lymphoma, which turned out to be the correct diagnosis, but failed to properly treat for it, this was still a failure to diagnose case meriting immunity; a differential diagnosis that is not chosen and/or treated as the ultimate diagnosis is, by definition, a misdiagnosis and, thus, the gravamen of the plaintiff's cause was the failure to properly diagnose the lymphoma and not the treatment

received nor the diagnosis the defendants should have made).

¶ 41 Just as in *Johnson*, *Hemminger*, and *Wilkerson*, as well as *Michigan Avenue*, the essence of plaintiff's cause of action here is that defendants failed to adequately examine Dennis and/or diagnose his throat cancer. With Dr. Gawo's CT scan, the defendants were examining Dennis' neck for the purpose of determining whether he had a disease or physical condition that would constitute a hazard to his health. Even accepting as true that Dr. Gawo made an initial, differential diagnosis of throat cancer upon his examination of Dennis on May 3, 2010 (which is why he ordered the CT scan), the record shows that he ruled this out when the CT scan he ordered to test that differential diagnosis came back normal. Dr. Gawo noted as much in his patient report, ruling out both cancer and HIV and writing on Dennis' patient chart that his final diagnosis that day was oropharyngeal candidiasis and GERD, for which he prescribed two antibiotics and a referral to a primary care physician. In retrospect, and only as of December 2010, throat cancer proved to be the correct diagnosis in Dennis' case. However, it was at most here, during the cited period of April to July 2010, a differential diagnosis that was, for various reasons as evidenced by the expert testimony presented, not chosen and/or considered as the ultimate diagnosis. Dr. Gawo's CT scan, then, was, clearly and simply, a screening test that was part of the diagnostic process. What we have here is a misdiagnosis and, thus, the gravamen of plaintiff's cause is the failure to properly diagnose, and not the treatment Dennis received nor the diagnosis the defendants should have made, *i.e.*, not the negligent prescription of treatment but, rather, the failure to prescribe treatment as a result of a failure to diagnose. It is exactly this conduct on the part of defendants alleged here that section 6-106(a) of the Act immunizes.

¶ 42 Ultimately, although a plaintiff need not prove her entire case at the summary judgment stage, she must nonetheless present some sort of factual basis which would arguably entitle her to a judgment. See *Michigan Avenue*, 191 Ill. 2d at 517-18; accord *Johnson*, 2015 IL App (1st) 131122, ¶ 59. Based on our review of the pleadings, depositions and admissions on record in this cause, even when construed strictly against defendants and in favor of plaintiff, we hold that plaintiff cannot demonstrate that this was a failure to treat case. Instead, it is clearly a failure to diagnose case and, in light of the plain and applicable language of sections 6-105 and 106(a) of the Act, defendants are immune from liability. Summary judgment was wholly proper here.

¶ 43 CONCLUSION

¶ 44 Accordingly, for all the foregoing reasons, we affirm the judgment of the trial court.

¶ 45 Affirmed.