2015 IL App (2d) 141106-U
No. 2-14-1106
Order filed September 8, 2015

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

JOSE RENTERIA,	)	Appeal from the Circuit Court
	)	of Du Page County.
Plaintiff-Appellant,	)	
	)	
v.	)	No. 08-L-921
	)	
EDWARD HEALTH SERVICES	)	
CORPORATION and NAPERVILLE	)	
PSYCHIATRIC VENTURES d/b/a	)	
LINDEN OAKS HOSPITAL AT EDWARD,	)	Honorable
	)	Kenneth L. Popejoy,
Defendants-Appellees.	)	Judge, Presiding.

JUSTICE JORGENSEN delivered the judgment of the court.
Justices McLaren and Zenoff concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court properly allowed defendants' expert's testimony on proximate cause, and defense counsel's closing remarks were not so prejudicial that they affected the outcome of the trial. Affirmed.

¶ 2 In this medical malpractice case, plaintiff, Jose Renteria, sued defendants, Edward Health Services Corporation and Naperville Psychiatric Ventures d/b/a Linden Oaks Hospital at Edward, raising claims for negligence and *res ipsa loquitor*. He alleged that, while an in-patient at defendants' psychiatric hospital, defendants failed to adequately monitor him and, as a result,

he lay in the same position for many hours and developed compartment syndrome (*i.e.*, increased pressure that decreases blood flow, which leads to muscle death) on his right side and arm and is now permanently disfigured and disabled. A jury found in defendants' favor, and the trial court subsequently denied plaintiff's motion for a new trial. Plaintiff appeals, arguing that he is entitled to a new trial because the trial court erred in allowing: (1) speculative and prejudicial expert testimony concerning proximate causation; and (2) defense counsel's remarks in closing argument concerning drug use and her urging the jury to consider plaintiff's use of the money verdict. We affirm.

¶ 3 I. BACKGROUND

¶ 4 On August 18, 2008, plaintiff sued defendants, alleging that, on October 9, 2007, he presented himself for in-patient treatment at Linden Oaks. He was diagnosed with depression and was noted to be potentially suicidal. In his complaint, plaintiff, who is bipolar, alleged that his treatment required that he receive close supervision and monitoring. On October 11, 2007, he was found unresponsive in his room. EMTs administered Narcan, and he was taken to Edward Hospital, where he was diagnosed with compartment syndrome in his right forearm and arm. Plaintiff alleged in his negligence count that he developed the syndrome by laying on his right side and right arm for many hours. He further alleged that defendants failed to properly monitor him, failed to interact with him for hours or take his vital signs, and allowed him to lay in the same position. In the count alleging *res ipsa loquitur*, plaintiff raised essentially the same allegations, in addition to arguing that the room in which he was placed was under defendants' control and that, in the usual and ordinary course of in-patient psychiatric admissions, patients do not develop compartment syndrome in the absence of negligence by those responsible for

monitoring the patient's condition. Defendants filed an answer to the complaint, denying the allegations. They did not file an affirmative defense.

¶ 5 Prior to trial, plaintiff moved *in limine*, seeking to bar any references to plaintiff's cocaine use or bipolar disorder as contributing causes of his injury (motion No. 12). He argued that it was irrelevant and prejudicial. Plaintiff also sought to bar any reference to his drug use prior to any use immediately before his admission to Linden Oaks, arguing that no physician had testified that any other possible cocaine use caused his compartment syndrome (motion No. 15). The trial court denied both motions. The court rejected plaintiff's suggestion that the fact that cocaine use and bipolar disorder can predispose a person to compartment syndrome was an affirmative defense; the court stated that, because plaintiff pleaded a *res ipsa* count, he had opened the door to alternative causal theories.

¶ 6 Trial commenced on April 15, 2014.

¶ 7 A. Plaintiff's Case

¶ 8 1. Jose Lorenzo Renteria

¶ 9 Jose Lorenzo Renteria, plaintiff's son, testified that plaintiff was a semi-truck driver up to 2004 or 2005 when he developed back issues. Plaintiff suffered from depression. Jose, who was 21 years old, spoke to plaintiff about seeking help for his depression and talked to him about going to Linden Oaks. After consulting with Dr. Timothy Chandra, plaintiff's psychiatrist, plaintiff agreed to check himself into the hospital.

¶ 10 On October 9, 2007, Jose observed plaintiff check in. Plaintiff was searched, and Jose did not observe that staff found any contraband or drugs. Jose visited his father on October 10, 2007. He did not appear to be sick with the flu that day.

¶ 11 2. Dr. Timothy Chandra

¶ 12 Dr. Timothy Chandra, plaintiff's psychiatrist, testified that, in late 2007, he had diagnosed plaintiff as bipolar I (a severe, lifelong condition where the patient experiences symptoms of manic episodes for greater than seven days) with psychotic features (*i.e.*, hallucinations). He prescribed Depakote, Risperdal, and Effexor. Plaintiff also took methadone for chronic back pain. Plaintiff saw Dr. Chandra for two years (2005 to 2007). In between visits, according to Dr. Chandra, plaintiff would stop taking his medications.

¶ 13 Plaintiff checked into Linden Oaks on October 9, 2007. Dr. Chandra was the admitting physician, and Dr. Asensio was assigned as his doctor. At this time, plaintiff's bipolar disorder was manifesting itself as suicidal thoughts, sleeplessness, irritability, agitation, and harmful ideations toward himself and others. Dr. Chandra ordered plaintiff to attend chemical dependency groups, that vital signs be taken twice daily for three days, and that he be put on suicide precautions (*i.e.*, that plaintiff be monitored every 15 minutes). He also ordered a drug screen. A specimen that was taken at 3 p.m. on October 10, 2007, one day before plaintiff's injury, was presumptively positive for cocaine.

¶ 14 Dr. Chandra saw plaintiff on October 10, 2007. He noted in records that plaintiff had stopped his medications for two weeks (Depakote and Risperdal) and was having mood swings, chronic back pain, decreased sleep, suicidal thoughts, was upset at his wife for hanging out with a neighbor, and had threatened his neighbor. Dr. Chandra noted a history of suicide attempts, bipolar disorder, cocaine abuse (last use one week earlier), back pain (three surgeries), and that plaintiff had started drinking two weeks earlier. (Plaintiff denied to Dr. Asensio that he had recently used cocaine; he reported using it years earlier.) Dr. Chandra's diagnoses were: bipolar I disorder with psychotic features; cocaine abuse versus dependence; back pain; and marital and

financial stress. The plan was to discontinue Risperdal and start Geodon at 40 milligrams, twice per day. Plaintiff was still prescribed methadone, and Dr. Chandra believed that he was taking it.

¶ 15 He next saw plaintiff on the morning of October 11, 2007. Plaintiff complained of weakness, headache, chills, nausea, and dizziness. Based on plaintiff's complaints, Dr. Chandra withheld psychiatric medications so as not to aggravate plaintiff's symptoms or in case they caused them. On October 11, unlike the prior day, plaintiff's physical, not psychiatric, symptoms were the primary issue. Dr. Chandra advised staff that plaintiff needed to be evaluated for possible flu. At 10:20 a.m., Dr. Asensio issued a telephone order that plaintiff remain in his room (isolated) and be given Motrin, as needed. Dr. Chandra expected plaintiff to be aroused for medication, assessments, meals, or encouragement to attend group therapy. On this day, plaintiff slept from 2:30 p.m. to 10:30 p.m. (There were 34 15-minute checks wherein plaintiff was found to be sleeping during that period.) He was found unresponsive at 10:30 p.m. and moved to Edward Hospital at 10:45 p.m. Dr. Chandra testified that *decreased* sleep is a symptom of bipolar disorder.

¶ 16 3. Craig Franz

¶ 17 Craig Franz worked at Linden Oaks beginning in February 2007 as a behavior health associate. He testified that behavior health associates would do rounds on patients, make sure they went to their meals on time, and do room checks. Patients on suicide precautions were checked every 15 minutes to ensure the patients were safe, alive, and not a danger to others. Although patient breathing would be checked, it was not assessed to record if it was rapid, shallow, or short.

¶ 18 On October 11, 2007, plaintiff's vitals were taken at 7 a.m. He complained of headache. His vitals were not recorded thereafter on that day until 10:30 p.m. At Linden Oaks, both nurses

and behavior health associates took vital signs, although policy dictated that they were to be taken by nursing staff.

¶ 19 For plaintiff, personnel were not instructed to look for any particular breathing pattern. They did not check for skin color, bruising, or discoloration. Nor did they note whether the patient was lying in the same position or moving around. Based on the precautions log for October 11, 2007, the only activity plaintiff engaged in from 2:30 to 10:45 p.m. was sleep in his room. It would not cause concern for Franz that plaintiff had not previously shown a pattern of sleeping all day.

¶ 20 4. Sarah Gresk

¶ 21 Sarah Gresk, a new nursing graduate in 2007, testified that she had started with Linden Oaks in August of that year. The hospital consists of 12 rooms with two beds each; a TV room; and a group room. For 24 patients, staffing includes four nurses and four behavior health associates. They traded off charting from one shift to the next. Behavior health associates usually completed the precaution log, but nurses sometimes filled it out as well.

¶ 22 When a nurse assesses a patient, he or she speaks to the patient about their mental and physical condition. Taking vital signs (*e.g.*, pulse, blood pressure, temperature, and respirations) is purely the physical aspect. Vitals also includes taking into account whether the patient is getting better or worse. Group notes are checked to ensure the patient is attending therapy because it might be indicative of the psychological component of a patient assessment.

¶ 23 The precautions record, she explained, tells a nurse when a patient has, for example, been to the hospital or if he or she is interacting on the unit. A reference to a hospital trip alerts the nurse to look back in the charting to see what is going on physically and mentally with that patient. Gresk was taught to reassess the patient when those types of things came to her

attention. For the 15-minute checks, a patient would be checked visually to ensure they were breathing, but no one would have to enter the room. As long as one could see the patient's chest moving up and down, they were okay for that check. There was no standard to look for fast or slow breathing, or shallow or agonal breathing. Whether there should be a concern when a patient sleeps during the day depends upon the patient's physical condition.

¶ 24 Gresk charted on plaintiff's "Code Blue." She was present at 11:30 p.m., and the information for her charting was given to her by the charge nurse. Plaintiff's notation was that plaintiff was unresponsive, his breathing was rapid and shallow, and his blood pressure was 74 over 40.

¶ 25 At 9 a.m. on October 11, 2007, the charting reflects that plaintiff went to the hospital (in a wheelchair) because of pounding headaches. (The prior night, Gresk's records reflect that plaintiff had slept all night and needed no sleep medication; he was also eating and drinking.) Plaintiff returned from the hospital at about 12:30 p.m., went to sleep in his room around 2:30 p.m., and remained asleep until 10:30 p.m., when he was found unresponsive. (There was no record that he was reassessed after he returned from the hospital.) Based upon the charting and records, there is no way to tell at what time between 2:30 and 10:30 p.m. plaintiff started to breathe at 32 breaths per minute, when his breathing became rapid and shallow, when he became unresponsive (as opposed to asleep), and when his blood pressure dropped to 74 over 40.

¶ 26 5. Lawrence Jefferson

¶ 27 Lawrence Jefferson, a behavior health counselor at Linden Oaks, testified that he monitored patients who were on suicide precautions every 15 minutes. If a patient was asleep in their room, Jefferson was instructed to look for the rise and fall of the chest to make sure they were breathing. He was not instructed to look for the difference between shallow or deep

breathing or fast or slow breathing. He was taught to take vital signs, but was unaware of any policy as to how often vital signs were to be taken. Jefferson checked on patients more often if he knew they were having medical problems.

¶ 28 No one told Jefferson on October 11, 2007, that plaintiff was having physical health problems or that his psychiatrist had removed him from psychiatric medications. Nor did anyone inform him that Dr. Chandra was concerned that plaintiff was experiencing side effects from those medications or expected plaintiff to be aroused if he was sleeping when a group counseling session was being conducted.

¶ 29 On the day of plaintiff's injury, Jefferson made notations from 10:30 p.m. to 10:45 p.m. At 10:30 p.m., he recorded that plaintiff was asleep in his room; he made no note if plaintiff's breathing was fast or shallow. He did not check to see how long plaintiff had been asleep because it was not of any concern to him. At 10:45 p.m., Jefferson recorded that plaintiff was asleep in his room. Even though he was in the midst of a "Code Blue" at 10:45 p.m., plaintiff was marked as sleeping because Jefferson could not actually see plaintiff through the nurses gathering around.

¶ 30 6. Dr. Fred Ovsiew

¶ 31 Dr. Fred Ovsiew, a psychiatrist and one of plaintiff's expert witnesses, opined that plaintiff's compartment syndrome was caused by his being allowed to lay on his side, unmoved, for several hours. Dr. Ovsiew further opined that methadone contributed to this altered mental state (plaintiff was given 30 milligrams of methadone on October 9 and 60 milligrams on October 10 (and more at 2 p.m. on October 11 per nurse Barbara Levin)), including the fact that he responded to Narcan, which reverses the sedation or depression of breathing that occurs with narcotics, but "other factors may have gone into it." Methadone would have had more of an

impact on someone who was already physically weakened. If the methadone was not having an effect on plaintiff, the Narcan would not have done anything to bring him out of the stupor in which he was found.

¶ 32 He explained that methadone is an oral narcotic pain reliever. Addressing Narcan or naloxone, Dr. Ovsiew explained that it is an antagonist (*i.e.*, it blocks the action of narcotics). The EMTs administered Narcan to plaintiff after he was found unresponsive (two doses of two milligrams each for a total of four milligrams). Narcan is an antagonist of opiate medicines and has no effect on any other medicine. In plaintiff's case, the only narcotic he was on while at Linden Oaks was methadone.

¶ 33 Dr. Ovsiew opined that plaintiff's injury does not happen in the usual and ordinary course of caring for similar patients in a psychiatric hospital and would not happen in the usual course of treatment. He could not opine about the time of the onset of plaintiff's compartment syndrome or about the duration of plaintiff's unresponsiveness. He also testified that compartment syndrome is not his area of expertise and that he relied on Dr. Karlsson, the orthopedic surgeon, to provide expertise on it.

¶ 34 Dr. Ovsiew testified that he had never before seen a patient develop compartment syndrome while a psychiatric inpatient and under observation. He also testified that muscle injury can also be caused by drugs (*i.e.*, an adverse reaction to psychiatric medicines called neuroleptic malignant syndrome, which affects the whole body), cocaine, and alcohol. As to cocaine, it can cause vasoconstriction, which can lead to compartment syndrome. (At his deposition, Dr. Ovsiew had testified that plaintiff's cocaine use could have led to some vasoconstriction.) The more time that has passed since one has "done" cocaine, the less

vasoconstriction there is and that type of vasoconstriction is global because cocaine does not affect just one part of the body; it goes to the whole body.

¶ 35 At the time of his injury, plaintiff was 42 years old. He had just been re-started on his medications (that he had stopped taking a couple of weeks before admission). Upon admission on October 9, Dr. Asensio had noted that plaintiff had long-standing problems with back pain, including three surgeries and an implanted stimulator of the spine to treat the pain. This is why he was on methadone. During his second day at Linden Oaks, plaintiff complained of chills, nausea, and chest pain. He was sent to the emergency room at Edward Hospital on the evening of October 10. The doctors there concluded that he had musculoskeletal chest pain, which is "quite benign." Plaintiff returned to Linden Oaks.

¶ 36 On October 11, Dr. Chandra saw plaintiff again and plaintiff seemed worse, complaining of chills, nausea, dizziness, and generally feeling unwell. Dr. Chandra discontinued the psychiatric medications on the grounds that they might have been contributing to the "medical picture." He asked nursing staff to have Dr. Asensio return and see plaintiff again and to take a nasal swab to test for influenza. Dr. Ovsiew testified that the fact that Dr. Chandra discontinued the medications less than 48 hours after he started plaintiff on them means that he was "quite concerned about his patient's general medical status." Dr. Asensio never came to see plaintiff. Dr. Ovsiew would have wanted to be informed if the internist had not been able to see his patient that day. After the morning of October 11, nothing was done to address plaintiff's medical condition. When he went to the emergency room on the morning of October 11, he was so weak and dizzy that he required a wheelchair for transportation, which had not been the case the previous day.

¶ 37 On October 9 and 10, plaintiff was noted to have slept six or seven hours. After plaintiff returned from the hospital on October 11, he was noted to have fallen asleep around 2:30 p.m. Other than suicide precautions every 15 minutes, there appeared to be no assessment of his physical or mental condition, nor were vitals taken, until he was found unresponsive at 10:35 p.m. When plaintiff woke up after the administration of Narcan, he was confused or delirious. His mental state was not normal. Between 2:30 and 10:30 p.m., "something serious had gone wrong and he had become confused."

¶ 38 7. Barbara Levin

¶ 39 Barbara Levin, an orthopedic nurse, surgical nurse, and legal nurse consultant, testified as plaintiff's standard-of-care expert. Levin opined that plaintiff developed compartment syndrome because he was laying on his arm for hours. If any of the assessment or re-assessments were done as called for under the standard of care, the process by which he developed compartment syndrome would have been interrupted.

¶ 40 Levin has written in the area of compartment syndrome and developed programs and given presentations on the topic for the Orthopedic Nursing Association. She also instructs nurses concerning their role in the diagnosis, treatment, and causes of compartment syndrome. Levin has not worked in a psychiatric hospital in 27 years, but she regularly takes care of psychiatric patients on the orthopedic trauma unit.

¶ 41 Levin opined that the failure to document any information regarding plaintiff's health condition after he returned to Linden Oaks at 12:30 p.m. on October 11 was a deviation from the standard of care. Every shift should have re-assessed his condition so that health care providers could have determined if there were any changes that needed to be addressed. In her opinion, the

staff should have been better educated on abnormal breathing patterns and how to do a respiratory assessment.

¶ 42 Levin explained that compartment syndrome is an increase in the pressure in a closed fascial space that causes a decreased blood flow, followed by tissue and muscle ischemia and, finally, muscle death. The muscle dies because there is not enough oxygen to feed the area because the blood flow has been cut off or compressed.

¶ 43 On October 11, Dr. Asensio put plaintiff in isolation after he complained of headache, chills, and nausea. Mask, gown, and gloves would have been required when entering his room. Within one hour of Dr. Chandra's visit, Dr. Asensio also called in an order for Motrin, as needed, which was not administered. Plaintiff was so weak that he required a wheelchair to go to the hospital for a nasal swab. He should have been re-assessed when he returned from the hospital at 12:30 p.m. because of the previous abnormal findings. Another re-assessment should have been done at the beginning of the evening shift between 3 and 4 p.m. because he had chest pains the previous day and complained of flu-like symptoms on October 11. Finally, an assessment should have been done at 8 p.m. for vital signs and 9 p.m. for medication. In between, given his condition, there should have been additional contact. In Levin's view, communication to the various doctors caring for plaintiff was necessary concerning any conditions that grew better or worse. Because Dr. Chandra had discontinued the psychiatric medications, he should have been advised if plaintiff was better so that consideration could be given to resuming that care. There is no contemporaneous documentation that plaintiff had dinner or drank anything on October 11.

¶ 44 Plaintiff's condition when he was found unresponsive would not have generated immediately. He was brought out of his stupor by Narcan. At the emergency room, he was found to have rhabdomyolysis, or muscle breakdown, which was extensive. His CPK numbers,

which show muscle breakdown, were 58,000, where a normal reading would be in the single digits. Similarly, he had acute renal failure. Kidney failure does not occur until far later in the disease process.

¶ 45 Levin opined that, based upon the emergency room findings, plaintiff's compartment syndrome would have been ongoing for at least four to eight hours. His potassium was high, his white blood cell count was elevated, and the labs were grossly different from the labs done the previous day. Plaintiff's urine had blood in it from the muscle breakdown. His creatinine level was 2.9, which was significantly elevated. Pressures in the muscle compartment, normally between 0 and 15, were up to 60.

¶ 46 Levin further testified that cocaine or alcohol could cause vasoconstriction. With cocaine, vasoconstriction occurs soon after the patient ingests the cocaine ("within a very short period of time"), not several days later. As to urine, a positive result may occur over a prolonged period even though the effects of the cocaine are no longer causing any disturbances in the body. Headaches, weakness, nausea, and mood swings can be side effects of cocaine, but they would not be seen several days after using cocaine.

¶ 47 8. Dr. Troy Karlsson

¶ 48 Dr. Troy Karlsson, a board-certified orthopedic surgeon, treated plaintiff in the emergency room for compartment syndrome. He explained that compartment syndrome occurs when the pressure in the muscle compartment gets too tight and damages the muscles. The excess pressure can be caused by bleeding into the compartment, trauma such as a fracture, or death of some of the muscle that causes swelling. Laying on a limb for a extended period can cause compartment syndrome. The pressure in plaintiff's forearm was in the 60s, whereas normal pressure is under 10; surgery is considered when the pressure is 30 or more. Dr.

Karlsson was aware that plaintiff was found unresponsive, which explains why plaintiff did not have the normal reaction of shifting or turning in his sleep.

¶ 49 Dr. Karlsson performed emergency surgery on plaintiff's arm and three subsequent surgeries to relieve swelling and remove unviable tissue. Based upon the damage he observed during the first surgery, Dr. Karlsson estimated that plaintiff laid on his arm a minimum of one hour. Plaintiff's muscle loss and scarring is permanent.

¶ 50 Dr. Karlsson could not rule out cocaine as causing or contributing to plaintiff's compartment syndrome. Cocaine distributes throughout the entire body. Plaintiff was hypotensive (*i.e.*, low blood pressure) upon admission to the emergency room; this generally reflects that there was not a lot of vasoconstriction. (Cocaine is a vasoconstrictor.)

¶ 51 9. Dr. Tom Karnezis

¶ 52 Dr. Tom Karnezis, a board-certified orthopedic surgeon specializing in hand and upper extremity surgery, saw plaintiff in September 2008. Plaintiff had an ischemic contracture to the arm (*i.e.*, it was useless due to lost circulation and muscle death). Dr. Karnezis described plaintiff's hand as severely clawed and dysfunctional, similar to what is commonly seen after a severe stroke or brain injury.

¶ 53 He further testified that there are multiple causes of compartment syndrome, including an injection of heroin.

¶ 54 10. Patricia Pekoc

¶ 55 Patricia Pekoc was the charge nurse on October 11, 2007. She testified that plaintiff was responsive and talking when the paramedics gave him Narcan, but acknowledged that this information did not appear on his chart. Rather, the paramedics charted that plaintiff was unresponsive with snoring respirations. Pekoc acknowledged that the emergency room records

reflect that plaintiff became responsive only after four milligrams of Narcan were administered to him. Also, the records reflect that, initially, plaintiff spoke Spanish to the paramedics and did not make any sense; after 10 minutes, he spoke English and understood them.

¶ 56 Pekoc further testified that, on the evening of October 11, she had contact with plaintiff six times. During her rounds, Pekoc observed that plaintiff had regular unlabored breathing. She spoke with him at 4 p.m. and then again during the "Code Blue." She did not chart the 4 p.m. conversation/interaction, explaining that, if plaintiff had complaints at that time, she would have recorded them. The charting does not reflect whether anyone asked plaintiff how he was doing between 4 and 10:30 p.m. The charting reflects that plaintiff ate no dinner on October 10 and had no meals on October 11, except at 9 a.m., when nurse Carol Drake documented that she pushed fluids and Gatorade. When she responded to the "Code Blue," Pekoc observed that plaintiff's hand was dusky, but this is not mentioned in the chart. There is no record of any status between 9 a.m. and the "Code Blue," and there is no information on plaintiff's condition between 2:30 and 10:30 p.m. The vitals taken at plaintiff's "Code Blue" sufficed to comply with the requirement that patients' vital signs get taken twice a day.

¶ 57 11. Plaintiff

¶ 58 Plaintiff testified that, due to marital troubles, one month before he entered Linden Oaks, plaintiff started using drugs and alcohol. He testified that he had used cocaine three or four times before he went to Linden Oaks. "Nothing excessive." The last time he used it before admission was three to four days prior; he spent $40 on the cocaine. He does not believe that he was under the effects of cocaine when he checked in to Linden Oaks because he was feeling depressed at that time. According to plaintiff, he snorted the cocaine; he did not inject it. While under Dr. Chandra's care from 2005 to 2007, plaintiff used cocaine once or twice per month. It made him

"feel a little happier." Its effects wore off the same day he used it. Plaintiff did not experience headaches, panic attacks, or feel sleepy when he stopped using cocaine, nor did he experience muscle weakness, nausea, chest pain, hallucinations, or insomnia while he used it.

¶ 59 At the end of the day on October 10, plaintiff "was feeling okay." After he went to bed, he does not remember anything until he woke in the hospital.

¶ 60 While at Linden Oaks, his only visitors were his son, daughter, parents, and older brother, all of whom visited after his arm surgery. Only his son came before that, and it was one day after check-in. He used the phone to call his wife. Plaintiff denied taking any pain medications with him to Linden Oaks. His medical bills totaled $227,562.80.

¶ 61 B. Defendants' Case

¶ 62 1. Mark Russo

¶ 63 Mark Russo, a behavior health associate at Linden Oaks at the time of plaintiff's injury, but a police officer at the time of trial, testified that, at 6 p.m., on October 11, 2007, he had a verbal exchange with plaintiff. He told plaintiff that his dinner tray had arrived, and plaintiff responded that he was not hungry and did not want dinner. (That evening, Russo observed a partially-eaten slice of pizza on the dinner tray.) Russo testified that plaintiff spoke clear coherent English. There "was a bit of irritation in his voice," and plaintiff told Russo that he was sure he did not want dinner and to leave him alone. This conversation is not recorded in hospital records.

¶ 64 Russo performed the 15-minute precautions checks on plaintiff between 8:30 and 10:15 p.m. During this time, plaintiff was asleep. If he had observed anything unusual, Russo would have notified the nurse; he did not observe that plaintiff's breathing was distressed.

¶ 65 Russo next observed plaintiff speaking Spanish to the paramedics. His speech pattern had changed, and a Spanish-speaking paramedic stated that plaintiff "was talking crazy about the devil and other things."

¶ 66 Finally, Russo testified that he accompanied plaintiff, pursuant to Linden Oaks policy, when he went to Edward Hospital the day before (October 10). Hospital policy requires this so as to minimize the likelihood of contraband being brought back from Edward to Linden Oaks.

¶ 67 2. Mary Johnson

¶ 68 Mary Johnson, a nurse and Ph.D., testified as defendants' nursing standard-of-care expert. She was a professor at Rush University College of Nursing and has worked in psychiatric nursing since 1975.

¶ 69 Johnson opined that both the nurses and behavior health assistants at Linden Oaks complied with the standard of care in treating plaintiff. Pekoc acted within the standard of care on October 11. The nursing documentation, in her view, was also within the standard of care. She had no opinion concerning the cause of plaintiff's compartment syndrome.

¶ 70 Johnson explained that it is not unusual for psychiatric patients to sleep during the day. Plaintiff's extended sleeping on October 11 was not a reason for the staff to feel that he was medically unstable. This was so because he had exhibited flu-like symptoms, his vital signs were within normal limits that morning, and he had awakened for dinner without complaint. She also opined that there was no reason to suspect that plaintiff was acutely medically ill before he was discovered to be unresponsive.

¶ 71 3. Dr. Charles Nemeroff

¶ 72 Dr. Charles Nemeroff, a board-certified psychiatrist and geriatric psychiatrist, testified as defendants' proximate causation expert.

¶ 73 Prior to trial, defendants stated in their Illinois Supreme Court Rule 213 (eff. Jan. 1, 2007) disclosures that Dr. Nemeroff would opine that "cocaine was a major contributing cause to the development of" plaintiff's compartment syndrome. He based his opinion on the October 11 urine test that reflected a positive result. Further, plaintiff's cocaine abuse was documented by Dr. Chandra, his psychiatrist, on the discharge summary, which reflected that plaintiff had relapsed on cocaine and was using it one week earlier. Dr. Nemeroff would also testify that there are multiple known causes of compartment syndrome and that cocaine was among them. Plaintiff was using cocaine.

¶ 74 At his discovery deposition, Dr. Nemeroff testified that plaintiff's drug screen was negative for opiates, which was unusual because plaintiff was on methadone just prior to his admission to Linden Oaks and it would still have been positive in his urine even if he stopped taking it for a day or two. Dr. Nemeroff opined that plaintiff's compartment syndrome was caused primarily by his bipolar disorder and polysubstance abuse. Bipolar disorder is associated with a shortened life expectancy (due either to suicide or vascular disorder such as inflammation, heart attacks, and diabetes; compartment syndrome is a vascular disorder because it involves inflammation). As to plaintiff's polysubstance abuse, plaintiff had a "considerable history" of cocaine abuse (which is a major risk for vascular disorders) and had been prescribed opiate narcotic analgesics for pain (and patients "get into trouble" when they're prescribed these medications). He opined that the combination of substance abuse and mood disorders confers additional risk of vascular disorders. Dr. Nemeroff was asked if he knew whether plaintiff snorted cocaine or administered it intravenously, and he stated that he did not know and that it would not matter if it was used chronically. He further stated that both could result in compartment syndrome, but intravenous use would be a greater risk.

¶ 75 At trial, Dr. Nemeroff testified that cocaine abuse (and the associated inflammation) caused plaintiff's injury. Dr. Nemeroff is chairman of the Department of Psychiatry and Behavioral Sciences at the University of Miami, and Chief of Psychiatry at Jackson Memorial Hospital and the University of Miami Hospital. Dr. Nemeroff also has a Ph.D. in neuroscience. He sees patients about 15 hours per week and has been working in the field for 30 years. He developed a mood disorder program at Miami to treat psychiatric patients who suffer from disabling depression and bipolar disorder. Dr. Nemeroff has been published in over 900 peer-reviewed publications and book chapters. He has published on the subject of risk of vascular problems in association with mood disorders.

¶ 76 Dr. Nemeroff disagreed with Dr. Ovsiew's opinion that plaintiff's unresponsiveness was due to medication given at Linden Oaks. Dr. Nemeroff opined that patients who take methadone over many days become very tolerant of any sedating effects. (Plaintiff had re-filled his prescription in close proximity to his admission to Linden Oaks.)

¶ 77 He opined that plaintiff's compartment syndrome was caused by multiple potential contributing factors: vascular disease (patients with mood disorders such as bipolar disorder are at risk for vascular disease and have about a four-year reduced life expectancy), inflammation (patients with mood disorders have a hyper-active inflammatory system), cocaine abuse (which is a major risk factor for vascular events, including heart disease, stroke, and compartment syndrome), polysubstance abuse (use of narcotic analgesics in an abusive setting, particularly in combination with the medications),[1] and being hypersomnic (sleeping 14 or 16 hours per day).

[1] Dr. Nemeroff noted that the medical records reflected that, prior to his stay at Linden Oaks, plaintiff had used greater-than-prescribed amounts of narcotic analgesics (*i.e.*, methadone, oxycodone, and Dilaudid).

¶ 78 Addressing whether plaintiff abused cocaine, Dr. Nemeroff opined that he did, pointing to his presumptively positive urine screen at the hospital ("The fact of the matter is if it tests positive with such a crude screening method, it's absolutely positive") and Dr. Chandra's records. Dr. Chandra's psychiatric evaluation on plaintiff at Linden Oaks stated that plaintiff was cocaine dependent and a cocaine abuser. Addressing the timing of plaintiff's cocaine use, Dr. Nemeroff testified that the drug has a short half-life and, so, there are two possibilities: (1) plaintiff used cocaine either in the hospital or immediately prior; or (2) his use was "incredibly heavy" prior to coming to Linden Oaks so that it was still present in his body when the urine sample was taken. All use of cocaine is abuse because "we don't sanction the use of cocaine," and this includes someone who uses it once every four months.[2]

¶ 79 Dr. Nemeroff was asked how cocaine abuse could lead to compartment syndrome. Plaintiff's counsel objected, arguing lack of foundation and stating that "[t]here's no 213 on this." The trial court overruled the objection, noting that there "was a motion *in limine* which was dealt with in exhaustion prior to the trial commencing." Dr. Nemeroff then explained that cocaine is a vasoconstrictor and, when patients take it, the blood vessels constrict and blood flow is reduced to the organ of interest. It can also cause constriction of arteries in the appendages. Thus, cocaine would be a contributing factor to compartment syndrome. Inactivity on its own is not sufficient to cause compartment syndrome. In plaintiff's case, several factors contributed to causing his compartment syndrome: inactivity, cocaine, a history of opiate abuse, and inflammation. The cocaine and opiate abuse have effects on the body over time that do not go away. As to the major factors here, cocaine was "probably the biggest factor and the associated

[2] Cocaine dependent refers to someone who uses cocaine on a regular basis and it interferes with their social or occupational function.

inflammation." Without cocaine, polysubstance abuse, and bipolar disorder, it is "very unlikely" that plaintiff would have developed compartment syndrome only from sleeping on his arm for several hours.

¶ 80 Defense counsel asked Dr. Nemeroff about the effects on the vasculature of snorting cocaine versus injecting it and whether cocaine that is snorted acts on one part of the body versus the entire system. Over plaintiff's objection, Dr. Nemeroff testified that snorted cocaine is very rapidly absorbed as compared to injecting it because the nose's vasculature is one of the richest in the body. Addressing which body parts are affected, he testified that it depends on what is going on locally. If a person has a family history of heart disease, he or she is genetically vulnerable and cocaine may cause a heart attack or stroke.

¶ 81 Addressing bipolar disorder, Dr. Nemeroff testified that he has treated many patients with this condition and that 51% of such patients had an additional diagnosis of substance or alcohol abuse. "So this is a very common co-occurrence."

¶ 82 Dr. Nemeroff stated that compartment syndrome is an "extremely rare event" and that the association between the syndrome and bipolar disorder and substance abuse would not have been part of the knowledge required of psychiatrists such as Dr. Chandra (who was treating plaintiff) in 2007. In his 30 years of practice, Dr. Nemeroff has not had a case of compartment syndrome in the hospital. "I would not hold someone like Dr. Chandra responsible for having a deep knowledge or awareness about compartment syndrome." Dr. Nemeroff's own knowledge stems from his research in bipolar disorders and other mood disorders.

¶ 83 The fact that plaintiff slept all day on October 11 was not unusual because bipolar patients "classically have hypersomnia," and because plaintiff had flu-like symptoms. It was

also not unusual for a bipolar patient to go from sleeping 8 hours a day to sleeping 14 hours a day; it is a "cyclical illness."

¶ 84 On cross-examination, Dr. Nemeroff testified that, although he has authored over 900 articles, none were about compartment syndrome. He has never treated anyone with compartment syndrome. Addressing the timeframe for the development of compartment syndrome, his knowledge comes from reading the literature on it, not from personal knowledge.

¶ 85 Dr. Nemeroff could not say whether plaintiff was prone to any vascular disorder such as stroke or heart attack that would lead to compartment syndrome. Relevant tests were never conducted. "We don't know what his vascular state is because it hasn't been scrutinized."

¶ 86 The cocaine screening test is crude and qualitative (*i.e.*, "yes or no"). More sensitive testing would reveal metabolites and the absolute level of cocaine. "So it wouldn't be fair to say that, well, there aren't a lot of metabolites found." No subsequent testing was done. As to whether there were enough found to say that cocaine caused plaintiff's compartment syndrome, Dr. Nemeroff explained that "we have no idea about the amount of cocaine that's necessary to cause a particular physiological effect on a given person." Thus, "the fact that there was cocaine present has to be considered important."

¶ 87 At this point, plaintiff's counsel asked that Dr. Nemeroff's opinions as to compartment syndrome be stricken. The trial court denied the request, noting that it went to the weight of the witness's opinions, not to its admissibility. "Whether it be more generalized or specific, that's something to your continued cross[-]examination."

¶ 88 Dr. Nemeroff did not disagree with Dr. Karlsson's testimony that plaintiff was lying on his arm for quite some time, but he thinks that there were other contributing factors. Lying on the arm was a cause; it combined with other causes to result in plaintiff's injury. The

polysubstance abuse was a pre-existing condition that made him more susceptible to the injury, as was his bipolar disorder, and cocaine use. He explained that the literature reflects that polysubstance abuse is a contributing factor to many diseases, including vascular diseases. Plaintiff's records from the Joliet Pain Clinic (which pre-date his visit to Linden Oaks) reflect that he had used greater-than-the-prescribed amounts of narcotic analgesics, including oxycodone and Dilaudid. The effects of chronic opiate use and chronic cocaine use are permanent; over time, polysubstance abuse leaves a permanent scar on your body, including your vasculature.

¶ 89 Plaintiff's counsel asked Dr. Nemeroff to point to where polysubstance abuse was mentioned in the Rule 213 interrogatories. Defense counsel objected, noting that the witness discussed it at his deposition. The trial court sustained the objection. "The law provides for natural corollaries that come from the disclosures and the like. *** There's other things besides a 213 disclosure that come into an individual's determination of expert testimony."

¶ 90 Dr. Nemeroff expressed no opinion as to when the compartment syndrome developed. He further explained that compartment syndrome is a vascular *syndrome*.

¶ 91 C. Closing Arguments and Subsequent Proceedings

¶ 92 During closing argument,[3] defense counsel summarized the medical experts' testimony that linked plaintiff's injury to his cocaine use. Next, counsel stated:

> "Now, how do we know that [plaintiff] used cocaine?
>
> And, you know, you are the judge of the credibility of witnesses, and [plaintiff] clearly tried to minimize his cocaine use, when he testified.
>
> Well, what is the reason for that?

[3] Plaintiff's closing argument (and any rebuttal) is not contained in the record on appeal.

Why do they want to minimize it?

Less cocaine, less likelihood of vasoconstriction. I mean, that's pretty obvious to all of you.

We've got a positive urine screen – presumptive positive, excuse me.

Now, why was that such a touchy subject with Nurse Levin?"

Counsel then noted that Levin testified that cocaine did not cause the compartment syndrome because the urine screen was negative, which was "a huge mistake."[4] Defense counsel also addressed polysubstance abuse, stating that Dr. Ovsiew, plaintiff's expert, was not provided with the Joliet Pain Clinic records. "They didn't want him to have the ability to look in there because it shows exactly what the opiate narcotics were that [plaintiff] took for years before this." Defense counsel stated that plaintiff "denies that he was ever told that he should take a drug holiday." Plaintiff's counsel did not object to these comments.

¶ 93 Next, after defense counsel noted that plaintiff sought over $3 million in damages, she also stated that damages were based on "the effect on somebody's life, and you'd have to consider the effect on [plaintiff's] life of all of the things that he does, cocaine, alcohol." At this point, plaintiff's counsel objected, stating that the comment was prejudicial and not based on the evidence. The trial court overruled the objection, noting that the jury would weigh the evidence and that plaintiff's counsel could comment on it during rebuttal (a transcript of which is not contained in the record on appeal). Defense counsel continued, stating that plaintiff had a

[4] Initially, Levin replied "correct" when asked if the October 10 urine test was negative for cocaine, adding that it "was actually presumptive positive, but there weren't further tests that were done on it. That is true, I did state that." When asked again if the urine test results were negative for cocaine, she replied that it was "a presumptive positive, but without confirmation."

diminished life expectancy due to his bipolar disorder. She noted that 31 years was an average life expectancy (and the jury was instructed that the average life expectancy of a 50-year-old person is 31.6 years), but it did not take into account "what the life expectancy would be of someone that has other issues going on."

¶ 94 The jury deliberated for over four hours and returned a verdict for defendants. Plaintiff subsequently moved for a new trial, and, on October 6, 2014, the trial court denied the motion. Plaintiff appeals.

¶ 95 II. ANALYSIS

¶ 96 Plaintiff argues that he is entitled to a new trial because the trial court erred in allowing: (1) Dr. Nemeroff's speculative and prejudicial expert testimony concerning proximate causation; and (2) defense counsel's closing argument remarks concerning drug use and her urging the jury to consider plaintiff's use (*i.e.*, to purchase drugs and alcohol) of the money verdict. For the following reasons, we find plaintiff's arguments unavailing.

¶ 97 "On a motion for a new trial a court will weigh the evidence and set aside the verdict and order a new trial if the verdict is contrary to the manifest weight of the evidence." *Lawlor v. North American Corp. of Illinois*, 2012 IL 112530, ¶ 38. "A verdict is against the manifest weight of the evidence where the opposite conclusion is clearly evident or where the findings of the jury are unreasonable, arbitrary and not based upon any of the evidence." *Villa v. Crown Cork & Seal Co.*, 202 Ill. App. 3d 1082, 1089 (1990). A trial court's ruling on a motion for a new trial will be reversed where the court abused its discretion. *Maple*, 151 Ill. 2d at 455. The reviewing court, in making this determination, "should consider whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial." *Id.* at 455-56.

¶ 98 The decision whether to admit expert testimony is within the trial court's discretion (*Thompson v. Gordon*, 221 Ill. 2d 414, 428 (2006)), as is the admission of evidence pursuant to Rule 213 (*Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 109 (2004)).

¶ 99 The scope of closing argument is within the trial court's discretion, and we will reverse only if the argument is prejudicial. *Drakeford v. University of Chicago Hospitals*, 2013 IL App (1st) 111366, ¶ 50.

¶ 100 A. Dr. Nemeroff's Testimony

¶ 101 Plaintiff first argues that he is entitled to a new trial because the trial court abused its discretion in allowing Dr. Nemeroff's causation testimony, which he contends lacked foundation and was speculative. Specifically, he argues that: (1) Dr. Nemeroff did not have relevant qualifications or expertise; (2) Dr. Nemeroff had no foundation or basis for opining that plaintiff was prone to any vascular disorder or condition; (3) the witness had no expertise or foundation to testify that cocaine had anything to do with plaintiff's compartment syndrome and that this testimony was irrelevant and prejudicial; (4) the testimony did not affect either liability or damages; (5) Dr. Nemeroff never disclosed any opinion that plaintiff was a polysubstance abuser; and (6) the testimony concerning injecting cocaine should have been barred.

¶ 102 Plaintiff's complaint raised claims for negligence and *res ipsa loquitur*. " 'In a medical malpractice action, a plaintiff must prove: (1) the proper standard of care by which to measure the defendant's conduct; (2) a negligent breach of the standard of care; and (3) that the resulting injury was proximately caused by the defendant's lack of skill or care.' " *Clayton v. County of Cook*, 346 Ill. App. 3d 367, 384 (2004) (quoting *Susnis v. Radfar*, 317 Ill. App. 3d 817, 826 (2000)). A plaintiff must present expert testimony to establish the foregoing elements. *Seef v. Ingalls Memorial Hospital*, 311 Ill. App. 3d 7, 16 (1999). "The doctrine of *res ipsa loquitur*

requires that (1) the occurrence is one that ordinarily does not occur in the absence of negligence; and (2) the defendant had exclusive control of the instrumentality that caused the injury." *Britton v. University of Chicago Hospitals*, 382 Ill. App. 3d 1009, 1011 (2008).

¶ 103 In deciding whether to allow expert testimony, a trial court should assess five requirements: (1) the testimony must be relevant to a material fact in the case; (2) it must be shown that the testimony would assist the trier of fact in determining a fact in issue; (3) the witness must be qualified to give such testimony; (4) the testimony must be reliable and have a proper basis for the opinion to meet foundational requirements; and (5) the testimony's probative value must not be substantially outweighed by the dangers of confusion, undue consumption of time, or unfair prejudice. *Bangaly v. Baggiani*, 2014 IL App (1st) 123760, ¶ 155.

¶ 104 1. *Dr. Nemeroff's Qualifications*

¶ 105 First, plaintiff argues that Dr. Nemeroff's testimony should have been stricken because there was no foundation laid as to the witness's ability to opine about compartment syndrome. Plaintiff asserts that Dr. Nemeroff had never previously been an expert in a compartment syndrome case, never authored an article on the syndrome or cocaine and the development of the syndrome, he referenced no authoritative articles or treatises that connected cocaine or bipolar disorder and the development of compartment syndrome, never treated a patient with compartment syndrome, he did not have knowledge about the timeframes within which the syndrome can develop, and did not rely on any particular literature (just his own general body of knowledge). Accordingly, plaintiff argues that Dr. Nemeroff's testimony was speculative, where no foundation was laid to show that he had some knowledge about the area about which he expressed an opinion.

¶ 106 Defendants respond that proper procedure dictates that plaintiff, via cross-examination, could have elicited information from Dr. Nemeroff that could have diminished his reliability in the jury's eyes. In any event, they further argue that an adequate foundation was laid for his opinions and that they were not speculative. Specifically, defendants respond that Dr. Nemeroff's education and professional accomplishments attest to his qualifications, his testimony concerning his articles on the risk of vascular problems in association with mood disorders and his reference to four particular articles both reflect that a proper foundation was laid for his opinions. Further they contend that, based upon this foundation, his opinions linking plaintiff's injury to multiple contributing factors was not speculative.

¶ 107 Expert opinions based on guess, speculation, or conjecture are inadmissible. *Modelski v. Navistar International Transportation Corp.*, 302 Ill. App. 3d 879, 886 (1999). " 'There is no predetermined formula for how an expert acquires specialized knowledge or experience and the expert can gain such through practical experience, scientific study, education, training or research.' " *Thompson v. Gordon*, 221 Ill. 2d 414, 428-29 (2006). An expert may even give an opinion without disclosing the facts underlying such an opinion. *Wilson v. Clark*, 84 Ill. 2d 186, 194 (1981). It is, then, the opponent's responsibility to challenge the sufficiency or reliability of the basis for the expert's opinion during cross-examination, and the determination of the weight to be given the expert's opinion is left to the finder of fact. *People v. Lipscomb*, 215 Ill. App. 3d 413, 435 (1991). Stated differently, one of the purposes of cross-examination is to probe into the "general soundness" of an expert witness's opinion. *Halleck v. Coastal Building Maintenance Co.*, 269 Ill. App. 3d 887, 897 (1995); see also *Creighton v. Thomas*, 266 Ill. App. 3d 61, 69 (1994) (the principal safeguard against errant expert testimony is the opportunity of opposing counsel to cross-examine; it is important to bring to the jury's attention facts that may discount

the expert's credibility). The adverse party may also have its own expert witness testify as to the validity and reliability of the methodology underlying the opposing expert's opinion. See *Cox v. Doctor's Associates, Inc.*, 245 Ill. App. 3d 186, 211 (1993) (the defendant's expert testified that he could not say that plaintiff's expert's overall methodology was faulty and testified that he had used similar methods to calculate damages). However, when the opinion of an expert is totally lacking in factual support, it is nothing more than conjecture and guess and should not be admitted as evidence. See *Dyback v. Weber*, 114 Ill. 2d 232, 244 (1986).

¶ 108 We conclude that the trial court did not abuse its discretion in allowing Dr. Nemeroff's testimony. Dr. Nemeroff's background provided adequate foundation for his opinions. Although he had never treated a patient with compartment syndrome, his psychiatric focus is mood disorders, including bipolar disorder. Further, he testified that he had reviewed literature on compartment syndrome and had additional knowledge about it from his research on bipolar disorders and other mood disorders. Dr. Nemeroff also published articles on the risk of vascular problems in association with mood disorders. These are proper sources of expertise. *Thompson*, 221 Ill. 2d at 428-29. Dr. Nemeroff explained that compartment syndrome is an "extremely rare event," and he would not have held even Dr. Chandra, plaintiff's treating psychiatrist, to having a deep knowledge or awareness of the syndrome. Plaintiff's counsel vigorously cross-examined Dr. Nemeroff, eliciting, among others, the fact that he had never treated a patient with compartment syndrome. We find no error with respect to the witness's qualifications.

¶ 109 2. *Testimony that Plaintiff was Prone to a Vascular Disorder*

¶ 110 Next, plaintiff argues that Dr. Nemeroff had no foundation or basis for opining that plaintiff, as opposed to the general population, was prone to any vascular disorder or condition. He contends that there was no evidence that the risk factors for any vascular condition were at

play in plaintiff, that bipolar individuals are more susceptible to compartment syndrome, or that compartment syndrome is similar to a vascular disease. Thus, plaintiff asserts, Dr. Nemeroff's testimony constituted baseless conjecture and should not have been allowed. We disagree.

¶ 111 When asked at trial about whether the risk factors were actually at play in plaintiff's condition, Dr. Nemeroff testified that the literature suggested this link. "All I have to go by is the weight of the medical evidence and scientific evidence. And so because those risk factors have been shown to be risk factors for vascular disease, it stands to reason that they contributed." But how much they contributed, he added, was not clear. Dr. Nemeroff explained that population-based studies have revealed the risk factors for a particular disease. "But in a given patient, we [presumably the medical community] have to rely on that in order to come to a conclusion about risk." He explained, as an example, that we know that high cholesterol is a risk factor; thus, most people take statin medication.

¶ 112 The trial court did not abuse its discretion in allowing this testimony. The witness explained the nature of the research data he used to form his opinion. Any weaknesses in the causative link to plaintiff could have been brought out on cross-examination. Given the nature of the medical knowledge, there was no error in allowing the testimony on the basis that it did not specifically quantify plaintiff's risk.

¶ 113 3. *Testimony that Cocaine Proximately Caused Plaintiff's Injury*

¶ 114 *(a) Dr. Nemeroff's Expertise and Foundation*

¶ 115 Next, plaintiff argues that Dr. Nemeroff had no expertise or foundation to testify that cocaine caused plaintiff's compartment syndrome and that testimony concerning cocaine or drug use was irrelevant. We reject plaintiff's argument.

¶ 116 Proximate cause can only be established when there is a reasonable certainty that the defendant's acts caused the injury." (Emphasis omitted.) *Payne v. Mroz*, 259 Ill. App. 3d 399, 403 (1994). Proximate cause may not be based on "mere speculation, guess, surmise or conjecture." *Castro v. Brown's Chicken & Pasta, Inc.*, 314 Ill. App. 3d 542, 553 (2000).

¶ 117 Dr. Nemeroff opined that plaintiff abused cocaine, pointing to his presumptively positive urine screen at the hospital ("The fact of the matter is if it tests positive with such a crude screening method, it's absolutely positive") and Dr. Chandra's records. Addressing the timing of plaintiff's cocaine use, Dr. Nemeroff testified that the drug has a short half-life and, so, there were two possibilities: (1) plaintiff used cocaine either in the hospital or immediately prior; or (2) his use was "incredibly heavy" prior to coming to Linden Oaks so that it was still present in his body when the urine sample was taken. Dr. Chandra's psychiatric evaluation on plaintiff at Linden Oaks stated that plaintiff was cocaine dependent and a cocaine abuser.

¶ 118 Dr. Nemeroff was asked how cocaine abuse could lead to compartment syndrome. Plaintiff's counsel objected, arguing lack of foundation and stating that "There's no 213 on this." The trial court overruled the objection, noting that there "was a motion *in limine* which was dealt with in exhaustion prior to the trial commencing." Dr. Nemeroff then explained that cocaine is a vasoconstrictor and, when patients take it, the blood vessels constrict and blood flow is reduced to the organ of interest. It can also cause constriction of arteries in the appendages. Thus, cocaine would be a contributing factor to compartment syndrome. Inactivity on its own is not sufficient to cause compartment syndrome. In plaintiff's case, several factors contributed to causing his compartment syndrome: inactivity, cocaine, a history of opiate abuse, and inflammation. The cocaine and opiate abuse have effects on the body over time that do not go away. *As to the major factors here, cocaine was "probably the biggest factor and the associated*

inflammation." He opined that, without cocaine, polysubstance abuse, and bipolar disorder, it is "very unlikely" that plaintiff would have developed compartment syndrome from sleeping on his arm for several hours.

¶ 119 Addressing the amount of cocaine required to cause compartment syndrome, Dr. Nemeroff explained that no such sensitive testing was done, and he appeared to question its value. "So it wouldn't be fair to say that, well, there aren't a lot of metabolites found." But, as to whether there were enough, he explained that "we [presumably the medical community] have no idea about the amount of cocaine that's necessary to cause a particular physiological effect on a given person." Thus, "the fact that there was cocaine present has to be considered important."

¶ 120 Two other doctors corroborated Dr. Nemeroff's testimony linking cocaine use to compartment syndrome. Dr. Ovsiew testified that muscle injury can be caused by drugs (*i.e.*, an adverse reaction to psychiatric medicines called neuroleptic malignant syndrome, which affects the whole body), alcohol, and cocaine. As to cocaine, it can cause vasoconstriction, which can lead to compartment syndrome. (At his deposition, Dr. Ovsiew had testified that plaintiff's cocaine use could have led to some vasoconstriction.) The more time that has passed since one has "done" cocaine, he explained, the less vasoconstriction there is and that type of vasoconstriction is global because cocaine does not affect just one part of the body; it goes to the whole body. Similarly, Dr. Karlsson could not rule out cocaine as causing or contributing to plaintiff's compartment syndrome.

¶ 121 Plaintiff cites several cases that he claims support his argument that Dr. Nemeroff had no foundation for his opinions that cocaine caused the compartment syndrome. See *Gyllin v. College Craft Enterprises, Ltd.*, 260 Ill. App. 3d 707, 716 (1994) (finding upheld that expert lacked a factual basis for opinion that inhalation of toxic vapors from stain caused the employee-

driver to stray across road, where the employee denied experiencing any physical impairment due to inhalation of the stain; opinion that the employee could have experienced impairment was mere conjecture and not based on concrete facts; summary judgment for the defendant-employer affirmed); *Simers v. Bickers*, 260 Ill. App. 3d 406, 412-13 (1994) (verdict in eye technician's favor reversed and remanded; the defense expert's testimony held to be mere conjecture and should have been stricken, where the expert's opinion that the cause of the plaintiff patient's eye problems after she was fitted with contact lenses was an infection due to bacteria that entered the eye as a result of the plaintiff failing to clean her lenses; the expert had testified that he had to "surmise" the cause of the infection because a culture was never taken); *Coffey v. Brodsky*, 165 Ill. App. 3d 14, 25 (1987) (trial court should have been stricken the defense expert's testimony in a case where the plaintiff alleged that she was injured during a hysterectomy because the defendant placed a suture in the wrong place, which blocked her urinary tract; she presented the defendant doctor's admission; the defense expert's opinion that the plaintiff's injury may have been caused by an inflammatory process that may have thickened the peritoneum of her ureter and lessened the organ's pliability, not by the misplaced stitch, should have been excluded; nothing in the record showed that the plaintiff had a thickening of the peritoneum, especially since the post-operative report was silent regarding such a condition).

¶ 122 We find these cases easily distinguishable. Plaintiff here *admitted* that he used cocaine both *close* to the time of his admission to Linden Oaks and once or twice per month between 2005 and 2007, and his treating psychiatrist, Dr. Chandra, documented that plaintiff abused cocaine and used greater-than-the-prescribed amounts of his psychiatric medications. *Cf. Gyllin*, 260 Ill. App. 3d at 716 (the employee denied experiencing any physical impairment); *Simers*,

260 Ill. App. 3d at 412-13 (the expert admitted he had to "surmise" cause); *Coffey*, 165 Ill. App. 3d at 25 (there was no evidence of the plaintiff's condition in the record).

¶ 123 In summary, there was an adequate foundation laid (and expertise) for the witness's testimony that plaintiff's injury was caused by multiple factors—primarily, a history of cocaine abuse and associated inflammation.

¶ *124* *(b) Relevance and Prejudice*

¶ 125 Next, plaintiff argues that Dr. Nemeroff's testimony is so tenuous and lacked a factual nexus that evidence of drug use should have been excluded as irrelevant and prejudicial. Plaintiff complains that Dr. Nemeroff was allowed, without any quantifying test, literature, or personal experience, to give his opinion that drug use caused or contributed to the compartment syndrome. He contends that, without any factual nexus between the drug use and the injury, the evidence was extremely prejudicial. Plaintiff further asserts that defendants never proved anything more than consumption, and, thus, any evidence of consumption (versus impairment) was far more prejudicial than probative, even if relevant. See *Maffett v. Bliss*, 329 Ill. App. 3d 562, 574-75 (2002) (trial court erred in admitting evidence of the plaintiff's past visions problems, where the prejudicial effect outweighed the negligible relevant import of the evidence in her negligence suit against crop harvester operator; some of the vision problems had resolved years before the accident, were insufficiently serious to prevent her from driving, the evidence did not indicate when she had experienced certain vision issues, and their nature and extent were not demonstrated; reversed and remanded for a new trial).

¶ 126 We find plaintiff's argument unavailing. We determined above that there was a proper foundation (and qualifications) laid for Dr. Nemeroff's testimony. We do not agree that it was irrelevant and that any prejudicial impact deprived plaintiff of a fair trial. Dr. Chandra's records,

upon which Dr. Nemeroff relied, documented plaintiff's cocaine and polysubstance abuse. Both of these facts, but primarily the cocaine abuse, in Dr. Nemeroff's opinion, caused plaintiff's compartment syndrome. Plaintiff cannot complain that the central factor of an expert's opinion be omitted from trial because it casts plaintiff in a bad light. We hold that the trial court did not err in allowing this testimony.

¶ 127 4. *Pre-existing Conditions – Effect on Liability and Damages*

¶ 128 Plaintiff's next argument is that Dr. Nemeroff's testimony should have been stricken because it did not affect either liability or damages and was, therefore, irrelevant. He points to the witness's testimony that polysubstance abuse, cocaine, and bipolar disorder were pre-existing conditions that rendered plaintiff more susceptible to injury. Plaintiff also notes that defendants did not argue or submit an instruction on sole proximate cause. He argues that a pre-existing condition making a plaintiff more susceptible to an injury is neither a defense to liability nor a limitation on damages and it irrelevant and inadmissible. We find plaintiff's argument unavailing.

¶ 129 Evidence of a prior existing condition *is* admissible when relevant to negate causation, negate or reduce damages, or to impeach a witness. *Voykin v. Estate of DeBoer*, 192 Ill. 2d 49, 57 (2000). A prior injury is relevant to causation when it makes it less likely that the defendant's actions caused any of the plaintiff's injuries. *Id.* at 58. It is also admissible to show the extent, nature, and effects of the injury. *Requena v. Franciscan Sisters Health Care Corp.*, 212 Ill. App. 3d 328, 332-33 (1991). However, evidence of a prior existing condition should be excluded where there is no evidence of a causal connection between the preexisting condition and the current injury. *Wojcik v. City of Chicago*, 299 Ill. App. 3d 964, 976 (1998).

¶ 130 It is true, as plaintiff argues, that a pre-existing condition cannot limit a plaintiff's damages. Accordingly, here, the jury was instructed that, if they decided for plaintiff on the issue of liability, they could not deny or limit plaintiff's damages because his injury resulted from a pre-existing condition that rendered plaintiff more susceptible to injury. See Illinois Pattern Jury Instructions, Civil, No. 30.21 (Supp. June 2015).

¶ 131 However, when there is an evidentiary basis for an expert's opinion that a pre-existing condition proximately caused the plaintiff's injuries, such testimony is admissible. *Voykin*, 192 Ill. 2d at 57. That was the case here. Dr. Nemeroff testified that plaintiff's compartment syndrome was caused by multiple factors (specifically, vascular disease, inflammation, cocaine abuse, polysubstance abuse, and being hypersomnic), but that the *primary causes* were cocaine abuse and the associated inflammation. This testimony was used to negate plaintiff's argument that his injury was proximately caused by Linden Oaks' staff's failure to interact and monitor plaintiff, take his vital signs, and allowing him to lay in the same position for many hours. There was no error in admitting the testimony.

¶ 132 5. *Disclosure of Polysubstance Abuse Testimony*

¶ 133 Plaintiff's next argument is that Dr. Nemeroff never disclosed any opinion that plaintiff was a polysubstance abuser and, therefore, that testimony should have been barred. We reject this argument.

¶ 134 Rule 213 provides that, for each controlled expert witness, a party must identify "(i) the subject matter on which the witness will testify; (ii) the conclusions and opinions of the witness and the bases therefor; (iii) the qualifications of the witness; and (iv) any reports prepared by the witness about the case." Ill. S. Ct. R. 213(f)(3). Further:

> "The information disclosed in answer to a Rule 213(f) interrogatory, or in a

> discovery deposition, limits the testimony that can be given by a witness on direct examination at trial. Information disclosed in a discovery deposition need not be later specifically identified in a Rule 213(f) answer, but, upon objection at trial, the burden is on the proponent of the witness to prove the information was provided in a Rule 213(f) answer *or in the discovery deposition*. Except upon a showing of good cause, information in an evidence deposition not previously disclosed in a Rule 213(f) interrogatory answer *or in a discovery deposition* shall not be admissible upon objection at trial." (Emphases added.) Ill. S. Ct. R. 213(g).

The "rule is to be liberally construed to do substantial justice between or among the parties." Ill. S. Ct. R. 213(k).

¶ 135 The party offering the testimony "has the burden to prove that the opinions were provided in an answer to a Rule 213 interrogatory or in the witness's discovery deposition." *Wilbourn v. Cavalenes*, 398 Ill. App. 3d 837, 850 (2010); Ill. S. Ct. R. 213(g). Witnesses may elaborate on their properly disclosed opinions, and the fact that their trial testimony is more precise than the originally-disclosed opinion does not violate the rule. *Wilbourn*, 398 Ill. App. 3d at 849. However, the testimony "must be encompassed by the original opinion," and it "cannot state new reasons for the opinion." *Id.* at 849-50. But, as the trial court noted here, "a logical corollary to an opinion or a mere elaboration of the original statement is acceptable." *Id.* at 850.

¶ 136 Dr. Nemeroff's testimony concerning polysubstance abuse was properly disclosed. Although it was not disclosed in defendants' Rule 213 disclosures, the witness addressed polysubstance abuse at his discovery deposition. Specifically, he testified that such abuse, along with plaintiff's bipolar disorder, were the primary causes of his compartment syndrome. He added that plaintiff had a "considerable history" of cocaine abuse and had been prescribed opiate

narcotic analgesics for pain. According to Dr. Nemeroff, the combination of substance abuse and bipolar disorder conferred additional risk of vascular disorders, including compartment syndrome. At trial, Dr. Nemeroff repeated that plaintiff's injury was caused by multiple contributing factors, one of which was polysubstance abuse. He elaborated that the polysubstance abuse was a pre-existing condition that made plaintiff more susceptible to the injury, as was his bipolar disorder and cocaine use, and that polysubstance abuse is a contributing factor to many diseases, including vascular diseases. Plaintiff's records from the Joliet Pain Clinic (which pre-date his visit to Linden Oaks, but include records from 2006 and 2007) reflected that he had used greater-than-the-prescribed amounts of narcotic analgesics (including an example from 2007 of greater-than-prescribed amounts of methadone). Dr. Nemeroff testified that the effects of chronic opiate abuse and chronic cocaine abuse are permanent; that is, over time, polysubstance abuse leaves a permanent scar on your body, including your vasculature.

¶ 137 We reject plaintiff's argument that Dr. Nemeroff's reference to the pain clinic records that reflected that plaintiff had, in plaintiff's view, re-filled a prescription early, was an insufficient foundation or basis for his opinion that it was causally related to his compartment syndrome. At his deposition, Dr. Nemeroff testified that polysubstance abuse was a primary factor in plaintiff's injury, specifically referencing a "considerable history" of cocaine abuse and plaintiff's prescribed opiate narcotic analgesics for pain. At trial, he properly elaborated on this testimony, testifying to the permanent, long-term effects of chronic abuse and specifically referred to a 2007 example from the pain clinic records of overuse of methadone.[5] Accordingly,

[5] Although the trial testimony is not entirely clear, it appears that plaintiff was taking a dosage of at least 30% more than the prescribed amount of methadone at this time: 120

as the foregoing reflects, the witness's testimony concerning polysubstance abuse was disclosed at his discovery deposition and repeated and properly elaborated upon at trial. The trial court did not abuse its discretion in allowing it.

¶ 138 6. *Testimony Concerning Drug Injection*

¶ 139 Next, plaintiff argues that the trial court erred in allowing Dr. Nemeroff (over plaintiff's objection and through the court's denial of a motion *in limine*) to testify about the difference between injecting and snorting cocaine. He contends that there was never any proof, direct or circumstantial, that plaintiff ever injected any substance. We reject this argument.

¶ 140 At trial, defense counsel asked Dr. Nemeroff about the effects on the vasculature of snorting cocaine versus injecting it and whether cocaine that is snorted acts on one part of the body versus the entire system. Over plaintiff's *Rule 213 objection*, Dr. Nemeroff testified that snorted cocaine is very rapidly absorbed as compared to injecting it because the nose's vasculature is one of the richest in the body. Addressing which body parts are affected, he testified that it depends on what is going on locally. For example, if a person has a family history of heart disease, he or she is genetically vulnerable and cocaine may cause a heart attack or stroke.

¶ 141 We find plaintiff's argument asserting lack of foundation forfeited because that is not the objection he raised at trial. *Young v. Alden Gardens of Waterford, LLC*, 2015 IL App (1st) 131887, ¶ 71 (failure to raise or renew objection at trial results in forfeiture of issue on review).[6]

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milligrams per day versus a 90-milligram prescribed amount.

[6] Forfeiture aside, we conclude that the foundational argument fails because the effects of injecting cocaine were raised throughout trial, including by plaintiff's counsel during opening statements and by other witnesses (without objection by plaintiff). Accordingly, even if there

At trial, plaintiff argued that the witness's opinion was not properly disclosed. As to the Rule 213 objection, we conclude that the trial court did not err in allowing the testimony. At his deposition, Dr. Nemeroff was asked if he knew whether plaintiff snorted cocaine or administered it intravenously, and he stated that he did not know and that it would not matter if it was used chronically. He further stated that both could result in compartment syndrome, but intravenous use would be a greater risk. Because he addressed the issue of intravenous cocaine use at his deposition and its relationship to compartment syndrome, Dr. Nemeroff's trial testimony concerning the drug's absorption and its effects on the body were proper elaborations upon this testimony. The trial court did not abuse its discretion in allowing the testimony.

¶ 142 B. Closing Argument

¶ 143 Next, plaintiff argues that he is entitled to a new trial because defense counsel, in closing argument, mischaracterized the facts and appealed to the jurors' emotions and prejudice, which led to a biased verdict rather than an impartial consideration of the evidence. For the following reasons, we reject this argument.

¶ 144 The purpose of closing argument is to draw reasonable inferences from the evidence and assist the jury in fairly arriving at a verdict based on the law and evidence. *Copeland v. Stebco Products Corp.*, 316 Ill. App. 3d 932, 948 (2000). As a result, counsel is afforded wide latitude during closing argument and may comment and argue on the evidence and any reasonable inferences that may be fairly drawn from the evidence. *Clarke v. Medley Moving & Storage, Inc.*, 381 Ill. App. 3d 82, 95 (2008). "Even improper statements will not warrant reversal without a substantial showing of prejudice." *Wilbourn*, 398 Ill. App. 3d at 855. Where the trial

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was any error in allowing it, there was no prejudice to plaintiff because the issue was raised multiple times at trial without objection.

was fair and the evidence sufficient to support the jury's verdict, a reviewing court will not reverse. *Id.*

¶ 145 Plaintiff contends that the subject matter of Dr. Nemeroff's speculation deprived plaintiff of a fair trial and asserts that there was no testimony or opinion that plaintiff had a diminished life expectancy.

¶ 146 During closing argument, defense counsel stated that plaintiff tried to minimize his cocaine use during his testimony because "Less cocaine, less likelihood of vasoconstriction. I mean, that's pretty obvious to all of you." Defense counsel stated that plaintiff "denies that he was ever told that he should take a drug holiday." Plaintiff's counsel did not object to these comments.

¶ 147 Next, after defense counsel noted that plaintiff sought over $3 million in damages, she also stated that they were based on "the effect on somebody's life, and you'd have to consider the effect on [plaintiff's] life of all of the things that he does, cocaine, alcohol." At this point, plaintiff's counsel objected, stating that the comment was prejudicial and not based on the evidence. The trial court overruled the objection, noting that the jury would weigh the evidence and that plaintiff's counsel could comment on it during rebuttal (a transcript of which his not contained in the record on appeal). Defense counsel continued, stating that plaintiff had a diminished life expectancy due to his bipolar disorder. She noted that 31 years was an average life expectancy (the jury was similarly instructed that the average life expectancy of a 50-year-old is 31.6 years), but it did not take into account "what the life expectancy would be of someone that has other issues going on." The jury was instructed that its verdict "must be based only on the evidence presented" and that, if an attorney's statement or argument "is not supported by the law or the evidence, you should disregard that statement or argument."

¶ 148 Plaintiff complains that there was no testimony concerning the amount of cocaine plaintiff used and that defense counsel stated in closing argument that plaintiff tried to minimize his use. We find his argument unavailing. Dr. Chandra testified that plaintiff abused cocaine, as did Dr. Nemeroff (who further testified that the medical community did not know what amount of cocaine will have a physiological effect on a given person). Dr. Ovsiew and nurse Levin testified that compartment syndrome can be caused by cocaine. Additionally, Dr. Karlsson, the emergency room surgeon, could not rule out cocaine as causing or contributing to plaintiff's injury. Further, the evidence showed that plaintiff inconsistently reported his cocaine use prior to his admission to Linden Oaks (specifically, Dr. Chandra noted that plaintiff had last used cocaine one week earlier, but defendant reported to Dr. Asensio that he used it years ago and denied any recent use), which reasonably allows an inference that he wanted to minimize his use. Turning to the comment concerning a "drug holiday," we agree that it was improper, but we cannot conclude that it was so prejudicial that it affected the outcome of the trial. Next, as to counsel's comments concerning the effect a verdict in plaintiff's favor would have on his life "considering that he does cocaine and consumes alcohol" (implying that plaintiff would spend the money on consuming those items) we again agree that the comment was improper. "Generally, errors at trial relating solely to damages will not be considered on appeal where it is evident that the jury, having found in favor of the defendant as to liability, never reached the question of damages." *McDonnell v. McPartlin*, 192 Ill. 2d 505, 531 (2000). However, "[a]n exception exists where errors which go to the question of damages are 'so pervasive and prejudicial as to create the likelihood that they may have affected a jury's decision on the issue of liability.' " *Id.* (quoting *Mulvey v. Illinois Bell Telephone Co.*, 53 Ill. 2d 591, 599-600 (1973)). We conclude that, here, the comment (either alone or together with the "drug holiday"

comment) was not pervasive and so prejudicial that it likely affected the jury's decision on liability. Accordingly we cannot conclude that plaintiff was deprived of a fair trial.

¶ 149 Finally, we address plaintiff's assertion that there was no testimony that plaintiff had a diminished life expectancy. We disagree with plaintiff on this point. Dr. Nemeroff testified that chronic opiate and cocaine use leave permanent scars on your body, including your vasculature. He also testified (and has published articles on this point) that people with bipolar disorder are at risk for vascular disease and have about a four-year reduced life expectancy.

¶ 150 In summary, plaintiff was not unfairly prejudiced by defense counsel's closing argument remarks.

¶ 151 III. CONCLUSION

¶ 152 For the reasons stated, the judgment of the circuit court of Du Page County is affirmed.

¶ 153 Affirmed.