2021 IL App (3d) 200128-U

Order filed October 20, 2021

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IN THE

APPELLATE COURT OF ILLINOIS

THIRD DISTRICT

2021

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| BIRGIT S. HUFFMAN,<br><br>Plaintiff-Appellant,<br><br>v.<br><br>KATZ, HUNTOON and FIEWEGER, P.C.; KATZ NOWINSKI, P.C., f/k/a Katz, Huntoon and Fieweger, P.C.; and STEPHEN T. FIEWEGER,<br><br>Defendants-Appellees. | ) | Appeal from the Circuit Court of the 14th Judicial Circuit, Rock Island County, Illinois.<br><br>Appeal No. 3-20-0128<br>Circuit No. 17-L-29<br><br>Honorable Mark A. VandeWiele, Judge, presiding. |

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JUSTICE DAUGHERITY delivered the judgment of the court.
Justices Schmidt and Wright concurred in the judgment.

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**ORDER**

¶ 1 *Held*: The trial court erred in granting summary judgment in favor of the defendants on plaintiff's legal malpractice claim where there was a fact issue remaining as to whether the negligence of plaintiff's treaters in her underlying medical malpractice claim was a proximate cause of plaintiff's injuries.

¶ 2 Plaintiff, Birgit S. Huffman, filed a legal malpractice action against defendants, Katz, Huntoon and Fieweger, P.C., Katz Nowinski, P.C. (formerly known as Katz, Huntoon and Fieweger, P.C.), and Stephen T. Fieweger, stemming from defendants' legal representation of

plaintiff in a medical malpractice case. Defendants filed a motion for summary judgment pursuant to section 2-1005 of the Code of Civil Procedure (Code) (735 ILCS 5/2-1005 (West 2018)), which the trial court granted. Plaintiff appeals, arguing the trial court erred by granting summary judgment in favor of defendants. We reverse and remand.

¶ 3 I. BACKGROUND

¶ 4 A. Factual Background Set Forth by Trial Court

¶ 5 In its order granting summary judgment, the trial court indicated it "takes judicial notice and incorporates by reference" plaintiff's medical malpractice cases (case nos. 2014-L-79 and 2015-L-87), noting those cases are "relevant to the present case." Those cases are not included in the record on appeal.

¶ 6 The trial court set forth the following "Factual Background" in its order. Plaintiff's medical history included two prior spine surgeries (in 2005 and 2008), which resulted in her spine being fused from her thoracic vertebrae at T11 down to her lumbar vertebrae at L4. In December 2010 and November 2011, plaintiff experienced back pain and sought medical treatment from ORA Orthopedics, P.C. (ORA Orthopedics). Dr. Timothy Millea saw plaintiff in November 2011, and testified in his deposition that surgery was not mandatory at that time and he advised plaintiff, "in the absence of progressive or severe neurologic deficits, that surgery is certainly not mandatory." Plaintiff declined surgery at that time. On April 19, 2012, plaintiff (at age 68) underwent a right knee replacement surgery and, on May 24, 2012, underwent another surgery by Dr. Suleman Hussain of ORA Orthopedics on the same knee due to a prosthetic joint infection. On June 2, 2012, plaintiff went to the Trinity emergency room complaining of upper back and knee pain following a series of falls. She was diagnosed with a new T11 compression fracture at the top of her prior fusion. The trial court indicated that the next day (on June 3,

2012), Dr. Steven Boardman (an ORA Orthopedics surgeon) examined plaintiff and that he "recommended conservative treatment through pain medication and immobilization and his findings were communicated to Hussain." Plaintiff was periodically seen through July 25, 2012, at ORA Orthopedics for wound checks. By July 25, 2012, plaintiff was complaining of loss of function in her lower extremities. On July 31, 2012, plaintiff was examined by Dr. Myles Luszczyk, who noted issues of weakness and most likely permanent paralysis progressing over the past month. Luszczyk referred plaintiff for surgery. On August 2, 2012, plaintiff underwent a third spine surgery by Dr. Jeffrey Akeson, a pediatric spine surgeon, with the assistance of his partner Dr. Mulconrey, an adult spine specialist. In its order, the trial court indicated, "Akeson does not hold himself out as an adult spine specialist," but he "does hold himself out as a well-qualified general orthopedist."

¶ 7 The trial court further indicated in its order that plaintiff had hired attorney Fieweger, who filed case no. 2014-L-79 against Trinity Medical Center (on June 26, 2014). That case was subsequently voluntarily dismissed on September 18, 2014. Plaintiff hired subsequent counsel, who filed case no. 2015-L-87 against Heartland, Trinity Medical Center, ORA Orthopedics, Boardman, and Hussain. Summary Judgment was entered in that case for Heartland, ORA Orthopedics, Boardman, and Hussain because the claim had not been timely filed. Summary judgment was also subsequently entered in favor of Trinity Medical Center.

¶ 8 B. Plaintiff's Legal Malpractice Complaint

¶ 9 On March 14, 2017, plaintiff, by and through her new attorneys, filed this legal malpractice action (case no. 2017-L-29) against defendants (the law firm of Katz, Huntoon & Fieweger, the law firm of Katz Nowinski (formerly known as Katz, Huntoon and Fieweger), and attorney Fieweger).

¶ 10 1. Background Facts Alleged in the Complaint

¶ 11 In her complaint, plaintiff alleged, *inter alia*, the following. On June 2, 2012, she went to the emergency room at Trinity complaining of upper back and knee pain, was diagnosed with a new T-11 compression fracture, and was admitted to the hospital. The following day, she had an orthopedic consultation with Boardman, who noted the T-11 compression fracture, recommended conservative treatment with pain medicine and early mobilization, and noted that he would discuss plaintiff's case with Hussain. On June 6, 2012, plaintiff was transferred from Trinity Medical Center to Heartland of Moline (Heartland of Moline IL, LLC, d/b/a Heartland Healthcare Center-Moline (Heartland)) for further care and treatment. Upon her admission at Heartland, the T-11 compression fracture was noted. On June 11, 2012, plaintiff presented to ORA Orthopedics for a wound check of her right knee and was seen by physician assistant, Bradi Kipper. On June 20, 2012, plaintiff was again seen by Kipper, who noted that plaintiff had arrived in a wheelchair. From June 22 to 26, 2012, plaintiff was admitted to Trinity Medical Center (due to an infection) and then returned to Heartland. On July 6, 2012, plaintiff was seen by Hussain, who noted plaintiff presented in a wheelchair with an antalgic gait. On July 25, 2012, plaintiff was again seen by Hussain, who noted plaintiff's complaints of loss of function of her lower extremities. Hussain referred plaintiff to Luszczyk. Plaintiff alleged that from June 6 to July 31, 2012, she had exhibited signs and symptoms of neurological changes, including increased back pain, decreased function in her lower extremities, increased difficulties with bowel and bladder function, and significant numbness and inability to move her feet. On July 31, 2012, plaintiff was seen by Luszczyk, who noted plaintiff's history of increased back pain, decreased function in the lower extremities, increased bowel and bladder function, and significant numbness and inability to move her feet. Luszczyk assessed plaintiff as having

adjacent segment kyphosis, catastrophic collapse, and progressive paralysis, and he recommended "emergent" admission to the hospital for further care and treatment, including surgical intervention. Plaintiff was transferred from Trinity to a hospital in Peoria, Illinois, where she underwent a third spine surgery.

¶ 12 On October 11, 2012, plaintiff retained defendant law firm Katz, Huntoon and Fieweger, by and through defendant attorney Fieweger, to file a medical malpractice action against any potentially liable parties for injuries she sustained from June 2, 2012, through July 31, 2012. On June 26, 2014, Fieweger filed a complaint against Trinity Medical Center for medical negligence stemming from an alleged fall at Trinity on June 26, 2012. On September 12, 2014, Fieweger filed a motion to voluntary dismiss the complaint, which was granted on September 18, 2014, with leave to refile in one year. On September 22, 2014, Fieweger wrote plaintiff a letter informing her an expert could not be found to render an opinion in her favor by the deadline to disclose (on September 24, 2014), and they would be required to voluntarily dismiss the case.

¶ 13 On April 30, 2015, plaintiff hired the law firm of Kralovec, Jambois and Schwartz. On June 23, 2015, that law firm filed a medical malpractice complaint on plaintiff's behalf against Heartland, Trinity, ORA Orthopedics, Boardman, and Hussain. On January 11, 2017, the trial court granted Heartland, ORA Orthopedics, Boardman, and Hussain's motions for summary judgment based upon plaintiff's failure to timely file her complaint and, on February 7, 2017, also granted Trinity's motion for summary judgment.

¶ 14 2. Medical Malpractice Claim

¶ 15 As part of the allegations set forth in her legal malpractice complaint, plaintiff reiterated the following allegations from her medical malpractice complaint.

¶ 16 Plaintiff alleged in Count I that Heartland was negligent for failing to provide proper nursing care. Specifically, she alleged that Heartland violated provisions of the Nursing Home Care Act for failing, among other things, to monitor and treat her deteriorating condition and inform her physician in a timely manner of significant events and changes in her clinical condition.

¶ 17 She alleged in Count II that Heartland was guilty of one or more negligent acts or omissions, including, among other acts and omissions, failing to: document her true status and condition; treat her signs and symptoms of neurological deficit; adequately monitor, adequately treat, and timely treat her thoracic back condition from June 6 to July 31, 2012; recognize the importance of her complaints of increased back pain, decreased function in her lower extremities, increased difficulties with bowel and bladder function, and significant numbness and inability to move her feet; adequately monitor and treat her deteriorating condition; notify the physicians of a change in condition; and timely transfer her to an acute care facility.

¶ 18 In Count III, plaintiff alleged that Trinity Medical Center, by and through its agents, including Boardman, was guilty of one or more negligent acts or omissions, including: failing to communicate (communicate generally and specifically, communicate to Heartland) that her T-11 compression fracture needed to be monitored further and needed further treatment; failing to refer plaintiff to a qualified specialist following the June 2, 2012, T-11 compression fracture diagnosis; failing to properly monitor and properly treat plaintiff; and failing to adequately monitor and treat plaintiff's signs and symptoms of neurological deficit during her admission to Trinity from June 22 to 26, 2012.

¶ 19 In Count IV, plaintiff alleged that ORA Orthopedics, by and through its agents, including Boardman and Hussain, was guilty of one or more negligent acts or omissions, including: failing

to communicate (communicate generally and specifically, communicate to Heartland) that plaintiff's T-11 compression fracture needed to be monitored and needed further treatment; failing to timely refer plaintiff to a qualified specialist following the June 2, 2012, T-11 compression fracture diagnosis; failing to timely refer her to a qualified specialist following her signs and symptoms of neurological deficit; failing to properly monitor and adequately treat her signs and symptoms of neurological deficit; failing to adequately monitor, adequately treat, and timely treat plaintiff's thoracic back condition during June 2 through July 31, 2012; failing to recognize the importance of her complaints of increased back pain, decreased function in her lower extremities, increased difficulties with bowl and bladder function, and significant numbness and inability to move her feet; and failing to adequately monitor and treat her deteriorating condition.

¶ 20 In Count V, plaintiff alleged that Boardman was guilty of one or more negligent acts or omissions, including failing to communicate that plaintiff's T-11 compression fracture needed to be monitored further and needed further treatment; failing to communicate to Heartland that plaintiff's T-11 compression fracture needed to be monitored and needed further treatment; failing to timely refer plaintiff to a qualified specialist following the June 2, 2012, T-11 compression fracture diagnosis; and failing to properly monitor and properly treat plaintiff.

¶ 21 In Count VI, plaintiff alleged that Hussain was guilty of one or more various negligent acts or omissions, including failing to communicate (communicate generally and specifically, to Heartland) that plaintiff's T-11 compression fracture needed to be monitored further and that it needed further treatment; failing to timely refer plaintiff to a qualified specialist following the June 2, 2012, T-11 compression fracture diagnosis; failing to timely refer plaintiff to a qualified specialist following her signs and symptoms of neurological deficit; failing to properly monitor

and properly treat plaintiff; failing to adequately monitor and adequately treat plaintiff's signs and symptoms of neurological deficit; failing to adequately monitor, adequately treat, and timely treat plaintiff's thoracic back condition during the period of June 2 through July 31, 2012; failing to recognize the importance of plaintiff's complaints of increased back pain, decreased function in her lower extremities, increased difficulties with bowel and bladder function, and her significant numbness and inability to move her feet; and failing to adequately monitor and treat her deteriorating condition.

¶ 22 Plaintiff also alleged in the medical malpractice complaint that as a result of the negligent acts or omission of the named medical providers, she received care and treatment below the standard of care, constituting negligence, and as a result of receiving negligent treatment over a prolonged period of time, she sustained serious permanent injuries, suffered from disability and disfigurement, and experienced great pain and physical suffering.

¶ 23 3. Legal Malpractice Allegations

¶ 24 Plaintiff further alleged in her legal malpractice complaint that defendants were negligent in the handling of her medical malpractice claim by, *inter alia*, failing to: timely file a negligence lawsuit against Heartland, Trinity, ORA Orthopedics, Boardman, and Hussain; failing to timely file a negligence lawsuit against Trinity for failure to diagnose and treat plaintiff's T-11 compression fracture; and failing to act skillfully and diligently on plaintiff's behalf. Plaintiff alleged that but for defendants' negligence, her claims against Heartland, Trinity, ORA Orthopedics, Boardman, and Hussain would have resulted in a verdict or settlement in her favor and that, as a direct and proximate result of the alleged negligent acts or omissions of defendants, she was precluded from pursuing a medical negligence cause of action against Heartland, Trinity, ORA Orthopedics, Boardman, and Hussain for damages.

¶ 25 C. Defendants' Motion for Summary Judgment

¶ 26 Following discovery in this case, defendants filed a motion for summary judgment. Defendants argued that plaintiff could not establish that the alleged medical negligence caused her any harm, so that even if her claim had been properly pursued by defendants, she failed to show that she would have received a verdict in her favor. Specifically, defendants contended there was no testimony from any medical expert that the alleged negligence by plaintiff's medical providers proximately caused plaintiff to be injured.

¶ 27 In response, plaintiff argued that the x-ray taken on June 2, 2012, showed a "catastrophic collapse of [her] vertebrae," which required further imaging, a referral to a spine surgeon, and regular monitoring for neurological deficits. Plaintiff contended that due to the negligence of her providers in delaying treatment, her spinal condition was left untreated and her neurological function deteriorated past a point of meaningful recovery. Plaintiff argued the delay in treatment cost her the chance to recover the full use of her lower extremities. She contended that defendants' motion for summary judgment overlooked the "lost chance doctrine," under which she argued that her medical providers' failure to recognize, definitively diagnose, monitor, and treat her spinal condition, on and after June 2, 2012, allowed her condition to deteriorate and caused a delay in surgical intervention until August 2, 2012, at which point it was too late for her neurologic function to be recovered in any meaningful way. Plaintiff contended there had been "extensive testimony from various physicians" that with earlier intervention for a patient such as herself, there was a higher likelihood of a positive outcome.

¶ 28 In support of the motion for summary judgment and the response and reply thereto, the parties referenced and attached various exhibits, which included the deposition transcript of plaintiff's medical expert witness, Dr. Asheesh Bedi; the deposition transcript of defendants'

medical expert witness, Dr. Wellington Hsu; and the deposition transcripts of plaintiff's treaters, Akeson, Luszczyk, and Millea.

¶ 29 1. Deposition Testimony of Dr. Timothy Millea

¶ 30 Millea testified in his deposition that he was a board certified orthopedic surgeon employed by ORA Orthopedics. He had been board certified for 27 years. His practice was "entirely spine." Millea had reviewed plaintiff's ORA Orthopedics medical records and testified in accordance with those records.

¶ 31 Millea testified that plaintiff had her first fusion surgery in 2005 and a second fusion surgery in 2008. On November 18, 2010, plaintiff presented to ORA Orthopedics with a slow gait and round back deformity, particularly at the midback, and could not change her "kyphosis" (rounded back). The note meant that plaintiff was hunched over in the midback area and was not able to correct her posture. Plaintiff was referred for a surgical consultation. On December 8, 2010, plaintiff was seen by Dr. Collins and reported stabbing, throbbing pain (rated at 10 out of 10). She reported being able to walk less than one block without symptoms and that she had to use a walker for any distance more than five feet. Pain medication (which included opioids) relieved some, but not all, of her pain. Upon reviewing plaintiff's imaging, Collins noted it appeared as though plaintiff had a "transitional kyphosis." He also noted that plaintiff was not demonstrating any neurological changes or instability. Collins did not recommend surgery at that time, noting that indications for surgery would be instability, a neurologic change, or failure of the hardware (from her prior surgeries).

¶ 32 Millea testified that he agreed with Collins' assessment that plaintiff did not yet require surgery at that time because there was no apparent instability and no neurological symptoms. Given plaintiff's history, it would be the development of further neurological symptoms that

would largely answer the question of whether surgery remained discretionary. Millea defined "neurologic deficits" as "a definite change, decrease in strength." He explained that "sensation[s]"—numbness, tingling, prickly feelings—were not objectively measured, but a "strength deficit"—things like loss of bowel control, complete loss of lower extremity function—"that's a game changer there." He stated, "the game changers here would be neurologic deficits or a significant progression in the kyphosis." He agreed that neurological deficits such as marked weakness in the lower extremities, reflex degradation, and bladder control issues were the types of deficits that would move a surgery from discretionary toward mandatory. He testified, "any change in [a] neurologic examination, objective evidence" would be the "tip-off." Millea agreed that if certain segments of the spine are fused, there would be more stress on the segment north of that fusion. After a second fusion surgery, the likelihood of needing a subsequent revision fusion procedure increased. Millea stated statistics for someone to break down in that way were "as low as 10 to 15 percent" and in some studies 40 to 50 percent.

¶ 33 On November 16, 2011, when Millea saw plaintiff, her chief complaint was back pain. The purpose of plaintiff's consultation with Millea was to see if there was anything Millea could offer by way of surgery to help plaintiff with her chronic back pain. Plaintiff presented using a walker and her strides were very short. She also presented with same forward tilt to her posture as reported in 2010. Millea testified her use of a walker was understandable given her history of knee issues. Millea had noted that plaintiff's kyphosis was not a gibbus deformity (a more pronounced deformity at a sharp angle). Millea tested the strength of plaintiff's lower extremities, which was normal. There were no neurological findings indicating that surgery was necessary. Millea compared plaintiff's x-ray to a prior x-ray from 2010, noting her kyphosis had not changed to a significant degree.

¶ 34 Millea testified that he did not feel a third back surgery was necessary at that point, in part, due to a lack of neurological deficits. He explained that in doing an operation, he would like to check off four criteria: (1) nothing less is adequately helping (he testified that plaintiff was there "in spades with this"); (2) quality of life is unacceptable (he testified, "she [was] there"); (3) there is a reasonable chance of getting better (he testified that was "debatable"); and (4) the benefits outweigh the risks and complications (he testified that was "very debatable" due to the risks of plaintiff developing neurological deficits simply from having surgery).

¶ 35 Millea testified that his notes did not reflect it, but he "hoped" that he had gotten across to plaintiff that it was best to hold off on surgery until it was a "no way out of this" predicament, which would be at the time of "neurologic deficits or essentially pain that almost confined her to bed." Millea had advised plaintiff that "in the absence of progressive or severe neurologic deficits, that surgery is certainly not mandatory." He "strongly suspected" that he had explained what progressive or severe neurologic deficits that plaintiff should look for that would change having surgery to mandatory. He assumed he would have given plaintiff "the warning signs," and he "hoped" that he had advised her to call him (or someone) if she started having leg weakness, numbness or tingling in her lower extremities, uncontrollable pain, or bladder control issues. He indicated, "I usually do." He acknowledged that what he had, in fact, advised plaintiff was not well documented. He stated, "you've got to give her some indication, what do you look out for that says, now it's time to go," which was his normal habit or protocol.

¶ 36 Millea testified that elective surgery was offered in November 2011, and plaintiff declined having the elective surgery. Millea explained that even if plaintiff had been intent on having the surgery, he would generally tell a patient, unless it is an emergency, go home and think about it because "[i]t's a big deal." Millea's notes indicated, "[s]he is not at all interested in

further surgery at the present time, given her history." Millea gave plaintiff the option of calling back if she changed her mind.

¶ 37 In regard to plaintiff's gait issues since she had the third surgery on August 2, 2012, Millea testified:

> "The fact that she developed the paraparesis, the spinal cord compression, once the spinal cord has been irritated like that, it is very, very unpredictable and not highly likely there's significant recovery with that."

¶ 38 Millea testified that Akeson's notes from plaintiff's third spine surgery on August 2, 2012, indicated a two or three-month history of persistent back pain and progressive lower extremity weakness and numbness with bladder dysfunction, which Millea agreed outlined a two-to-three-month history of "neurological deficits." Akeson's preoperative report, however, had indicated "progressive weakness and bladder difficulty over the past 3 weeks." Akeson had also noted that plaintiff's x-ray from Trinity (June 2, 2012) showed a kyphotic deformity (rounded back) and fracture of T10-T11. Millea explained that a "kyphotic deformity" is a greater angle than normal, which plaintiff had in November 2011 but not to the degree that she had in 2012.

¶ 39 Millea testified that because there was not a significant change in plaintiff from 2010 to 2011, he did not measure plaintiff's Cobb angle (the angle of the tilt of the spine). Millea testified there is not a "threshold" increase of a Cobb angle that is indicative of whether surgery was emergent or urgent. Determining whether surgery was emergent or urgent would be based on a combination of factors—"the severity of the deformity in light of neurologic deficits." Millea testified that in a normal spine, a Cobb angle of the T10 and T11 was probably 10 degrees or less, and if it slipped, as plaintiff's had slipped, the Cobb angle could be 30 or 40. An

increased Cobb angle was one factor that went into the decision for surgery. The "key" was documenting a change.

¶ 40 Millea agreed that if plaintiff was going to need surgery for a "kyphotic situation," he would want to do it before there is damage to the spinal cord "or at the earliest indication of damage to the spinal cord." Plaintiff's attorney asked whether a catastrophic collapse of the kyphosis was the type of thing that a spine surgeon would consider as a reason to suggest surgery. Millea responded that if plaintiff had the increased kyphosis without neurologic deficits, he probably would have recommended surgery but "the combination of the two" would have been the "tipping point." If there had been a "catastrophic collapse" but the spinal cord function was not impaired, it would not be an "emergent" procedure. An "emergent versus urgent" surgery would depend on clinical signs and symptoms. Millea testified that a surgeon trained in following patients who potentially may need surgery would start following the patient. In following a patient with kyphosis, future treatment would depend on future radiologic studies.

¶ 41 2. Deposition Testimony of Dr. Myles Luszczyk

¶ 42 Luszczyk, an orthopedic spine surgeon with ORA Orthopedics, saw plaintiff on July 31, 2012. Luszczyk noted plaintiff had reported extreme pain to Millea on November 16, 2011. Millea had indicated that in the absence of progressive or severe neurologic deficits, surgery certainly was not mandatory. Luszczyk agreed with that assessment. If Luszczyk had seen plaintiff on November 16, 2011, he would have asked her to follow up and would have educated her on things to look for.

¶ 43 Luszczyk testified that plaintiff's x-ray of November 16, 2011, showed "adjacent segmental disease." From plaintiff's x-rays, Luszczyk testified that, plaintiff had a Cobb angle of 25 degrees on November 16, 2011, a Cobb angle of 31.6 degrees on June 2, 2012, and a Cobb

angle of 39 degrees on July 25, 2012 (plus or minus 5 degrees on the measurements). Luszczyk testified those were significant changes.

¶ 44 From when Millea saw plaintiff on November 16, 2011, until Luszczyk first saw plaintiff on July 31, 2012, and Luszczyk diagnosed her with "adjacent segmental disease with kyphosis and collapse," plaintiff's condition had gotten worse. The surgery that had been recommended by Millea was elective in November 2011, but it became emergent in July 2012.

¶ 45 Luszczyk further testified that the development of adjacent segment disease is a natural progression and, over time, the treatment to stabilize it "involves more surgery." Given plaintiff's age (75 years old at the time of the deposition), two prior knee surgeries, three spine surgeries, and the status of her fusion from S1 to T4, Luszczyk would expect her to have "some mobility issues" and limitations, irrespective of whether the third surgery took place in November 2011 or July 2012.

¶ 46 In reference to plaintiff's visit with him on July 31, 2012, Luszczyk had noted under plaintiff's "history of present illness" that "over the past month" plaintiff was having "more and more pain in the back," she was "listing forward more recently," and "again in the past month she's lost function in her lower extremities." In regard to the same one-month progression, plaintiff had reported becoming "more and more incontinent" and having "difficulties with bladder function as well as bowel function." Luszczyk also had noted plaintiff had "significant numbness and inability to move her feet," which he understood had been progressive over the last month. Plaintiff had indicated that she thought the loss of function in her lower extremities could possibly be related to her previous knee surgeries and deconditioning from the surgeries. Luszczyk could not remember how he felt at that time about her assessment of the source of her leg weakness.

¶ 47 Upon examining plaintiff, Luszczyk noted that plaintiff was "unable to walk secondary to weakness." He testified that as of July 31, 2012, plaintiff could not walk. In examining plaintiff and measuring plaintiff's lower extremities strength, the results showed neurologic compromise. Luszczyk could not determine how long the neurologic injury had been present. In assessing plaintiff on July 31, 2012, Luszczyk noted, "[a]t this point in time [plaintiff] is a 69-year-old female with adjacent segment kyphosis, catastrophic collapse, and progressive paralysis."

¶ 48 Luszczyk testified a "catastrophic collapse" was visible on the x-ray taken on June 2, 2012, which he described as plaintiff having "had developed incompetence throughout the segment that was causing her to develop this acute angle." He testified the x-ray at or about the T11 level was indicative of "adjacent segment disease," which over time results in failure. Plaintiff's subsequent x-rays from July 25, 2012, showed a "very acute angle to her thoracic spine," which was "not a natural occurrence." Based on his review of plaintiff's radiographs from 2010 through July 25, 2012, Luszczyk stated, "[t]his was slowly progressing in time."

¶ 49 Luszczyk testified that over time, after a fusion surgery, the patient will start "stressing" the levels above and below a fusion, leading to "adjacent segment disease" resulting in "stenosis." Adjacent segment disease refers to the breakdown of the level above and the level below the fusion—for plaintiff, it was the level above her previous construct and fusion. He explained that "stenosis" is compression on the nerves and potentially the spinal cord. Stenosis is a natural expectation after one fusion surgery and becomes more likely depending upon the length of the fusion. Based on his experience, Luszczyk testified the likelihood of an additional surgical intervention would increase after a person had a fusion surgery and then had another surgery to extend that initial fusion. Because of the progression of plaintiff's condition and the fact that she had earlier fusions, she most likely was going to require a third fusion surgery.

Typically, spine surgeons would want to perform such a third fusion surgery before their patients are paralyzed and before they develop serious neurological deficits. The fact that plaintiff was progressively not able to ambulate was a significant neurological change. Once there is a catastrophic collapse with significant neurological deficit, the goal would be to get the patient to surgery as quickly as possible in order to preserve neurological function before a patient becomes paralyzed.

¶ 50 An "absolute" indication for surgery in a patient with a progressive condition such as adjacent segmental disease is the development of some neurologic symptomatology. While neurological deficits are an absolute surgical indication, another surgical indication would be worsening instability, which can be seen on radiologic studies, where there are no neurological deficits. In regard to plaintiff, Luszczyk did not feel comfortable making a statement as to when the third fusion surgery became medically necessary for plaintiff.

¶ 51 When asked the treatment options for someone who had a prior fusion and was experiencing pain with adjacent segmental disease, Luszczyk indicated that surgical intervention would be indicated once "we start losing function" or if a patient has deemed their quality of life is unacceptable and wanted to have surgery. In the majority of cases, the progressive development of the adjacent segmental disease is a slow progression, although there are some instances where it can progress very rapidly. Luszczyk testified that plaintiff's adjacent segment disease was shown on the x-ray of June 2, 2012, and was an indication of such an ongoing progression. He believed that statistically, from November 2011 forward, plaintiff would have needed a third surgery to extend her fusion at some point if she lived long enough (barring some catastrophic event where she lost her life) as part of the natural progression of her condition and the treatment required.

¶ 52 Luszczyk testified comorbidities are a factor in such a progression and plaintiff had comorbidities that impacted the assessment and treatment of her thoracic spinal condition—having undergone a knee replacement surgery, contracting an infection after that surgery, developing a subsequent infection that mostly likely deconditioned her, and having a history of gastric bypass where her tissue quality would be very poor. Luszczyk did not have any criticisms of the care provided to plaintiff by Boardman or Hussain.

¶ 53 In plaintiff's case, her "adjacent segment disease" was a breakdown at the level above her previous construct and fusion. The structural collapse was a "continuum" of the adjacent segment disease. Neurologic symptoms would occur in a patient, such as plaintiff, where there is some injury to the spinal cord (either from constant pressure on the spinal cord from critical stenosis or from dynamic instability where things shift). Luszczyk testified in regard to plaintiff, "I can't state for certain which specific structure was causing the injury, but globally she was developing injury" at the "T10 to T11 level." He had no way of being able to state when her condition progressed to the point of her experiencing neurologic symptoms and necessitating surgery. He testified that by the time he examined plaintiff on July 31, 2012, surgery was needed.

¶ 54 In examining plaintiff on July 31, 2012, Luszczyk wrote:

> "Sadly the patient does have a rather significant issue. She does have weakness and most likely permanent paralysis progressing over the past month. I cannot guarantee that any type of surgery would improve any of this function. I do think that it's imperative that we stabilize the adjacent segment."

Luszczyk's reference to a "one-month progression" in his note was based on plaintiff's subjective complaints to him.

¶ 55 Luszczyk testified that "statistically" once function is lost, it is hard to regain it, particularly in the setting of developing chronically over time and particularly where there are comorbidities involved, as opposed to, for example, a situation where a young person acutely ruptures a disk that creates neurologic dysfunction and an operation takes place within 24 to 48 hours to allow recovery. He stated that with plaintiff as of July 31, 2012, it would have been a "rarity for [them] to recover that functional loss." At that point, Luszczyk recommended surgery, not with the hope of restoring some neurologic function but, rather, to "stabilize her spine and prevent further progression of neurologic dysfunction" so as to preserve what function she had left.

¶ 56 Because the surgery could not be performed at Trinity's hospital, plaintiff was transferred to St. Francis Medical Center in Peoria, Illinois, and Akeson performed the surgery on plaintiff on August 2, 2012. After the operation, Luszczyk first saw plaintiff on August 23, 2012, for her first postoperative visit. When comparing the result of her strength testing to her testing on July 31, 2012, Luszczyk testified, "[o]verall, to my general gestalt this would be very little improvement." He testified that paralysis was a "continuum" and plaintiff had paralysis. He considered the surgery a success in that they were able to preserve function and stabilize plaintiff's deformity.

¶ 57 3. Deposition Testimony of Jeffrey Akeson

¶ 58 Akeson testified he was the orthopedic spine surgeon who performed plaintiff's surgery on August 2, 2012. Plaintiff was hospitalized after the surgery until August 16, 2012.

¶ 59 Prior to the surgery, Akeson reviewed plaintiff's radiographic studies and noted her deformity and fracture just above the level of her previous fusion surgery. He took a history from plaintiff of some progression of weakness and bladder difficulty over the prior three weeks. In

the "indications" section of his operative report (taken from plaintiff), Akeson noted a history of two to three months of persistent back pain, progressive lower extremity weakness and numbness, and bladder dysfunction. He had noted radiographs from two months prior showed "kyphotic deformity" and "fracture at the T10-T11," which indicated that plaintiff had a stress fracture above her prior fusion. Akeson explained that plaintiff had developed a progressive deformity just above the previous fusion level, which was a "catastrophic collapse" of her kyphosis that could be seen on the x-ray of June 2, 2012.

¶ 60 When asked whether Akeson measured a patient's Cobb angle when treating someone with kyphosis, he responded:

> "I will say that I'm not considered really to be an adult spine surgeon. My training is primarily in pediatric spine and for a number of years in Peoria I was the only orthopedist, or at least at St. Francis, doing spine work. So I did do some adult spine and some adult trauma of spine, but at least for the past at 10 years, if not 15 or 20, I've done just pediatric spine and I have two partners who do primarily adult spine practice."

¶ 61 Akeson went on to testify that he had reviewed plaintiff's x-rays and findings with his partner, Dr. Mulconrey, who is an adult spine specialist, and they agreed on the necessity of surgery on an "urgent" basis because plaintiff had "what appeared to be obviously an unstable segment of her spine *** [and] significant neurologic compromise which appeared to be associated with that."

¶ 62 In following patients with kyphosis, Akeson measured the patient's Cobb angle to evaluate their progression. He would be concerned about "any increase" in the Cobb angle. It is a concern for patients who developed kyphosis above a previous level of fusion that "it may well

become progressive." Akeson agreed that it was an "accepted concept" that once someone is fused there is a possibility or likelihood that another surgery would be needed at the ends of the fusion. Akeson testified that it was not unusual that plaintiff needed a third fusion surgery. Akeson testified that he could not hold himself out as an expert to say with authority when a third fusion procedure would become surgically or medically indicated for a patient with two prior fusions, segmental kyphosis at the top of the fused area, and pain because he could not say "what the real current standard, up-to-date standard of care would be for a spine surgeon saying okay, if you start to see any change in that, if there's pain, if there's signs of instability."

¶ 63 When asked whether anyone had deviated from the care, Akeson testified, "it did appear that she was getting deformity and neurologic symptoms well before I saw her." He opined that plaintiff's third surgery likely had become medically necessary in June of 2012, based on plaintiff's x-ray at that time and plaintiff's report of when her symptoms were deteriorating. The "deteriorating" symptoms he referenced were symptoms such as weakness in the extremities, numbness, and tingling in the legs, which he believed had first manifested in June. Based on his review of plaintiff's x-rays, he thought the surgery he had performed, or a similar surgery, should have been done earlier.

¶ 64 Based solely on the x-ray of June 2, 2012, without any report of numbness or tingling down the legs, weakness, or bladder control issues, Akeson would have recommended surgery at that time, advising plaintiff that it was not mandatory but that she was likely to have something like the kind of problems that she ended up having. If Akeson had done plaintiff's surgery three weeks earlier, he could not absolutely say whether plaintiff would be getting along any better. Akeson testified that a person fused the way plaintiff had been fused, with no neurologic deficits,

would not necessarily have gait issues. Akeson generally agreed that plaintiff's age, weight, and prior knee replacements would, to some extent, cause plaintiff mobility issues.

¶ 65 Akeson further testified that with respect to kyphosis and a collapse, the goal is to perform surgery before there are significant neurological deficits. With the catastrophic collapse shown on the x-ray of June 2, 2012, the standard of care was for plaintiff to be educated as to what might occur to her in the future and to make sure she reported the first sign of tingling, bladder weakness, or ambulatory difficulties. Akeson testified what plaintiff had needed was an elective surgery that would have corrected her instability, thereby preventing her paralysis. Akeson agreed that a reason for radiologic studies for patients with kyphosis is to allow a physician to monitor the deterioration and recommend surgery prior to paralysis. Akeson testified that x-rays are followed to see if the deformity is increasing and if there is a risk of it causing neurologic problems or increased pain. It is a "basic tenet" amongst treaters of cord injuries to "treat a compression on a cord as soon as you can." The recovery of neurologic deficits is dependent on how long damage was being done to the cord, which is why plaintiff's third spine surgery was emergent.

¶ 66 Akeson acknowledged that he had indicated on plaintiff's initial admission paperwork that plaintiff reported progressive weakness and bladder difficulty over the past three weeks, whereas his surgical report indicated a two-to-three-month history of persistent back pain and progressive lower extremity weakness and numbness with bladder dysfunction. It was possible that the two-to-three-month indication was in relation to plaintiff's pain and not her neurological symptoms, but he did not know which note was more accurate.

¶ 67 Akeson testified that after reviewing plaintiff's x-rays, his impression was that "this should have been taken care of a long time ago." He testified, "it seems to me there was a time

where she had enough deformity and apparently instability at this level that she was doomed to have problems if she did not get it addressed." Akeson stated he was qualified to provide answers regarding "basic quality of care and what any reasonable orthopedist, whether they do spinal or not, should be able to decipher from looking at x-rays and taking a history from a person." He further stated, "I can't say that I am a current expert in adult spine."

¶ 68 Akeson confirmed that segmental kyphosis was progressive in nature and that the indication for the need for surgery was if there was a "neurologic component." He agreed, from a medical perspective, it was "critical" when a patient reported neurologically related symptoms, such as extremity weakness and numbness, tingling, or urinary issues. Akeson opined that "someone at some point should have recognized that this was a problem and dealt with it earlier." He agreed it was his opinion to reasonable degree of medical certainty, that a doctor deviated from the applicable standard of care in not performing surgery at an earlier time. When asked to opine when plaintiff's surgery should have been done, he indicated that he would have to look at plaintiff's x-rays to refresh his recollection as to how much kyphosis there was, whether it was progressive, and whether it appeared that it was going to continue to a point of definite neurologic issues.

¶ 69 Akeson was asked whether the "progression of the kyphosis" or the "neurologic component" was more critical. He responded, "[w]ell, the neurologic component is more critical." He went on to state:

> "but if the kyphosis is progressing, then – and so here's where you're getting to are you an orthopedist who does some spine but not that much adult spine and don't hold themselves up as an adult expert which I have yet to do, okay, and can

you see that X-ray from whatever, April, May, June, whatever, and say this lady is doomed, she needs to have something done."

¶ 70 Akeson testified that there are situations where just the structural problems and pain (with no neurologic component) would prompt another fusion surgery. As to determining how long a compression on the spine existed prior to surgery, that would be based on the subjective symptomology reported by the patient and X-rays, myelogram, MRI, or CT scans. Akseon was asked if mobility issues would be expected for someone who had been fused to the same extent as plaintiff. He responded, "[n]ormally not if they're neurologically intact." Akeson could not opine, to a reasonable degree of medical certainty, as to exactly when plaintiff first began to experience a compression on her spine at the T10/T11 area.

¶ 71 Akeson additionally testified that in plaintiff's case, her surgery was urgent when he saw her on August 2, 2012, because she had "what appeared to be obviously an unstable segment of her spine at this fracture level above her previous fusion and she had a significant neurologic compromise which appeared to be associated with that." Akeson testified that plaintiff's surgery had gone well and he relieved pressure on her spine. He testified that it was likely that there was "permanent neurologic compromise." While it was possible for some degree of recovery after relieving a compression on the spine, "there's less chance of recovery the more severe and longer it's gone on." Akeson testified, "I recall feeling about [plaintiff] that her care had not been managed what I felt was properly." He also stated, "I recall feeling that something could have been done earlier to stabilize her spine." Akeson confirmed that he was not holding himself out as an expert in the area of adult spinal surgery.

¶ 72 4. Deposition Testimony of Dr. Asheesh Bedi

¶ 73 Bedi testified as plaintiff's expert orthopedic surgeon. He specialized in sports medicine. He did not perform spine surgeries as part of his practice.

¶ 74 In testifying at his deposition, Bedi described "adjacent segment kyphosis," explaining that after a fusion of spine segments (vertebral bodies and discs), greater stress and force was placed on the adjacent segments above and below the fusion and often resulted in damage to the segments above or below. He testified, "[w]hen there's a fusion *** there's a risk for progressive deformity above or below the fusion." The term "kyphosis" by definition, "just means curvature, deformities," which can be progressive. "Adjacent segment kyphosis" refers to "continued collapse or flexing at the segment above a prior fusion mass."

¶ 75 If Bedi had determined that one of his patients was presenting with "adjacent segment kyphosis," the patient's ongoing care would depend on whether the patient was "manifesting with symptoms of progressive neurologic change" (worsening pain or symptoms of spinal cord compression or injury or nerve injury). If the patient's condition was asymptomatic, he would defer to "spine colleagues who are following the patient." Bedi testified that pain "absolutely" can be a neurologic symptom, depending on the type of pain. He also testified that he would "definitely recommend" a further workup, which "might include advanced imaging and certainly a prompt referral to [his] spine colleague." For either a compression fracture or adjacent segment kyphosis, he would not need to see "much" before referring the patient to spine surgeon. He explained that a compression fracture, burst fracture, or adjacent segment kyphosis are "at a higher level of complexity" and the patient is demonstrating that the issue is in the spinal column. With those concerns and worsening pain symptoms, Bedi would be "pretty quick to invoke a colleague."

¶ 76 Specifically as to plaintiff, Bedi testified that she had two prior fusion surgeries and there was an x-ray that had been interpreted as showing a compression fracture (on June 2, 2012). Bedi testified that for an acute compression with new pain, he would immediately "pass on to a spine specialist." After making an urgent referral to a spine specialist, Bedi would defer to their expertise in regard to when a surgery should be done.

¶ 77 Bedi further testified that compression of the spinal cord indicates a more urgent issue than the pain and discomfort plaintiff had reported in 2011. Bedi testified that Boardman, in diagnosing plaintiff with an acute compression fracture on June 2, 2012, should have communicated with Hussain, and Hussain should have assumed the management of that condition in addition to plaintiff's knee condition. Bedi testified that Boardman had noted that he would discuss plaintiff's case with Hussain, and Bedi would "assume" that Boardman debriefed Hussain. On June 20, 2012, plaintiff was seen by Hussain (in relation to her knee), who noted plaintiff was walking with an antalgic gait. Bedi testified that an antalgic gait is not specific to spinal cord issues. He also noted that there had been no documentation of "anything related to the spinal cord or back in general, so we also don't know that those findings are not present." He agreed, "we don't know one way or the other."

¶ 78 From June 22 to 26, 2012, plaintiff was hospitalized at Trinity due to an infection ("C difficile colitis," likely from being on antibiotics for her knee infection). During this hospitalization, plaintiff's knee was swollen, and she could not move or lift her leg. Bedi testified that those symptoms did not, by themselves, necessarily indicate a spinal compromise when there were other "confounding factors" of a prosthetic knee replacement, infection, and weakness from the infection. On July 25, 2012, plaintiff reported a number of symptoms to Hussain. Bedi would opine certain elements of plaintiff's complaints, in particular loss of bowel and bladder

function, worsening numbness, and her inability to move her feet, "start to be more symptomatic of myelopathy" (spinal cord compromise). Bedi further testified that the confounding nature of plaintiff's recent surgeries were factors that made identifying a spinal cord compromise more challenging but, therefore, increased the need for vigilance. He noted that back pain and radicular symptoms were "overlapping" symptoms and that weakness and issues with plaintiff's gait were affected by the knee issues. Thus, certain elements of an examination would be important to specifically isolate the spinal cord. Bedi testified, "particularly in this setting of spinal trauma or potential trauma, a workup may need to be that much more extensive" in light of plaintiff's overall "constellation of symptoms."

¶ 79 Bedi testified, "[i]t's the constellation of her physical exam findings, change in those findings, [a] change in the imaging studies that change something from being an elective option to a necessary one." Progressive neurologic changes indicate a more prompt or appropriate evaluation for the need for surgery. Bedi opined that at the time of her trauma on June 2, 2012, plaintiff presented with a potential spinal cord injury (based on a diagnosis of either acute compression fracture or adjacent segment kyphosis). At that time, an x-ray was taken, but no advanced imaging was performed to characterize the nature of the injury. An appropriate workup and series of imaging studies may have identified a potential spinal cord injury and, if spinal cord injury was in fact developing, "there was potential for intervention sooner." In Bedi's practice, a patient with plaintiff's history would have had advanced imaging "at the time of the index trauma." Also, the monitoring of plaintiff's neurologic examinations and symptoms from June 2, 2012, through July 31, 2012, would have been more thorough and deliberate given plaintiff's history of either a compression fracture or adjacent segment injury.

¶ 80 Bedi's opinion was "not necessarily" that the standard of care required a referral of plaintiff to a spine specialist on June 2, 2012, but that either advanced imaging (a CT and MRI) should have been taken to make a definitive diagnosis or, alternatively, serial x-rays should have been taken to monitor the diagnosed compression fracture to determine if it was "healing, collapsing, [or] progressing." Bedi did not see that any subsequent imaging studies specific to a spinal cord examination had been done to monitor plaintiff after June 2, 2012, in order to assess and confirm the absence of spinal cord compression. Bedi agreed that it could not be determined "one way or the other" from plaintiff's records whether plaintiff had neurologic or spinal cord related symptoms at the time of the doctor visits from June 2 to July 25, 2012. Plaintiff's medical records after June 2, 2012, did not speak to plaintiff's diagnosed "compression fracture" or document that any neurologic specific examination was conducted in order to confirm the absence of such symptoms.

¶ 81 Bedi did not form an opinion to a reasonable degree of medical certainty as to when the standard of care required that a referral to a spine specialist be made. Bedi testified when someone has such constellation of symptoms as plaintiff, with a note of "gibbus deformity" at the time of Hussain's documentation on July 25, 2012, it "necessitates a surgical emergency or urgent surgical consultation at minimum." Bedi would opine that the goal of surgical treatment, in part, was to treat the injury before permanent neurologic damage occurs. He was not opining when plaintiff experienced permanent neurologic damage. He explained, "with any spinal cord compression, earlier is better, so certainly if there is any opportunity for the earliest possible intervention, that's better."

¶ 82 Bedi opined that plaintiff suffered permanent neurologic damage. Bedi opined that plaintiff's worsening signs and symptoms were allowed to escalate and compromise her ultimate

outcome and long-term prognosis. Bedi also testified that at some point between June 2, and July 31, 2012, without a specific exact date, "there was a clear progression in [plaintiff's] symptoms and deformity and *** the surgery that was subsequently performed may have been performed or may have had the potential to have been addressed earlier." He was not opining that had the surgery been done prior to August 2, 2012, plaintiff would have been better to any specific degree. Bedi stated, "should there have been spinal cord compromise and injury, the literature would suggest the earlier intervention in the absence of those neurologic symptoms does better." Bedi opined, "a delay could impact the long-term prognosis" because a patient's outcome and long-term prognosis are better with earlier intervention. Bedi was not, however, applying those generalities to the specifics of plaintiff's case.

¶ 83 Bedi opined, to a reasonable degree of medical certainty, there had been a delay in diagnosing plaintiff's condition in the sense that the workup, imaging, and subsequent diagnosis were delayed. Bedi could not, however, state to a reasonable degree of medical certainty that a spine surgeon would have done the surgery any sooner than it was done, and he did not believe that anyone could do so where there was no prior workup. Plaintiff's symptoms significantly worsened from June 2, 2012, until she presented to Luszczyk on July 31, 2012, but without additional imaging after June 2, 2012, Bedi could not comment on the specific measurement of any deformity increase. Bedi could not quantify the difference an earlier surgery would have made on plaintiff's present-day condition or on her outcome. He did not believe that anyone could specify those percentages with any degree of certainty, "other than [to state] in the setting of spinal cord compression and deformity, earlier is better."

¶ 84 At trial, Bedi would not attempt to quantify how much better plaintiff might be today if the surgery was done earlier. Bedi testified that he believed "across any neurologic situation," the

reversibility of spinal cord compression and the return of function is always better "when the duration is minimized." Once upper motor neuron symptoms or spinal cord compression symptoms ensue (such as bowel and bladder incontinence or myelopathy-type symptoms), the outcome of the surgery would be "less good" than the outcome in the absence of those symptoms. Bedi could not identify a specific date the surgery would have needed to be done in order to avoid placing plaintiff in jeopardy of long-term permanent impairment, but on June 2, 2012, it appeared that plaintiff did not have those symptoms and by July 25, 2012, she did. Based on plaintiff's current outcome after the spinal fusion, Bedi testified that at some point prior to the surgery, plaintiff had developed upper motor neuron symptoms and spinal cord compression, which can adversely affect the prognosis of the surgery. Although plaintiff's upper extremity symptoms were first documented on July 25, 2012, it was not known exactly when those symptoms had developed. If Millea had advised plaintiff that if her symptoms progressed or if she had new neurological symptoms to contact her physicians at ORA Orthopedics, Bedi would expect that plaintiff could have contacted a provider. "But in this case, it was confounded by new trauma."

¶ 85 Bedi reviewed the deposition testimony of Luszczyk and Akeson, who had both indicated that the x-ray of June 2, 2012, showed a catastrophic collapse of the kyphosis. Bedi opined that the standard of care of the physicians involved in plaintiff care from June 2, 2012, through July 25, 2012, would be to refer plaintiff to a spine specialist based on the diagnosis of acute kyphosis segment collapse and/or a compression fracture. Bedi testified that he believed that the cause of plaintiff's injury was her fall and trauma and a delay in diagnosis—"[a] delay can potentially adversely affect the ultimate result." He was not opining that a delay in treatment of plaintiff's

spinal condition caused plaintiff's current difficulties but that "the delay in the diagnosis of the result after the trauma could affect the outcome."

¶ 86 5. Deposition of Dr. Wellington K. Hsu

¶ 87 Dr. Wellington K. Hsu was presented as an expert witness by defendant. He was a physician employed as an orthopedic spine surgeon. Hsu testified the chest x-ray of plaintiff taken on June 2, 2012, evidenced "definitely some progression of [plaintiff's] adjacent segments generation" compared to a 2010 x-ray and "was similar appearance to the July 25, 2012, thoracolumbar x-ray." Hsu believed that Boardman had incorrectly diagnosed plaintiff with a "T-11 compression fracture" at the time of x-ray on June 2, 2012, and the proper diagnosis was "proximal junctional kyphosis at T-11/12." Treatment for either diagnosis would have been conservative treatment, and the difference in those diagnoses did not impact plaintiff's care.

¶ 88 By the time plaintiff had surgery on August 2, 2012, she required an "urgent surgery." Plaintiff progressed from being an elective candidate for surgery to urgent shortly before August 1, 2012, when plaintiff "started to develop neurologic deficits." He noted that as of November 2011, plaintiff was a candidate for elective surgery and, at some point thereafter, plaintiff would have progressed to "urgent" at the first signs of progressive weakness or neurological deficits. As a spine surgeon, Hsu would want to operate on an urgent basis at the first signs of neurologic deficits "[t]o preserve as much neurologic function as possible."

¶ 89 Hsu testified that plaintiff would have been a candidate for urgent surgery on July 25, 2012, "if she presented with neurologic deficits in her lower extremities." The first report of a neurologic deficit indicated in plaintiff's medical records reviewed by Hsu was on July 31, 2012. "But since she reported those symptoms for one or two week prior, [Hsu] would say that in retrospect, yes, on July 25, 2012, [plaintiff] would have been a candidate for urgent surgery."

¶ 90 It had been noted by Hussain that as of July 25, 2012, plaintiff was no longer able to ambulate. If a physician was concerned that someone who was previously ambulatory was no longer ambulatory, a neurologic examination should have been conducted, "unless there was some other explanation as to why they were not able to ambulate." On July 25, 2012, Hussain referred plaintiff to a spine specialist. When asked whether a neurological exam should have been done on July 25, 2012, Hsu testified that if a referral was made to a spine surgeon, "then the neurologic exam would be done by the spine surgeon." Hussain had referred plaintiff to a spine surgeon because he was concerned about plaintiff's lower extremity weakness and her spine condition. Plaintiff was a candidate for urgent surgery at that point and "was appropriately referred to a spine surgeon at that point." Plaintiff was seen by Luszczyk six days later.

¶ 91 Hsu testified that in following a patient such as plaintiff, the patient's increased Cobb angle would be of interest. Hsu also testified that, based on his review of plaintiff's records, plaintiff had ambulated with assistance as of June 2, 2012, and by July 25, 2012, it had been noted that she was able to "get up with a Hoyer lift." Hsu would consider that to be a deterioration of plaintiff's "medical status" but not necessarily a deterioration of her "neurological status," although it possibly was a deterioration of plaintiff's neurological status. Hsu testified that he could not discern that there had been any change in plaintiff's neurological status from July 25 to 31, 2012.

¶ 92 Hsu did not agree that plaintiff urgently needed surgery as of June of 2012. Hsu testified that what was present on plaintiff's x-ray of June 2, 2012, was "proximal junctional kyphosis" and "in the absence of paralysis or neurologic issue, Hussain did not necessarily need to know about that x-ray." A spine specialist should have been consulted at the time of progressive lower extremity weakness and numbness.

¶ 93 As of July 25, 2012, plaintiff had difficulty ambulating. Hsu could not determine whether plaintiff had a neurologic deficit at that point "because [he] wasn't there." Although plaintiff was losing her lower extremity function, the exact cause was not determined at that point and would be best investigated by a spine surgeon. Based on his review of the records, Hsu did not see any evidence that plaintiff was experiencing any neurological symptoms that, under the applicable standard of care, warranted immediate surgical intervention prior to July 25, 2012. Hsu opined that based upon the x-ray of July 25, 2012, plaintiff needed a "spine surgery evaluation" at that time. In response to plaintiff's attorney asking whether the surgeon would have done an "urgent surgery" if he or she had seen plaintiff on July 25, 2012, Hsu replied, "urgent surgery doesn't mean it has to be done on that day, but yes." He opined that a surgery would have been done within a few days. The goal of spine surgery was to perform the surgery before complete paralysis. Hsu testified that there had been no change in plaintiff's condition from July 25 to 31, 2012, and opined that the outcome of plaintiff's surgery would not have been any different if she had undergone surgery on July 27 or 28, 2012, rather than on August 1, 2012 (her surgery was on August 2, 2012).

¶ 94 D. Ruling on Summary Judgment Motion

¶ 95 The trial court noted that defendants' contention was that there was no material question of fact. Defendants had admitted a professional relationship (attorney-client relationship) and a breach of duty on the part of attorney Fieweger. Defendant also contended, however, that plaintiff could not establish that in her underlying medical malpractice claim the alleged medical negligence had proximately caused injury to her. The trial court noted that plaintiff had claimed to have lost the chance to fully recover due to a delay in diagnosis and treatment. The trial court noted that: Luszczyk "did not opine to a reasonable degree of medical certainty that [the] delay

contributed to Huffman's injuries"; Hsu was "not critical of the medical care Huffman received"; Akeson "admitted in his deposition *** that he is not a current expert in adult spine" and did not opine to a reasonable degree of medical certainty that the delay in treatment or diagnosis caused or in any way contributed to plaintiff's injuries; and Bedi "spoke in generalities not specifics associated with this case" and did not opine to a reasonable degree of medical certainty that any delay contributed to plaintiff's injuries. The trial court concluded that proximate cause testimony to reasonable degree of medical certainty as to plaintiff's lost chance of recovery was "lacking" in this case and "without it plaintiff cannot establish proximate cause as a matter of law." The trial court granted defendants' motion for summary judgment.

¶ 96 Plaintiff appealed.

¶ 97 II. ANALYSIS

¶ 98 On appeal, plaintiff argues the trial court erred in granting summary judgment in favor of defendants. Plaintiff contends that it could be inferred from the evidence that the delay in referring her to a spine specialist cost her the chance of avoiding paralysis. Plaintiff notes that whether plaintiff's medical providers breached the standard of care is not at issue on appeal, with defendants' motion for summary judgment having been limited to their argument that plaintiff could not establish that any alleged deviation from the standard of care was the proximate cause of her paralysis. Plaintiff, therefore, requests that we reverse the trial court's order granting defendants' motion for summary judgment and remand for further proceedings.

¶ 99 In response, defendants contend there was no evidence presented that plaintiff suffered an increased risk of harm or lost chance of recovery due to the delay in referring plaintiff to a spine surgeon. Defendants argue plaintiff did not provide any expert testimony, to a reasonable degree of medical certainty, that her partial paralysis could have been avoided or that she would have

had a better outcome if she underwent surgery at an earlier time. Defendants request that this court affirm the trial court's determination that plaintiff was unable to establish the proximate cause element of her underlying medical malpractice claim and, thus, affirm the trial court's order granting summary judgment in defendants' favor in this legal malpractice action.

¶ 100 Summary judgment is proper when "the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." 735 ILCS 5/2-1005(c) (West 2018); *Northern Illinois Emergency Physicians v. Landau, Omahana, & Kopka, Ltd.*, 216 Ill. 2d 294, 305 (2005). In determining if there is genuine issue of material fact, the pleadings, depositions, admissions, and affidavits must be strictly construed against the movant and liberally in favor of the opponent. *Williams v. Manchester*, 228 Ill. 2d 404, 417 (2008). A triable issue precluding summary judgment exists where material facts are disputed or where reasonable persons might draw different inferences from undisputed facts. *Id.* The purpose of summary judgment motions is not to try a question of fact, but to determine whether there is a question of fact. *Northern Illinois Emergency Physicians*, 216 Ill. 2d at 305. Given that summary judgment is a drastic means of disposing of litigation, a court must exercise "extraordinary diligence" in reviewing the record to avoid preempting a party's right to fully present the factual basis for his or her claim. *Id.* at 305-06.

¶ 101 Although at the summary judgment stage plaintiffs are not required to prove their case, the plaintiff must present sufficient evidence to create a genuine issue of material fact. *Id.* at 306; *Wiedenbeck v. Searle*, 385 Ill. App. 3d 289, 292 (2008). A motion for summary judgment should only be granted when the right of the movant is "clear and free from doubt." *Northern Illinois Emergency Physicians*, 216 Ill. 2d at 306. Our review of an order granting summary judgment is

*de novo*. *Schultz v. Illinois Farmers Insurance Co.*, 237 Ill. 2d 391, 399-400 (2010); *Wiedenbeck*, 385 Ill. App. 3d at 292.

¶ 102 The basis of a legal malpractice claim is that but for the negligence of the former attorney, the plaintiff would have been compensated for an injury caused by a third party. *Stevens v. McGuireWoods LLP*, 2015 IL 118652, ¶ 12. For a legal malpractice claim, a plaintiff must plead and prove that the attorney-defendant owed the plaintiff a duty of due care arising from the attorney-client relationship, the attorney-defendant breached that duty, and, as a proximate result, the plaintiff suffered an injury. *Northern Illinois Emergency Physicians*, 216 Ill. 2d at 306. The plaintiff must establish what the result in the underlying action would have been without the attorney-defendant's alleged negligence. *Stevens*, 2015 IL 118652, ¶ 12.

¶ 103 In this case, the underlying action was a medical malpractice action. In a medical malpractice action, the plaintiff must prove: (1) the standard of care against which the medical professional's conduct must be measured; (2) a negligent failure to comply with that standard; and (3) the defendant's negligence was a proximate cause of the injuries for which the plaintiff seeks damages. *Freeman v. Crays*, 2018 IL App (2d) 170169, ¶ 21. In proving proximate causation, a plaintiff must establish by the preponderance of the evidence that it is probably more true than not true that defendant's alleged negligence was a cause of plaintiff's injury. *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 105, (1997) (citing *Borowski v. Von Solbrig*, 60 Ill. 2d 418, 424 (1975)). The proximate cause element in a medical malpractice case must be established by expert testimony to a reasonable degree of medical certainty, and the casual connection must not be contingent, speculative, or merely possible. *Freeman*, 2018 IL App (2d) 170169, ¶ 21. "[T]he weight to be given to medical expert testimony is for the trier of fact to determine, and where the

evidence is conflicting it is within the jury's province to resolve the conflict." *Wodziak v. Kash*, 278 Ill. App. 3d 901, 913-14 (1996).

¶ 104 The question of whether a physician's negligence was a proximate cause of the plaintiff's injuries is a question of fact for the trier of fact. *Borowski*, 60 Ill. 2d at 423. "Proximate cause is ordinarily a fact question to be decided by a jury, but if there is no material issue of fact or only one conclusion is clearly evident, it may be decided as a matter of law." *Buck v. Charletta*, 2013 IL App (1st) 122144, ¶ 58. "At the summary judgment stage, the plaintiff must present some affirmative evidence that it is 'more probably true than not true' that defendant's negligence was a proximate cause of the plaintiff's injuries." *Johnson v. Ingalls Memorial Hospital*, 402 Ill. App. 3d 830, 843 (2010) (quoting *Borowski*, 60 Ill. 2d at 424).

¶ 105 Here, plaintiff proceeded under the "lost chance" theory to satisfy the proximate cause element of her medical malpractice claim. The lost chance theory "refers to the injury sustained by a plaintiff whose medical providers are alleged to have negligently deprived the plaintiff of a chance to survive or recover from a health problem, or where the malpractice has lessened the effectiveness of treatment or increased the risk of an unfavorable outcome to the plaintiff." *Holton*, 176 Ill. 2d at 111. "To the extent a plaintiff's chance of recovery or survival is lessened by the malpractice, he or she should be able to present evidence to a jury that the defendant's malpractice, to a reasonable degree of medical certainty, proximately caused the increased risk of harm or lost chance of recovery." *Id*. at 119.

¶ 106 "Under the lost chance doctrine, a plaintiff may seek damages resulting from a healthcare provider's negligent treatment even though the patient's chance of recovering from the existing illness or injury may be less than 50%." *Meck v. Paramedic Services of Illinois*, 296 Ill. App. 3d 720, 726 (1998). Once it is shown that a defendant's negligence increased the risk of harm to the

plaintiff, and that the harm was, in fact, sustained, then the question of whether the increased risk was a substantial factor in producing the harm becomes a jury question. *Meck*, 296 Ill. App. 3d at 726-27.

¶ 107 Contrary to defendants' contentions in this case, there is no requirement that plaintiff prove that a better result would have been achieved absent the negligence of her physicians—*i.e.*, that she would have had a better outcome with an earlier referral to a spine surgeon or with an earlier surgery. See *Borowski*, 60 Ill. 2d at 424 (there is no requirement that plaintiff prove a "better result" would have been achieved without the alleged negligence); *Holton*, 176 Ill. 2d at 107 ("[t]he 'better result test' is not a part of plaintiff's burden of proof" in proving proximate cause). Also, as noted above, at the summary judgment stage, plaintiff was not required to prove her case but, rather, was only required to present some evidence that it is more probably true than not true that defendant's negligence was a proximate cause of her injuries. See *Northern Illinois Emergency Physicians*, 216 Ill. 2d at 306.

¶ 108 In the trial court, there was some evidence, to a reasonable degree of medical certainty, that the negligence of plaintiff's treaters in failing to timely refer her to a spine surgeon for further monitoring, radiographic studies, neurological examinations, and/or surgery increased her risk of harm and/or lessened the effectiveness of her treatment. In November 2011, plaintiff complained of severe back pain and her x-ray showed "adjacent segmental disease," which was progressive in nature and over time results in failure, with the treatment to stabilize it being more surgery. At that time in November 2011, however, there was no strength deficit in plaintiff's lower extremities or neurologic deficits and her kyphosis had not changed to a significant degree from the year prior. Although plaintiff was a candidate for elective spine surgery in November 2011, the surgery was not mandatory in the absence of progressive or severe neurological

deficits. Millea had "hoped" that he had advised plaintiff of neurologic deficits to be on the lookout for—tingling in her lower extremities, uncontrollable pain, or bladder control issues. Millea testified that it was his habit to do so, but it was not reflected in his notes whether he had, in fact, done so.

¶ 109 Indications for "urgent" surgery included instability, neurologic deficits (marked weakness, bladder or bowel control issues, or loss of lower extremity function), or a significant progression in plaintiff's kyphosis. An increased Cobb angle was also a factor. According to Millea, an increase in plaintiff's kyphosis along with neurologic deficits would be the "tipping point." Luszczyk testified that an "absolute" indication for surgery for a person with adjacent segmental disease is some neurological symptomology. Another surgical indication would be worsening instability identified by radiographic studies if there were no neurological deficits.

¶ 110 The evidence showed that as of June 2, 2012, plaintiff' presented to the emergency department at Trinity and an x-ray indicated a catastrophic collapse in her spine. Plaintiff's adjacent segment disease had progressed, and her Cobb angle had increased. Akeson testified that with respect to kyphosis and a collapse, the goal is to perform surgery before there are significant neurological deficits. He also testified that with the catastrophic collapse shown on the x-ray of June 2, 2012, the standard of care was for plaintiff to be educated as to what might occur to her in the future and to make sure she reported the first sign of tingling, bladder weakness, or ambulatory difficulties and that what plaintiff had needed was an elective surgery that would have corrected her instability, thereby preventing her paralysis. He also indicated that the reason for radiologic studies for patients with kyphosis was to allow a physician to monitor the deterioration and recommend surgery prior to paralysis, with the x-rays being followed to determine whether the deformity is increasing and if there is a risk of neurologic problems. He

stated that a spinal cord compression should be treated as soon as possible, with recovery of neurologic deficits depending on how long the damage was being done to the cord.

¶ 111 Thus, there was some evidence that plaintiff should have been offered elective surgery and advised of symptoms for which she should be vigilant prior to her paralysis. With a patient with a catastrophic collapse, once there is the development of a significant neurologic deficit, surgery should happen as soon as possible to preserve neurologic function before the patient becomes paralyzed. Notably, although plaintiff had been offered and declined elective surgery in November 2011, at that time her condition had not changed in any significant way from the prior year. By June 2, 2012, plaintiff's spine condition had progressed and there was a catastrophic collapse, so the "risk verse reward" analysis for undergoing a third fusion surgery would have undoubtedly been different for plaintiff.

¶ 112 Also, interpreting the pleadings and depositions strictly against defendants and liberally in favor of plaintiff, there was evidence indicating that plaintiff had, in fact, been experiencing neurologic deficits at the time of her June 2, 2012, emergency department visit at Trinity. Akeson had indicated in his notes on August 2, 2012, that plaintiff reported a two-to-three-month history of neurological deficits. Thus, there was some evidence that as of June 2, 2012, plaintiff had an increase in kyphosis with neurologic deficits—the tipping point for emergent or urgent surgery, and an absolute indication for surgery for a person, such as plaintiff, with adjacent segmental disease. There was expert testimony that with spinal cord compromise and injury: the earliest possible intervention is better; intervention in the absence of neurologic symptoms does better; and a patient's outcome and long-term prognosis are better with earlier intervention. Neurological symptoms and a spinal cord compression can adversely affect the prognosis of the surgery.

¶ 113 As noted above, whether plaintiff's medical providers breached the standard of care of is not at issue. Regardless of whether plaintiff was experiencing neurologic deficits on June 2, 2012, the x-ray taken on that day was indicative of a spinal column issue. Surgery would be indicated, even in the absence of neurological deficits, if there was worsening instability, which could be identified by radiographic studies. Radiographic studies for patients with kyphosis allow physicians to monitor the deterioration and recommend surgery prior to paralysis. However, from June 2 to July 25, 2012, plaintiff's treaters did not follow up on plaintiff's spine condition with radiographic studies, or otherwise in any meaningful way, for the first sign of neurologic deficits or for worsening instability.

¶ 114 The purpose of monitoring plaintiff's condition was to perform the requisite surgery before damage to the spinal cord, at the first signs of neurologic deficits—before serious neurological deficits and before paralysis. As of June 2, 2012, plaintiff was still able to walk. Just over two weeks later, on June 20, 2012, plaintiff presented in wheelchair (as reported by physician assistant Kipper). While hospitalized at Trinity from June 22 to 26, 2012, plaintiff could not move or lift her leg. Plaintiff again presented in a wheelchair on July 6, 2012, (as noted by Hussain), but still she was not neurologically assessed or referred to a spine specialist. Hsu, defendants' expert, testified that a spine specialist should be consulted once there is progressive lower extremity weakness and numbness, with the exact cause of plaintiff losing lower extremity function best investigated by a spine surgeon. Although lower extremity weakness is a sign of neurologic deficit and not being able to ambulate is a significant neurological change, plaintiff was not seen by a spine specialist until July 31, 2012, after she could no longer walk and, at which point, it would have been a "rarity" to recover her loss of function.

¶ 115 Understandably, plaintiff appears to have assumed that her symptoms involving her lower extremities may have been attributable to her knee surgeries and infections rather than to spinal issues that had the potential to, and did in fact, lead to paralysis. From June 2 to July 25, 2012, it appears plaintiff's treaters may also have attributed plaintiff's loss of mobility issues, lower extremity weakness, and other neurologic deficit symptoms (numbness/tingling, bladder weakness, etc.) wholly to plaintiff's prior knee surgeries and comorbidities, without regard for the existence of plaintiff's spine issues. However, as Bedi testified, the plaintiff's other issues indicated a need for vigilance and for thorough examinations related to plaintiff's spine issues due to possible overlapping symptomology.

¶ 116 In this case, plaintiff presented some evidence that defendants' negligence increased her risk of paralysis and that she did, in fact, become paralyzed. Whether that increased risk of paralysis was a proximate cause of her paralysis was for the jury to determine. See *Meck*, 296 Ill. App. 3d at 726-27. Plaintiff's spine condition had progressed (as shown on the x-ray of June 2, 2012), but her treaters appeared to have failed to identify there had been a progression and/or recognize the relevance of that progression, so that the appropriate treatment could not even be considered. See *Holton*, 176 Ill. 2d at 108 ("[b]ecause of the hospital's negligent failure to accurately and timely report [the plaintiff]'s symptomology, the appropriate treatment was not even considered"). After June 2, 2012, plaintiff was not further monitored or followed in regard to her spinal issues for the first signs of neurologic deficits in order to preserve as much neurologic function as possible—she was not followed up with radiographic studies, her Cobb angle was not measured, and it does not appear that she was administered any neurologic examinations. Plaintiff, therefore, did not undergo surgery until after she had become paralyzed.

¶ 117 We conclude that plaintiff presented some evidence showing to a reasonable degree of medical certainty that the negligence of plaintiff's medical providers was a proximate cause of her spinal condition progressing to the point of her developing a spinal cord injury resulting in paraparesis, after which point there was not a high likelihood that there would be any significant recovery. Thereby, there was some evidence that the negligence lessened the effectiveness of treatment and/or increased the risk of an unfavorable outcome. See *Holton*, 176 Ill. 2d at 111. "[E]vidence which shows to a reasonable certainty that negligent delay in diagnosis or treatment *** lessened the effectiveness of treatment is sufficient to establish proximate cause." *Northern Trust. Co. v. Louis A. Weiss Memorial Hospital*, 143 Ill. App. 3d 479, 487-88 (1986) (quoting *James v. United States*, 483 F. Supp. 581, 585 (N.D. Cal. 1980)); *Holton*, 176 Ill. 2d at 116-17 (concluding *Northern Trust Co.* reflects "the correct application of proximate causation principles when a defendant's negligent medical care is alleged to have denied the patient a chance of survival or recovery").

¶ 118 Consequently, a genuine issue of material fact remains as to whether the negligence of plaintiff's treaters proximately caused plaintiff's injuries, precluding summary judgment. See *Borowski*, 60 Ill. 2d at 423 (whether a physician's negligence was a proximate cause of the plaintiff's injuries is a question of fact for the trier of fact). We, therefore, reverse the trial court's grant of summary judgment in favor of defendants and remand for further proceedings.

¶ 119 III. CONCLUSION

¶ 120 The judgment of the circuit court of Rock Island County is reversed and this cause is remanded.

¶ 121 Reversed and remanded.