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Newsletters

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Reducing Monetary Recovery in "Lost Chance Of [Medical] Recovery" Cases

In medical malpractice cases involving solely "iatrogenic" loss (e.g., harm of or relating to medical treatment), plaintiff bears the burden of proof in establishing that medical negligence was more probably true than not true the cause of his or her ultimate injury. When an iatrogenic cause combines with an innocent cause, such as an underlying medical condition of the patient, plaintiffs often pursue a cause of action under the "loss of chance" doctrine and its arguably relaxed burden of proof. That doctrine permits recovery when a medical expert opines to a "reasonable [degree of medical] certainty" that the physician's negligence caused a lost chance of recovery. *Holton v. Memorial Hospital*, 679 N.E.2d 1202, 1211-13 (Ill.Sup.Ct. 1997).

It is nearly axiomatic that one could more easily prove that a chance of harm, rather than an actual harm, resulted from medical negligence. Should "loss of chance" plaintiffs be entitled to recover 100% of their damages absent proof of actual harm? As some commentators have argued, fair application of the "loss of chance" doctrine requires treating the lost chance of recovery itself as the compensable harm, rather than the ultimate injury sustained by the patient (the so-called "separate injury approach," which has been adopted in Iowa, Kansas, Michigan, Missouri, Nevada, and Washington). J. King, Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 Yale L.J. 1353, 1365 (1981). In this way, the medical tortfeasor is held accountable only for damages flowing from iatrogenic causes, rather than compensating patients for innocent causes which the medical tortfeasor played no role in causing, such as the patient's underlying medical condition. Id.

The Supreme Court has never imposed any limitation on a patient's right to recovery in cases alleging medical negligence resulted in a "lost chance of recovery." Instead, probabilistic proof that medical negligence caused a chance of an injury is sufficient to allow the patient to recover 100% of his or her

damages. Notably, Supreme Court dicta suggests that a reduction of damages in proportion to the lost chance of recovery, as would occur under the "separate injury" approach, is the proper result in these cases. *Holton*, 679 N.E.2d at 1210, n1., and 1213, n2. *Borowski v. Von Solbrig*, 328 N.E.2d 301, 305 (Ill.Sup.Ct. 1975). Under the present application of the "loss of chance" doctrine in Illinois, however, jurors are not instructed by the court on any methodology for reducing damages in proportion to the lost chance of survival. In that regard, jurors are ill-equipped to properly assign value to the injury at issue, the probabilistic harm itself, rather than the ultimate injury. This results in juries overcompensating "loss of chance" plaintiffs not only for harm attributable to iatrogenic causes, but also for "innocent causes" such as the plaintiff's underlying medical condition, without any differentiation between the two.

The Supreme Court, or the Supreme Court Committee on Jury Instructions in Civil Cases, could resolve this inequity with jury instructions providing a formula for the jury to reduce damages in proportion to the lost chance of harm. This is not a foreign concept to the Illinois Supreme Court. For example, in Dillon v. Evanston Hosp., 771 N.E.2d 357 (Ill.Sup.Ct. 2002), the Supreme Court determined that a jury had not been properly instructed on damages in an increased risk of future harm case, commenting that "a Plaintiff can obtain compensation for a future injury that is not reasonably certain to occur, but the compensation would reflect the low probability of occurrence." 771 N.E.2d at 370 (emphasis added). The Dillon Court remanded and provided the trial court with a proposed instruction adopted from another jurisdiction, which specified a formula for the jury to apply in assigning damages to the "chance" of a future injury. I.P.I.Civil 30.04.03, a pattern jury instruction which memorializes the Dillon ruling, refers to the use of a corresponding instruction providing a methodology for how such damages are calculated, I.P.I.Civil 30.04.04.

As the Dillon Court concluded, instructions aid the jury in the difficult task of assigning reducing damages to account for proof of only probabilistic harm. Similar instructions could be used in "loss of chance" cases to aid the jury not only in differentiating between iatrogenic and innocent causes, but also in properly assigning value to probabilistic harm (i.e., the lost chance of recovery). For example, if the patient's chance of recovery from the underlying medical negligence was 49% in the absence of negligence, then jury instructions guiding the jury to multiple the recoverable damages by that percentage should be given. Not instructing the jury in this fashion risks overcompensating patients, by allowing juries to conclude that full recovery of damages is allowing even without proof that an iatrogenic cause of harm was more likely than not the proximate cause of the actual harm suffered by the plaintiff. Allowing this reduction will result in more efficient and fairer outcomes for medical providers in those cases where the actual harm results in greater part from underlying medical conditions which the medical tortfeasor played no role in causing in the first instance.

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Agency Update: Physicians Not Agents of Hospital

In *Magnini v. Centegra*, 2015 IL App (1st) 133451, plaintiff brought a medical malpractice action against Centegra Health Systems and several doctors seeking to recover damages for a personal injury allegedly sustained as a result of gastric bypass surgery and later surgeries to treat complications arising out of the original surgery. The sole theory of liability asserted against the hospital (Centegra) was vicarious liability for the actions of the doctors who were alleged to have been actual agents of the hospital.

The appellate court affirmed summary judgment in favor of the hospital. The court reasoned that the doctors were independent contractors and not agents of the hospital. Therefore, the hospital could not be held vicariously liable for the alleged negligence of the doctors.

The case contains a well-founded and thorough discussion of the law on the issue of the principal-agent relationship in the hospital setting. As a result, the decision is helpful to the analysis of medical malpractice actions sounding in agency.

The court states the general rule that in Illinois a hospital may be liable in a medical malpractice action into circumstances: directly, when the hospital owes the plaintiff an independent duty to review and supervise the plaintiff's medical care, or vicariously, where there exists a principal-agent relationship between the hospital and the physician accused of malpractice. In order to prevail on a claim for actual agency, or respondeat superior, a plaintiff must establish that:

1. A principal-agent relationship existed between the defendant and the actor;

2. The principal controlled or had the right to control the conduct of the alleged agent; and
3. The alleged conduct fell within the scope of the agency.

"The hallmark of agency" is the principal's right to control the manner in which the agent performs the work. By contrast, an independent contractor undertakes to produce a given result but is not controlled with regard to how that result is achieved. A principal will not be held vicariously liable for the acts of an independent contractor. Generally, a hospital is not liable for the actions of one who provides medical care as an independent agent outside the hospital's control.

In *Magnini*, the appellate court reviewed the evidence and agreed that the doctors were independent contractors. All of the doctors testified in their depositions that they were not employees of the hospital. The doctors also testified regarding their independence in making patient care decisions, and how the surgery was performed. The type of surgery that was performed was based on the physicians own expertise as an independent member of the medical staff. The provision of the healthcare services was up to the physician's independent judgment.

The court also reviewed the bariatric services agreement and the medical director services agreement, both of which provided that the physicians retain exclusive control over treatment decisions. The court noted, consistent with case law, the fact that an independent contractor is required to follow certain policies and procedures does not, standing alone, constitute sufficient control to create an agency relationship. Thus, although the hospital promulgated various policies and procedures via its bylaws, there was no evidence that the hospital retained the right to control patient care decisions, decisions that were expressly committed to the individual doctor's discretion and independent medical judgment.

Hinshaw Representative Matters

Paul Buschmann obtained a defense verdict in a chiropractic malpractice case. The plaintiff claimed he had suffered a shoulder injury (winged shoulder) after receiving chiropractic care, and that his injury prevented him from working for over two years. Paul was able to obtain testimony from plaintiff's treating physician that plaintiff's anatomy was unique and that the injury occurred notwithstanding the treatment. Paul also had two experts that testified that the treatment could not have caused the injuries complained of by the plaintiff. He did a fantastic job in obtaining a defense verdict.

Jeffrey Glass obtained a defense trial victory in St. Clair County, Illinois. Plaintiff was a 58-year-old woman who was seen by our client, an orthopedic surgeon, for severe ankle pain and general osteoarthritis. The defendant surgeon gave a steroid injection into the ankle. About three weeks later, the plaintiff developed a severe systemic sepsis which lodged in her ankle. The defendant performed numerous debridements and other therapy before transferring the patient to a tertiary care center. After several rounds of treatment, the plaintiff's leg was amputated below the knee. The plaintiff's theory was that the ankle was already infected and the doctor failed to diagnose this at the time he performed the injection in his office. Our defense showed that the ankle was not infected at the time of the office visit, but became infected because of a generalized systemic infection that occurred just days before the patient was admitted to the hospital. The jury agreed that the infection which caused the loss of the plaintiff's leg was unrelated to the steroid injection and the jury rendered a defense verdict in favor of our client.

Mike Henrick and Rich Kolodziej obtained a defense verdict in a medical negligence case following six days of trial. Plaintiff claimed that the defendant emergency room physician had been negligent in his care and treatment of a 53-year-old woman patient with a gastrointestinal bleed which led to her death. The patient came into the emergency room with a history of stomach ulcers, an episode of hematemesis that morning, and a hemoglobin level of 8.3 (7.0 being critical). While in the emergency room the plaintiff had one melanous stool with a drop in systolic blood pressure below 100, which returned to normal with fluid resuscitation. The plaintiff otherwise presented in stable condition. Plaintiff claimed that the defendant emergency room physician failed to have the patient timely seen by a gastroenterologist and failed to give blood sooner. The defense claimed that the Plaintiff remained stable throughout her stay in the Emergency Department and the first signs of a worsening condition did not occur until an hour after the patient had been transferred to the floor. The jury deliberated for an hour and a half before returning a unanimous verdict for the Defense.

Dawn Sallerson and William Hardy were successful at the trial court level and again subsequently before the Appellate Court, with the Appellate Court affirming the trial court's dismissal of a medical malpractice suit. Dawn and William defended a physician who was sued as a result of a patient who was injured during a spinal epidural procedure. It was

alleged that during the procedure, the table height was improperly adjusted, which caused the table to abruptly fall and the plaintiff to fall off the operative table itself, resulting in spinal injuries. The plaintiff contended that our client manipulated and/or provided instructions regarding the pedal, which controlled the table height, and that when the table suddenly fell, it was due to our client's actions. The plaintiff's complaint failed to include the necessary attorney affidavit and reviewing health care professional report as mandated by 2-622 for an action sounding in medical malpractice. The plaintiff argued additional time should be provided to obtain the reviewing health care professional report and then filed an affidavit stating that the lack of a response for medical records from the co-defendant hospital prevented the plaintiff from timely filing the physician report. The plaintiff argued in the alternative that the action sounded in ordinary negligence and/or a battery, and that a physician report was not required at all. Our motion to dismiss raised that the plaintiff's complaint should be dismissed on the grounds that the appropriate attorney affidavit and report were not appropriately or timely filed. Additional grounds for dismissal included that the plaintiff's action did not sound in ordinary negligence and/or a battery. The trial court agreed and our physician's motion to dismiss was granted with prejudice. The plaintiff appealed the trial court ruling. William and Dawn were successful in obtaining an appellate court decision affirming the trial court dismissal.

Michael Russart successfully defended a medical negligence and informed consent case in Milwaukee County Circuit Court in which during opening argument plaintiff's counsel told the jury he would be asking for $40 million in damages. Plaintiff, age 25, noticed bleeding from one of her nipples. A biopsy diagnosed invasive intraductal carcinoma. Oncology and surgical consults developed a treatment plan. She had the affected breast removed and, because she had tested positive for BRCA two gene, she had her other breast and ovaries removed prophylactically. Aggressive chemotherapy was recommended and accepted. She was given dense dose Adriamycin, along with other agents. The quantity of Adriamycin was below the level considered to be a significant risk for cardio-toxicity. Four months after her last chemotherapy dose, she began to exhibit dyspnea, and she was eventually diagnosed with cardiomyopathy. It was assumed to Adriamycin related. Her cardiomyopathy progressed despite medical therapies, and she received a new heart on New Years Day. She sued her oncologist for negligence based upon the failure to conduct pre- and intra-treatment heart testing to evaluate the effect of the Adriamycin on her heart and the failure to obtain a thorough family history. Her mother's family had an extensive history of cardiomyopathies, some fatal. During the course of this lawsuit, her mother developed cardiomyopathy and required a heart transplant. The oncologist had asked the plaintiff, in the presence of her father, about significant family health issues and none were mentioned. Two days after this consult, the plaintiff saw a radiation oncologist who reported that plaintiff's family history included "heart disease." In fact, we learned that the father and plaintiff's twin sister had mitro valve failure which required surgical repair. Four years before her diagnosis of cancer, plaintiff had joined the Coast Guard and revealed her twin sister's condition, and the Coast Guard had required her to undergo a cardiac ultrasound which was read as normal. The oncologist admitted seeing the radiation oncology consult report but testified that he would not have looked at the history or physical because he had just done his own a few days earlier but would have read the report to see if the treatment plan changed. The plaintiff also argued that the cardio-toxic effects of the chemotherapy were not adequately explained.

At trial the plaintiff testified that she did not read the information provided to her, including the informed consent form, which indicated that the chemotherapy could affect her heart's muscles and could impair its ability to pump blood. The oncologist testified that his routine informed consent included a statement that the chemotherapy could impact the heart's beating ability. The plaintiff agreed that the doctor may have said so, but she did not recall the statement. Plaintiff claimed to not be able to work and to be limited in her activities due to her heart transplant. Given her young age, her transplant surgeon opined that she will need a second transplant at about age 39. The life care plan and lost earnings, according to plaintiff, along with non-economic damages, placed her potential damages in the range of $40 million. After a two week trial, with experts on both sides, the jury found for the doctor and Mike's client, the Wisconsin Injured Patients and Families Compensation Fund, after about two hours of deliberations, one of which was the lunch hour.

Kyle Oehmke obtained summary judgment in favor of two nurses in a suit pending before the United States District Court for the Southern District Court of Illinois. A former inmate of Tamms Correctional Center filed suit against the nurses for deliberate indifference to his medical needs in violation of the Eighth Amendment. Specifically, the inmate alleged inadequate medical treatment following an altercation with prison staff, improper refusal to transfer the inmate to a hospital outside the prison, and failure to provide follow-up treatment. Kyle argued that the inmate failed to file a proper grievance against the nurses and thereby failed to exhaust his administrative remedies. The Court agreed and entered summary judgment accordingly. The Court's decision can be read as follows: *Wilborn v. Ealey, et al.*, 2015 WL 1258428, Case No.

13-cv-70.