The Lost Chance Doctrine

by Mark R. McKenna & Clint T. Pierce

In medical malpractice cases, there are often multiple providers who have committed errors over an extended period of time, leading to a catastrophic result. Defense lawyers often misrepresent to trial judges the law on proximate cause in Illinois and argue that a jury should not be allowed to consider defendants liable for errors early in a course of treatment if the errors did not directly cause the ultimate injury.

In cases where medical errors by different providers occur over many hours or days, defense lawyers argue that a plaintiff cannot establish proximate because a) a defendant's errors later in the course of care "broke the causal chain" for errors by other defendants early in the course of care, or b) plaintiff cannot prove the mistakes early in the course of care caused the ultimate injury. Take this birth injury scenario:

A 36-week pregnant woman goes to the emergency room at 10:40 p.m. with headache, shortness of breath, palpitations and protein in her urine. These were signs of preeclampsia, a pregnancy-related condition. However, the defendant hospital's triage nurse admitted the mother to the ER instead of sending her to the labor and delivery unit for monitoring of both mother and baby—the first deviation from the standard of care.

The ER physician kept the mother in the ER for hours without contacting the attending obstetrician, and without ordering electronic fetal heart monitoring [EFM]—additional deviations from the standard of care. Eventually the mother's blood pressure rose to 180/105—abnormally high and a clear sign of severe preeclampsia. The treatment of severe preeclampsia is delivery of the baby. However, the ER physician and a consulting cardiologist chose to send the mother to the hospital's cardiac catheterization lab instead of the labor and delivery unit, losing an opportunity to monitor the baby and perform a cesarean section.

A labor and delivery nurse came to the ER to check for fetal heart tones with a Doppler device, but never recorded her findings in the chart and never instituted continuous fetal heart monitoring. The nurse left and never returned to monitor the baby.

At 7:30 a.m., the defendant attending obstetrician arrived in the cardiac catheterization lab. Using a Doppler device, the obstetrician noted that the baby's heart rate was normal and in the "130's." The obstetrician diagnosed the mother as having severe preeclampsia, and ordered a cesarean section delivery of the baby. When the obstetrician performed the cesarean section at 8:42 a.m., the baby was pulseless, motionless, and suffering from severe hypoxia and acidosis. The baby's cord blood pH was less than 6.8, and her APGAR scores were 0 for twenty minutes. A neonatologist revived the baby after twenty-five minutes of resuscitation efforts. Neonatologists diagnosed the baby with a severe hypoxic-ischemic brain injury soon after birth.

Since all the defendants failed to ever use a continuous electronic fetal heart monitor, there was no hard evidence regarding when the baby's heart rate and heart rate patterns showed signs of fetal distress. In the Complaint at Law and in the plaintiff's Rule 213(f)(3) disclosures, we carefully described how multiple deviations from the standard of care over nine hours—in combination—were a proximate cause of the child's brain injury:

- Untreated preeclampsia subjects the fetus to hypoxic injury.
- Over time, untreated preeclampsia subjects the fetus to gradual depletion of fetal oxygen reserves and ultimately hypoxic injury.
- Between the time the mother arrived at the hospital to the time of the cesarean section delivery at 08:42, the fetus was experiencing a gradual depletion of her oxygen reserves and hypoxic distress secondary to her mother's preeclampsia.
- The treatment for preeclampsia is delivery of the fetus.
- The failure to place the mother on continuous electronic fetal monitoring when she arrived at the hospital led to the failure to detect the fetus' gradual loss of oxygen reserves, fetal distress, and hypoxic injury before the cesarean section delivery was accomplished at 08:42.
- The negligent failure to utilize continuous electronic fetal monitoring when the mother arrived in the ER, and throughout the time the mother was in the hospital before delivery, makes it difficult to pinpoint the time that fetal distress began - except to say that it began before delivery at 08:42. The fetal distress was more likely than not prolonged and severe and the longer the fetus

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went undelivered the more she was exposed to the dangers of hypoxia.

• If the mother had been sent to the labor and delivery unit when she arrived at the hospital, she would have been put on an electronic fetal monitor in that unit, and the baby would have been delivered at the first sign of distress. This would have eliminated all risk of hypoxia and hypoxic injury to the baby. This does not excuse the later failures that delayed delivery until 08:42. When it comes to fetal distress, every minute counts and any delay in detecting and addressing the fetal distress can and will increase the risk of harm to the fetus from hypoxic injury. Similarly, any delay in detecting and addressing the fetal distress will lose the chance to prevent hypoxic injury to the baby.

• Ultimately, all of the deviations listed in these disclosures prolonged the preeclampsia and increased the risk of harm to the child in a way that made the injury an inevitability.

All the defendants had the duty and the opportunity to utilize continuous electronic fetal monitoring but failed to do so, and in so failing, contributed to the fetal distress which caused the child's irreversible brain damage.

All of the experts agreed that the baby was likely healthy and neurologically intact when the mother arrived at the hospital. All the experts agreed that the baby likely began experiencing hypoxemia and fetal distress after the mother was in the cardiac catheterization lab with deteriorating oxygen saturation levels—over six hours after the mother arrived in the hospital's ER.

At trial, the hospital and ER defendants sought to bar via Motions *in Limine* all evidence regarding the failure of the ER physician and nurses to utilize continuous electronic fetal heart monitoring. The defendants argued that without evidence EFM would have shown changes to the baby's heart rate in the ER, there was no causal connection between the failure to use EFM and the baby's ultimate injury.

The trial court denied the defense motions based on a doctrine more important than ever in medical negligence cases—the lost chance doctrine.

I. What is the Lost Chance Doctrine?

The lost chance doctrine is a tool for plaintiffs to prove proximate cause.[1] Lost chance is not a separate theory of recovery. It is a concept that is part of the proximate cause analysis.[2] A plaintiff can establish proximate cause when evidence shows that negligent conduct either a) increased the risk of harm, or b) lost a chance to prevent the harm. For example, in a medical malpractice case, a plaintiff can use the lost chance doctrine when a defendant negligently deprived the plaintiff of a chance to survive or recover from a health problem, or where the malpractice lessened the effectiveness of treatment, or increased

the risk of an unfavorable outcome to the plaintiff.[3]

Most importantly, the lost chance doctrine gets the entire series of mistakes in front of the jury. The case goes from one defendant making one mistake, to multiple defendants making multiple mistakes. When the series of mistakes occur over time, the defendant who made the first mistake in the series is still on the hook as a proximate cause of the ultimate outcome. The lost chance doctrine allows the jury to determine whether each defendant's conduct in the series of mistakes increased the risk of harm to a plaintiff and/or lost a chance to prevent the ultimate outcome.

II. What does a plaintiff need to establish for the jury to hear the entire series of negligence?

A plaintiff proves each defendant's conduct in the series the traditional way: expert testimony to a reasonable degree of medical certainty. Proximate cause under the lost chance doctrine is the same as traditional proximate cause.[4] The only difference from a standard proximate cause analysis is specifically tailoring the opinion to the lost chance doctrine. Each defendant's conduct, to a reasonable degree of medical certainty, proximately caused the increased risk of harm or lost chance of recovery.[5] A plaintiff must present "some evidence" that the alleged negligence proximately caused an increased risk of harm or decreased the plaintiff's chance of a better outcome.[6]

Illinois courts have applied the lost chance doctrine in various scenarios. For example, in *Shicheng Guo v. Kamal*, when the defendant failed to send the CT film even though they sent the report which identified plaintiff's bleed.[7] In *Holton v. Memorial Hosp.*, when nurses did not report plaintiff's loss of sensation in her legs.[8] In *Vanderhoof v. Berk*, when defendants failed to take four steps before surgery which led to injury, and diminished plaintiff's chance of successful treatment.[9] In *Buck v. Charletta*, when a nurse failed to call a doctor about MRI results.[10] In *Northern Trust Co. v. Louis A. Weiss Memorial Hosp.*, when the hospital failed to provide a specially trained nurse for the nursery.[11]

In cases involving a lost opportunity for treatment, a plaintiff can establish proximate cause through evidence "to a reasonable degree of medical certainty, that the defendant's failure to timely diagnosis more probably than not compromised the effectiveness of treatment received or increased the risk of harm to the plaintiff."[12] The Illinois Supreme Court provided another example in *Holton*, stating "Had the doctors been given the opportunity to properly diagnose [the plaintiff's] condition based on accurate and complete information, they would have had the opportunity to treat her condition by ordering the appropriate treatment. Because of the hospital's negligent failure to accurately and timely report [the plaintiff's] symptomology, the appropriate

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treatment was not even considered." Further, a plaintiff may prove that he was deprived of a chance of a better outcome by showing that different treatment would have followed absent defendant's negligence.[13]

III. What if a defendant or treater, who becomes involved later in the series, claims they would not have done anything differently despite any earlier negligence?

That defendant or treater created an ideal question of fact to get that conduct in front of the jury. This scenario "only adds consideration for the jury to resolve on this material question of fact."[14] Plaintiff's expert must establish what a healthcare professional acting within the standard of care would have done.

For example, a nurse failed to communicate a critical test result to the doctor. The doctor claims he would not have acted any differently even if the nurse had communicated the result. The defense moves to bar all testimony regarding the nurse's negligence, arguing no proximate cause. With expert testimony establishing what a doctor acting within the standard of care would have done with that test result, the doctor's testimony creates a question of fact. Thus, the court will allow the jury to consider the nurse's deviation.

Illinois courts have rejected the "I would not have done anything differently" testimony as a defense. "... [A] plaintiff would always be free to present expert testimony as to what a reasonably qualified physician would do with the undisclosed information and whether the failure to disclose the information was a proximate cause of the plaintiff's injury in order to discredit a doctor's assertion that the nurse's omission did not affect his decision making."[15]

Another example, in *Shicheng Guo*, at ¶34, the court found that "resolution of the conflict between the Lutheran General doctors' testimony that they would not have changed their treatment plan and plaintiff's expert testimony as to what the standard of care required to treat Bao, involves factual findings and credibility determinations that should be left to the jury."[16] Where the evidence is conflicting, it is within the jury's province to resolve the conflict.[17]

The question of whether a physician's treatment of the plaintiff would have been the same if other providers accurately informed the doctor of the plaintiff's true condition is a question of fact for the jury. "Unquestionably, however, issues involving proximate cause are fact specific and therefore uniquely for the jury's determination."[18]

IV. What is a plaintiff not required to prove under the Lost Chance Doctrine?

A plaintiff is not required to prove that she would have obtained a better result absent the defendant's negligence, or that a defendant's negligence actually deprived plaintiff of a better outcome.[19]

Rather, a plaintiff only needs to show that the alleged negligence increased a *risk* of harm or a lost *chance* of recovery. The court in *Hemminger v. LeMay*, 2014 IL App (3d) 120392, ¶23 stated:

> "In other words, Hemminger only needed to show that Dr. LeMay's negligence deprived Tina of the opportunity to undergo treatment that ***could*** have been more effective if given earlier, not that such treatment ***would*** have been effective. See, *e.g.*, *Walton v. Dirkes*, 388 Ill.App.3d 58, 61, (2009) (plaintiff may survive a motion for directed verdict by presenting evidence that an earlier diagnosis would have led to treatment that "*may* have contributed to the [plaintiff's] recovery" (emphasis added and quotation marks omitted)); *Topp v. Logan*, 197 Ill. App.3d 285, 299–300, 143 Ill. Dec. 519, 554 N.E.2d 454 (1990) (plaintiff must present evidence that earlier diagnosis *could* have altered final result); see also *Wodziak v. Kash*, 278 Ill.App.3d 901, 913, 215 Ill.Dec. 388, 663 N.E.2d 138 (1996). Under *Holton*, Hemminger only had to show a lost *chance* of survival, not that Tina actually would have survived absent Dr. LeMay's negligence."[20]

A defendant is liable if their conduct contributed in whole or in part to the plaintiff's injury, and more than one negligent act can be the proximate cause of an injury.[21] With expert testimony establishing each deviation increased a *risk* of harm or lost a *chance* to prevent the ultimate outcome, a court should allow the entire series of negligence in front of the jury because proximate cause is fact specific and uniquely for the jury's determination.[22]

Conclusion

Knowing the lost chance doctrine, and how courts apply it, is not only important for trial. Plaintiffs must use it when drafting the complaint, deposing defense witnesses, and disclosing expert opinions. The key is to always tie an expert's opinion regarding each deviation from the standard of care to an increased risk of harm to the plaintiff, and to the lost chance to prevent the ultimate outcome.

Endnotes

1 *Holton v. Memorial Hosp.*, 176 Ill.2d 95 (1997).

2 *Sinclair v. Berlin*, 325 Ill. App. 3d 458, 466 (1st Dist. 2001).

3 *Holton*, 176 Ill.2d at 111.

4 *Bailey v. Mercy Hospital and Medical Center*, 2021 WL 5365298 (Nov. 18, 2021).

5 *Vanderhoof*, 2015 IL App (1st) at ¶61.

6 *Vanderhoof v. Berk*, 2015 IL App (1st) 132927.

7 *Shicheng Guo v. Kamal*, 2020 IL App (1st) 190090.

8 *Holton v. Memorial Hosp.*, 176 Ill.2d 95 (1997).

9 *Vanderhoof v. Berk*, 2015 IL App (1st)

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[10] *Buck v. Charletta*, 2013 IL App (1st) 122144.

[11] *Northern Trust Co. v. Louis A. Weiss Memorial Hosp.*, 143 Ill.App.3d 479 (1st Dist. 1986).

[12] *Shicheng*, 2020 IL App (1st) at ¶18, quoting *Scardina v. Nam*, 333 Ill.App.3d 260, 269 (1st Dist. 2002).

[13] *Aguilera v. Mount Sinai Hosp. Med. Ctr.*, 293 Ill.App.3d 967, 975 (1st Dist. 1997).

[14] *Shicheng Guo v. Kamal*, 2020 IL App (1st) 190090, ¶21.

[15] *Buck*, 2013 IL App (1st) at ¶¶72-73.

[16] *Shicheng Guo*, at ¶34.

[17] *Wodziak v. Kash*, 278 Ill.App.3d 901, 913-14 (1st Dist. 1996).

[18] *Suttle ex rel. Central Trust Bank v. Lake Forest Hosp.*, 314 Ill.App.3d 96 (2000).

[19] *Lambie v. Schneider*, 305 Ill.App.3d 421, 426 (4th Dist. 1999) citing *Holton*, 176 Ill.2d 95 at 111; *Borowski v. Von Solbrig*, 60 Ill.2d 418, 424 (1975).

[20] *Id.*

[21] *Kunz v. Little Co. of Mary Hospital and Health Care Centers*, 373 Ill.App.3d 615, 622 (1st Dist. 2007); *Dunning v. Dynegy Midwest Generation, Inc.*, 2015 IL App (5th) 140168, ¶ 39.

[22] *Shicheng Guo v. Kamal*, 2020 IL App (1st) 190090; see also *Williams v. Univ. of Chicago Hospitals*, 179 Ill.2d 80, 88 (1997); *Holton*, 176 Ill.2d at 107.

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