IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

LYDIA D. CASSARO, *individually, and as the Special Administrator of the Estate of Randall R. Bianchi,* Plaintiff,	)	No.
v.	)	
HARVEY J. FRIEDMAN, DANIEL D. RIVARD, THOMAS H. BURNSTINE, HEIDI B. FURR, KELLEY HARRISON, and ADVOCATE CONDELL MEDICAL CENTER, Defendants.	)	

COMPLAINT

AND NOW comes the Plaintiff, Lydia D. Cassaro, individually, and as the Special Administrator of the Estate of Randall R. Bianchi, by and through her undersigned counsel, to file this Complaint, pursuant to the Illinois Wrongful Death Act, 740 ILCS 180/0.01, *et seq.*, and avers as follows:

Jurisdiction and Venue

1. Plaintiff seeks damages in excess of $50,000.

2. At least one of the Defendants resides in Cook County, Illinois.

Parties

3. Plaintiff, Lydia D. Cassaro ("Lydia"), is the biological mother of the decedent, Randall R. Bianchi, and is the Special Administrator of the Estate of Randall R. Bianchi. Ms. Cassaro is an adult individual, who, resides in Deltona, Florida.

4. Defendant, Harvey J. Friedman, M.D., is an adult individual, who, resides in Cook County, Illinois. Defendant Friedman is a licensed medical professional, employed by Pulmonary Medicine Associates, which is located at 675 W. North Avenue, Suite 214, Melrose Park, IL, 60160-1604. During all relevant times, Defendant Friedman was an agent and/or employee of Advocate Condell Medical Center. Dr. Friedman is certified by the Board of Internal Medicine in internal medicine, critical care medicine, and pulmonology. Dr. Friedman holds himself out to be a pulmonologist.

5. Defendant, Daniel D. Rivard, M.D., is an adult individual and a licensed medical professional, employed by Best Practices Inpatient Care, Ltd, which is located at 3880 Salem Lake Drive, Suite F, Long Grove, IL 60047. During all relevant times, Defendant Rivard was an agent and/or employee of Advocate Condell Medical Center. Dr. Rivard is certified by the American Board of Internal Medicine in internal medicine, and practices as a hospitalist.

6. Defendant, Thomas H. Burnstine, M.D., is an adult individual and a licensed medical professional, employed by Thomas H. Burnstine, MD SC, 755 S. Milwaukee Avenue, Suite 220, Libertyville, IL 60048. During all relevant times, Defendant Burnstine was an agent and/or employee of Advocate Condell Medical Center. Dr. Burnstine is board certified in neurology.

7. Defendant, Heidi B. Furr, RN, is an adult individual and a licensed medical professional. During all relevant times, Defendant Furr was an agent and/or employee of Advocate Condell Medical Center, performing the duties of a registered nurse in the intensive care unit.

8. Defendant, Kelley Harrison, RN, is an adult individual and a licensed medical professional. During all relevant times, Defendant Harrison was an agent and/or employee of Advocate Condell Medical Center, performing the duties of a registered nurse.

9. Defendant, Advocate Condell Medical Center ("Condell"), is located at 801 S. Milwaukee Avenue, Libertyville, Lake County, IL 60048. The treatment and care provided by Defendant Condell and its agents and employees hastened and caused Randall's death. Defendant Condell acted through its agents and employees, including but not limited to, its physicians, nurses, and administrators.

Decedent and Familial Relationships

10. The Decedent is Randall R. Bianchi ("Randall"), who, on the date of his death, was domiciled in Grayslake, Illinois.

11. Lydia D. Cassaro ("Lydia") is Randall's biological mother, who lives in Deltona, Florida.

12. Mark R. Bianchi ("Mark") is Randall's biological father, who is believed to reside in Crystal Lake, Illinois.

13. Aaron J. Lindvall is Randall's biological brother, who lives in McHenry, Illinois.

14. Angelica R. Cassaro is Randall's biological sister, who lives in Debary, Florida.

15. Mikayla M. Cassaro is Randall's biological sister, who lives in Deltona, Florida.

16. CHM, a minor, is Randall's biological brother, who lives in Deltona, Florida.

17. On the date of his death, Randall was not married, and did not have any children.

Factual Background

18. This case involves 22-year old Randall R. Bainchi ("Randall"), a former United

States Marine, who served in warzones in Afghanistan and Iraqi, and who, as a result, suffered from Post-Traumatic Stress Disorder ("PTSD"), and a drug addiction.

19. The drug addiction resulted in an 'other than honorable discharge' from the U.S. Marines, leaving Randall to fend for himself, without Veteran's Association or other health insurance or benefits.

20. On December 21, 2012, Randall and his girlfriend returned to his residence in Illinois, after visiting with his mother, Lydia, for a week in Florida.

21. During the flight home from Florida to Illinois, Randall proposed to his girlfriend, and she accepted.

22. Later that day, Randall's fiancé found him unconscious, as a result of an apparent accidental drug overdose.

23. CPR was initiated, and emergency medical personnel transported Randall to the Advocate Condell Medical Center ("Condell"), 801 S. Milwaukee Avenue, Libertyville, Lake County, IL 60048.

24. Randall did not have health insurance, power of attorney, living will, or other medical directive.

25. The Defendants admitted Randall to the Advocate Condell Medical Center, and assumed complete responsibility for his medical care.

26. At 1:16 PM, medical personnel administered an AED shock to Randall, and Randall's pulse returned.

27. At 2:00 PM, medical personnel initiated the hospital's cooling protocol.

28. Pursuant to the cooling protocol, the target temperature "will continue for 24 hours from initiation of cooling."

29. In addition, pursuant to the protocol, "controlled re-warming . . . will take about 8 hours."

30. Importantly, pursuant to the hospital's cooling protocol, rewarming should have begun on December 22, 2012, at 2:00 PM, and ended at around 10:00 PM.

31. The Defendants, however, did not follow the cooling protocol.

32. The Defendants gave Randall numerous medications, including but not limited to, Amiodarone, Dopamine, ivf, Versed, Propofol drip, and Fosphenytoin.

33. Defendant Rivard noted in Randall's medical records that Randall was "estranged from father" and had a "brother in Rockford," and a "mom in FL."

34. At 2:23 PM, Dr. Alexander Zartaisky (diagnostic radiology/neuroradiology) spoke with Randall's mother, and advised her about Randall's medical case and condition.

35. At 2:45 PM, a nurse indicated in the medical records that "Pt's mother is next of kin and was notified by MD of pt's condition. Fiancé reports that his father lives in area but is estranged and has no way of contacting him. Mother's contact info entered in computer by registration."

36. At 3:10 PM, medical records indicate that Randall was medically stable but unresponsive.

37. At 3:34 PM, Randall exhibited signs of shivering and/or mild seizure activity, and as a result, medication was administered to paralyze him.

38. At 3:35 PM, medical records indicate that Defendant Rivard admitted Randall to the intensive care unit ("ICU") in stable condition and that Defendant Rivard counseled the "Family," regarding "diagnosis" and "diagnostic results."

39. Randall was placed on a ventilator.

40. At around 4:10 PM, Defendant Burnstine (neurology) examined Randall and noted, "Muscle twitching does not look like typical seizure activity, and I suspect it is muscle activity; however, I have ordered a stat EEG . . . The patient should have a CT scan of his head or an MRI when stable enough to go to radiology."

41. None of the Individual Defendants, however, ever performed a CT scan or an MRI.

42. At 4:50 PM, Defendant Ginsburg (critical care/pulmonary disease), examined Randall and noted "he is definitely twitching and an EEG is now being attempted."

43. Defendant Ginsburg noted at the time that "he is on amiodarone."

44. Defendant Ginsburg further noted that "we will contact Gift of Hope."

45. At around 6:39 PM, Defendant Burnstine performed an Electroencephalograph ("EEG") test on Randall.

46. During the EEG, low voltage discharges were observed, and the test was ultimately determined to be a "severely abnormal electroencephalograph."

47. On December 22, 2012, at around 10:00 AM, Defendant Burnstine noted, "breathing over ventilator at times," which means that Randall had slight improvement in his neurological functioning, despite the presence of Propofol and/or other medications in his system.

48. Defendant Burnstine further noted, "seizures and breathing over vent, seizure seem controlled, he is not brain dead."

49. At around 10:12 AM, while Randall was receiving Propofol and likely other medications, Defendant Friedman (internal medicine, critical care medicine, pulmonology) similarly noted, "Remains unresponsive. RR 16 on AC 16, turned down to rate of 10, and he does breath at 15."

50. At around 11:00 AM, Defendant Rivard noted, "Per nurse, pt has been occasionally breathing over vent."

51. At around 11:50 AM, Defendant Freidman noted, "D/w mother and explained situation. She is having a hard time believing that he OD'ed and that he likely will not improve. Will continue to update her regularly."

52. Lydia advised all Defendants to whom she spoke, not to discontinue life support for any reason, and that she was making arrangements to travel from Florida to the hospital.

53. Pursuant to the Health Care Surrogate Act (755 ILCS 40/10), "Available" under the Act is defined as follows:

> 'Available' means that a person is not 'unavailable'. A person is unavailable if (i) the person's existence is not known, (ii) the person has not been able to be contacted by telephone or mail, or (iii) the person lacks decisional capacity, refuses to accept the office of surrogate, or is unwilling to respond in a manner that indicates a choice among the treatment matters at issue.

54. Despite the fact that Lydia was "available" to consult with about and to direct Randall's medical care, the Defendants advised Lydia that since Randall's estranged father, Mark, was at the hospital, they would be taking direction from Mark only.

55. Lydia advised the Defendants that they were required by law to follow her medical directions, and reiterated the fact that she did not give consent to the termination of life support, or to a do not resuscitate order ("DNR").

56. Lydia communicated clearly and unequivocally to the Defendants that she wanted the Defendants to use all medical means necessary to save and to preserve Randall's life; regardless of the possibility of long-term disability.

57. On December 22, 2012, at around 2:40 PM, Defendant Burnstine performed a follow-up EEG test on Randall while he was still medicated.

58. Defendant Burnstine determined that the EEG exhibited "electrocerebral silence," and the medical records indicate that Defendant Burnstine advised Defendant Freidman accordingly.

59. Despite the fact that a cerebral blood flow study is the most reliable test for determining whether brain functioning is intact, the Defendants failed to conduct a cerebral blood flow study.

60. Moreover, Defendant Freidman did not perform another EEG test to confirm the diagnosis of "electrocerebral silence."

61. The applicable standard of care is for the Defendants to keep an accurate medical record of the treatment provided to patients.

62. After the EEG test, however, the Defendants inexplicably stopped recording in the medical records whether or not Randall was breathing over the ventilator, and other relevant facts regarding Randall's treatment or non-treatment.

63. Furthermore, the Defendants stopped providing medical treatment intended to improve Randall's medical condition and to prolong his life.

64. Instead, the Defendants began to administer medical treatment to Randall's organs, to protect the organs, and to prepare Randall's organs for harvesting.

65. The medical treatment administered to Randall's organs, however, negatively impacted Randall's medical condition and prognosis.

66. Despite the fact that only a few hours prior, two doctors and one nurse had confirmed that Randall was breathing over the ventilator, at 4:00 PM, medical records indicate that Defendant Friedman administered an apnea test.

67. The apnea test – which cuts off oxygen to the brain – causes hypoxia and hypercapnia, and will bring about severe, irreversible brain damage in patients, who, with proper care, would otherwise survive.

68. Despite being available, the Defendants did not obtain informed consent from both Lydia and Mark to perform the apnea test.

69. To the contrary, Lydia had already communicated clearly and unequivocally to the Defendants that she wanted the Defendants to use all medical means necessary to save and to preserve Randall's life; a goal undermined by the administration of an apnea test.

70. It is believed that discovery will reveal, and therefore averred, (a) that medically accepted prerequisites for the apnea test, and (b) accepted standards for conducting the apnea test, were not followed.

71. By way of example, it is believed and therefore averred that since Randall's liver and kidneys were not functioning at full strength, the Defendants performed the aforementioned diagnostic testing while Propofol and/or other medications or drugs remained in Randall's system, and while he was still sedated and/or paralyzed.

72. Moreover, it is believed and therefore averred that Randall was, or should have been, still hypothermic when Defendant Friedman performed the apnea test.

73. Defendant Friedman, a pulmonologist, who is neither a neurologist nor a neurosurgeon, decided that his findings during the apnea test indicated that brain death had occurred.

74. Despite knowing that Randall was estranged from his father, per Defendant Freidman, he "updated father at bedside."

75. After the first apnea test, Defendant Freidman noted, "GOH coming."

76. At 4:05 PM, Defendant Furr (ICU RN) noted the following in her progress note:

> Progress Note: Pt brought from ER on cart, placed on ICU bed and monitors. BP high, HR 90, sinus. Dopamine stopped, IVF bolus stopped. *Pt cool, on cooling blanket, but not currently cooling since he's already hypothermic*. Intraoseous IV removed. Using left hand PIV and right femoral TLC. Foley temp hooked up to monitor. Assessment completed. Dr. Ginsburg notified that pt has arrived. Critical care panel repeated. 1700 3 amps of bicarb given and adjustments made in vent support.1705 GOH notified. EEG here, test taking approximately 30 minutes. Then Dr. Bernstein here reading EEG. 1800 rechecking abg. Vent adjustments made. Insulin drip started per protocol. *1830 Dr. Ginsburg placing arterial line. Levo drip started for low BP (SBP 80's). GOH at bedside, updated.*

77. At 8:00 PM, Defendant Friedman, administered a *second* apnea test, likely causing further irreversible brain injury.

78. Again, the Defendants did not obtain informed consent from both Lydia and Mark to perform the second apnea test.

79. To the contrary, Lydia had already communicated clearly and unequivocally to the Defendants that she wanted the Defendants to use all medical means necessary to save and preserve Randall's life; a goal undermined by the administration of a second apnea test.

80. It is believed that discovery will reveal, and therefore averred, (a) that medically accepted prerequisites for the second apnea test, and (b) accepted standards for conducting the second apnea test, were not followed.

81. At 8:06 PM, Defendant Harrison (RN) indicated in the medical records the following:

> Family notified that apnea test was positive for brain death. I called the patients mother in Florida to inform her of the results. She insisted that we were lying and was in shock. Father at bedside and told staff that his son was an organ donor and requested to speak to Gift of Hope. Gift of hope spoke with Father and aunt who were at the bedside. *Mother called back and was upset saying that the results were made up and she was going to seek counsel if we "pull the plug".* The patients [sic] aunt spoke with the patients mother (they are sisters)[1] and tried to inform her of the grave prognosis of her son, but the mother is unable to come to Illinois.[2] The father is in agreement to honor the patients [sic] wishes for organ donation.

82. At 8:17 PM, Defendant Friedman, a pulmonologist, pronounced Randall dead.

83. It is believed that discovery will reveal, and therefore averred, that before pronouncing Randall dead, despite their availability, Defendant Freidman did not consult with a neurologist and/or neurosurgeon to determine Randall's diagnosis, prognosis, or whether or not brain death criteria had been met.

84. Likewise, it is believed that discovery will reveal that despite their availability, no neurologist and/or neurosurgeon examined Randall or participated in the diagnosis of brain death.

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[1] Lydia does not have a sister.

[2] Lydia advised the Defendants that while she could not get to the hospital immediately because she was in Florida, she was making financial and travel arrangements to get to Illinois as soon as possible, and that she intended to seek a second medical opinion.

85. In Illinois, legal "death" occurs "when, according to accepted medical standards, there is (i) an irreversible cessation of circulatory and respiratory functions; or (ii) an irreversible cessation of all functions of the entire brain, including the brain stem." 755 ILCS 50/1-10.

86. The diagnosis of brain death signifies the loss of those critical brain functions that maintain the integrity of the body as a living organism.

87. The loss of critical brain functions would result in the disintegration and deterioration of Randall's body, regardless of whether or not he remained on mechanical life support systems.

88. However, it is believed that discovery will reveal, and therefore averred, that despite pronouncing Randall brain "dead," the Defendants cannot establish that Randall suffered an "irreversible cessation of *all functions* of the *entire* brain, including the brain stem," as required.

89. Specifically, it is believed that discovery will reveal, and therefore averred, that despite being declared brain dead, Randall's brain continued to regulate his body's homeostatic functions, i.e., circulation, digestion, metabolism of food, excretion of wastes, hormonal balance, temperature, PH, salt and water balance, wound healing, and growth.

90. Since Lydia and Mark, as Randall's biological parents, were in an equal class, in order for the Defendants to be permitted to lawfully terminate life support, *both* Lydia *and* Mark needed to provide informed consent for the removal of life support and a DNR, which neither of them did.

91. To the contrary, Lydia had already communicated clearly and unequivocally to the Defendants that she wanted the Defendants to use all medical means necessary to save and preserve Randall's life – not to "pull the plug" – a goal undermined by the administration of two

apnea tests, Randall's removal from the ventilator, and the Defendants' cessation of medical treatment necessary to sustain life.

92. Moreover, despite knowing that Randall was estranged from his father, and despite knowing that Lydia remained immediately accessible by telephone, the Defendants permitted Mark only to make unilateral end-of-life medical decisions on Randall's behalf, and manipulated Mark into agreeing to the termination of life support, and to a DNR.

93. When Lydia called the hospital to speak further with the Defendants, the Defendants refused to speak with her.

94. Instead, the Defendants told Lydia that she should speak with Mark and his fiancé, because according to the Defendants, Mark and his fiancé were directing Randall's care.

95. The Defendants did not explain to Mark that an agreement to the termination of life support, and a DNR for the purpose of harvesting Randall's organs, would change the medical treatment being provided to Randall, and would set in motion a chain of events that would ensure Randall's demise.

96. Based solely on Mark's *uninformed* consent, the Defendants discontinued Randall's life support, causing his untimely death.

97. It is believed and therefore averred that Randall had neither experienced brain death nor cardiac death prior to when life support was terminated.

98. Since Randall's medical condition had improved in the 24-hour period of time from when Randall was admitted to the hospital on December 21, 2012, the Defendants should have based their medical decisions and treatment plan on the entire clinical picture and not just on the EEG.

99. Had the Defendants done so, the Defendants would not have (a) deviated from the cooling protocol, (b) conducted EEG tests less than 24 hours apart, (c) conducted two apnea tests that likely caused irreversible brain injury, and (d) removed Randall from the ventilator and discontinued necessary medical treatment.

100. The medical testing performed could not have diagnosed the Illinois criteria for death, as an apnea test (which only tests for breathing function of the brain) cannot determine the irreversible cessation of all functions of the entire brain, and an EEG, does not evaluate the functioning of the brain stem.

101. Also, the lack of a neurologist performing one of the neurological examinations for brain death determination resulted in the determination being made by a physician not trained or qualified as a neurologist; despite a neurologist being on staff at the hospital and already having been consulted in regard to Randal's care.

102. The nurse Defendants either knew or should have known that unless *both* Mark *and* Lydia provided informed consent to (a) specific medical treatments, or (b) removing Randall from the ventilator and ceasing other necessary life sustaining medical treatment, the Defendants were not lawfully permitted to do so.

103. As nurses, the nurse Defendants were obligated to advocate on Randall's behalf but failed to do anything to challenge or to stop the course of medical treatment that caused Randall's untimely death.

104. But for the desire to harvest Randall's organs, and to free up a hospital bed, there was no reason for the Defendants to rush to declare Randall dead.

105. During all relevant times, the Individual Defendants acted pursuant to the policies and practices of the entity Defendant, and in furtherance of the entity Defendant's financial and business interests.

106. The entity Defendant knew of, permitted, and ratified, the Individual Defendants' aforementioned conduct.

107. After being declared dead, without proper consent from the surrogates, Defendant Condell permitted Gift of Hope to take over Randall's medical care, knowing that Gift of Hope would treat Randall's organs, instead of his medical condition.

108. It is believed and therefore averred that between the time that Randall was pronounced dead and the time that his organs were harvested, there were instances wherein he had productive coughing and breathed over the vent.

109. Regardless, to Randall's detriment, the Defendants continued to move forward with medically treating Randall's organs only, and with organ harvesting.

110. Healthy vital organs cannot be retrieved from a cadaver.

111. It is for this reason that doctors administer paralyzing/anesthetic drugs to "donors," to control for pain and movement, just prior to removing organs.

112. On December 24, 2012, from approximately 3:00 PM until approximately 8:00 PM, Gift of Hope harvested Randall's heart, bilateral lungs, bilateral kidneys, and liver.

COUNT I

Plaintiff v. Defendants
Medical Malpractice Pursuant to Illinois Law
(Pursuant to the Illinois Wrongful Death Act)

113. Paragraphs 18-112 are incorporated herein by reference.

114. Medical malpractice occurs when a doctor or other healthcare professional, or institution, breaches the standard of care when treating a patient, resulting in an injury or death.

115. The standard of care is the generally accepted set of standards and practices that other medical professionals would take when treating a similar patient.

116. The Defendants breached the standard of care while treating Randall, which caused Randall's unlawful and untimely death.

A. Violation of the Illinois Health Care Surrogate Act

117. After examining Randall, the Defendant attending physicians determined that Randall lacked decisional capacity and noted this fact in writing in his medical records by stating their observations, findings, diagnosis, and prognosis.

118. One or more of the Defendants determined that there was no authorized agent to act on Randall's behalf; thus, the Defendants determined that a surrogate needed to be located.

119. Pursuant to the Health Care Surrogate Act (HCSA), the Defendants determined that *both* Lydia *and* Mark, Randall's parents, were available, competent, and legally authorized surrogates to act on Randall's behalf.

120. As such, the Defendants repeatedly provided both Lydia and Mark with updates, albeit at times incomplete and/or misleading, regarding Randall's medical diagnosis and prognosis, intending to influence their medical decisions.

121. Pursuant to the HCSA, "decisions concerning medical treatment on behalf of an adult patient who lacks decisional capacity may be made by a surrogate decision maker, in consultation with the attending physician, with the exception that decisions to forgo life-sustaining treatment may only be made when a patient has a "qualifying condition."

122. Pursuant to the HCSA, (1) the attending physician shall note the existence of a "qualifying condition" in writing in the patient's medical record, and (2) a qualified physician must note his/her concurrence in the medical record.

123. It is believed and therefore averred that neither occurred in Randall's case.

124. Therefore, it is believed and therefore averred that at the time when the Defendants terminated life support, Randall had not been properly diagnosed as suffering from a "qualifying condition."

125. Moreover, pursuant to the HCSA, the Defendants knew that prior to the Defendants being authorized to terminate life support, (a) a surrogate decision maker must express his/her decision to forgo life-sustaining treatment to the attending physician and one adult witness, and (b) the decision and the substance of any known discussion before making the decision must be documented by the attending physician in the patient's medical record and signed by the witness.

126. Again, it is believed and therefore averred that neither occurred in Randall's case.

127. Furthermore, pursuant to the HCSA, the decision to terminate life support must be made after, and completely independent of, the decision of whether or not a patient suffers from a qualifying medical condition under the Act.

128. As evidenced by GOH being bedside at 6:30 PM on December 22, 2012, prior to the second apnea test being performed, the Defendants improperly blended the issues and began to discuss the termination of life support and the donation of Randall's organs prior to confirming and certifying that Randall suffered from a qualifying medical condition.

129. The Illinois Health Care Surrogate Act, 755 ILCS 40/25, further provides in relevant part that "If 2 or more surrogates who are in the same category and have equal priority

[such as Lydia and Mark] indicate to the attending physician that they disagree about the health care matter at issue, a majority of the available persons in that category (or the parent with custodial rights) shall control, unless the minority (or the parent without custodial rights) initiates guardianship proceedings in accordance with the Probate Act of 1975 [755 ILCS 5/1-1 et seq.]."

130. The Act further provides, "After a surrogate has been identified, the name, address, telephone number, and relationship of that person to the patient shall be recorded in the patient's medical record."

131. Finally, the Act provides, "In the event an individual in a higher, a lower, or the same priority level or a health care provider seeks to challenge the priority of or the life-sustaining treatment decision of the recognized surrogate decision maker, the challenging party may initiate guardianship proceedings in accordance with the Probate Act of 1975 [755 ILCS 5/1-1 et seq.]."

132. Lydia and Mark were surrogates in the same category with equal priority.

133. Lydia and Mark communicated to the Defendants that they disagreed about whether or not life support measures should be terminated.

134. Lydia advised the Defendants that she intended to seek an injunction to stop the Defendants from terminating life support.

135. In this regard, on Friday, December 21, 2012, Lydia consulted with counsel, and was advised that as soon as the Court opened, appropriate documents would be filed to seek an injunction to prevent the immediate removal of Randall's life support.

136. While Lydia informed the Defendants that she intended to take legal action, no other persons or entities initiated guardianship proceedings or was appointed guardian over Randall.

137. The Defendants knew that Lydia and Mark disagreed about whether or not life support should be discontinued, and opted, without legal authority, to permit Mark only, who was known to be estranged, to decide the issue.

138. Since Lydia, Mark, and the Defendants were not in agreement regarding the proper course of treatment to be provided to Randall, the Defendants should have convened a medical ethics committee, or similar type committee, to mediate the apparent dispute.

139. In the alternative, if the Defendants wished to deviate from the course of care directed by the surrogates, or if the Defendants were unable to obtain a majority opinion/direction from the surrogates, the Defendants were required to request court intervention.

140. Due to the failure to implement and/or follow proper policies and procedures regarding hospital administration, the Defendants failed to convene a medical ethics committee and/or to seek court intervention.

141. Likewise, instead of providing Randall with a sufficient opportunity to improve or to recover, the Defendants rushed to declare Randall brain dead, so that his organs could be harvested.

142. The Defendants terminated Randall's life support and caused his untimely death.

B. Violation of the Illinois Anatomical Gift Act

143. The Illinois Anatomical Gift Act, 755 ILCS 50/1-1, *et seq.*, provides in relevant part that, "An anatomical gift of a donor's body or part that is to be carried out *upon the donor's death* may be made during the life of the donor for the purpose of transplantation, therapy, research, or education, by: (1) the donor[.]" See 755 ILCS 50/5-5(a)(1) (emphasis added).

144. Randall's driver's license indicated that, *upon death*, he consented to organ donation.

145. For the purposes of the Illinois Anatomical Gift Act, "*death*" is defined as, "when, according to accepted medical standards, there is (i) an irreversible cessation of circulatory and respiratory functions; or (ii) an irreversible cessation of all functions of the entire brain, including the brain stem." See 755 ILCS 50/1-10.

146. Prior to harvesting Randall's organs, Randall's medical condition did not meet the definition of "death" provided in the Illinois Anatomical Gift Act.

147. Moreover, as discussed in detail above, the Defendants did not act in "good faith."

148. As such, pursuant to the Illinois Anatomical Gift Act, the Defendants are not entitled to civil, criminal, or administrative immunity. See 755 ILCS 50/5-45(c).

C. Additional Breaches of the Standard of Care

149. Dr. Rivard was in charge of Randall's medical care but in the process of determining brain death, failed to ensure that Randall received necessary and appropriate medical evaluation and testing.

150. Defendants Rivard and Friedman did not allow Lydia, or any other family member to provide or withhold consent for the apnea test, which is a procedure that has risks involved, especially if a patient is not brain dead and has anoxic brain injury (which the apnea test induced hypercapnia—increased CO2—can worsen).

151. The Defendants knew that Lydia was available and participating in the medical treatment decision-making process, but ignored her decision to *not* terminate life support measures.

152. Despite knowing that the Defendants were not permitted to terminate life support measures, Defendant Ginsburg had Gift of Hope contacted before the determination of brain death had even occurred.

153. Defendant Burnstine did not advise against stopping the hypothermia protocol prematurely, after less than the recommended 24-48 hours, despite the fact that this reduced Randall's chances of improvement in his cerebral functioning, and most likely worsened his anoxic brain damage.

154. Defendants Rivard and Friedman did not allow for the hypothermia protocol to continue for at least 24 to 48 hours which allowed for further brain injury to occur.

155. Defendant Burnstine neither recommended a cerebral blood flow study nor opposed Defendant Friedman's attempt to pronounce Randall braindead without input and examination by a neurologist.

156. According to the EEG report from 12/22/2012, Defendant Burnstine was in direct communication with Defendant Friedman regarding the EEG results.

157. Defendant Burnstine, however, did not direct that a blood brain-flow study should be performed.

158. Defendant Burnstine, as the only fully qualified medical consultant, did not request to perform, or perform, a neurological evaluation on Randall to confirm brain death.

159. Defendants Rivard and Friedman pronounced Randall braindead, prematurely, without having at least one of the examinations for brain death determination be performed by a neurologist, and without ordering a cerebral blood flow study – both of which are necessary in order to make a brain death determination.

160. Defendants Furr and Harrison did not advocate on behalf of Randall for appropriate and necessary medical care.

161. Without objection, Defendants Furr and Harrison permitted the hypothermia protocol to be violated.

162. Without objection, Defendants Furr and Harrison permitted the administration of an apnea test without proper consent.

163. Without objection, Defendants Furr and Harrison permitted Randall to be removed from the ventilator, despite the fact that they knew that he had been breathing over the ventilator just 10 hours prior.

164. Without objection, Defendants Furr and Harrison permitted Randall's life to be terminated without proper consent.

165. As the consulting neurologist, Defendant Burnstine did not document the fact that the determination process used by the co-defendants to determine brain death was inadequate.

166. The Defendants rushed to have Randall pronounced brain dead, despite Randall breathing over the ventilator just 10 hours prior to his brain death determination.

167. The medical care provided by the Defendants was not in Randall's best interests, but rather to procure organs for transplantation.

168. In deciding the course of medical care to be provided, the Defendants improperly considered the fact that Randall did not have health insurance.

169. The Defendants intentionally permitted Randall to be killed for the purpose of harvesting his organs for donation.

170. The Individual Defendants acted pursuant to Defendant Advocate Condell Medical Center's flawed and dangerous brain death policy.

171. The brain death policy did not require that at least one of the exams to determine brain death be performed by a neurologist (despite having neurologists on staff) and that a brain blood flow study be performed as the best medical test to determine brain death, as defined by Illinois law as the irreversible cessation of all functions of the entire brain, including the brain stem.

172. Despite the significant risks involved, Defendant Advocate Condell Medical Center did not require a consent form to be signed by a proper surrogate(s) prior to performing the apnea test.

173. Defendant Advocate Condell Medical Center improperly permitted the brain death determination to be made prematurely, only hours after a brain injury.

174. Defendant Advocate Condell Medical Center provided incentives for physicians to reduce the cost of medical care, which encouraged the Individual Defendants to consider the fact that Randall did not have medical insurance or the financial means to pay for his medical care.

175. The Defendants did not take appropriate and necessary steps to determine who had the legal right to make medical decisions for Randall.

176. Pursuant to § 740 ILCS 180/2, Lydia seeks fair and just compensation, in excess of $50,000, for the pecuniary injuries resulting from Randall's death, including but not limited to damages for grief, sorrow, and mental suffering; loss of family advice, counsel, guidance, instruction, and training services; loss of household personal services; loss of family

accompaniment services; and loss of consortium, society, love, support, and companionship; and litigation costs.

COUNT II

Plaintiff v. Defendant Entity
Vicariously Liability Pursuant to Illinois Civil Law
(Pursuant to the Illinois Wrongful Death Act)

177. Paragraphs 18-176 are incorporated herein by reference.

178. A hospital is vicariously liable for the negligent acts of an independent contractor physician if (a) it acts in a manner, or knowingly acquiesces in the acts of an agent, that would lead a reasonable person to conclude that the physician is its agent or employee, and (b) the patient reasonably relies upon such conduct. See Gilbert v. Sycamore Municipal Hospital, 622 N.E.2d 788 (1993).

179. It may be assumed that if a patient has not selected a specific physician, he is relying upon the hospital to provide complete care, and even if he has selected a physician to perform particular services, he may be relying on the hospital for support services like radiology, pathology, or anesthesiology. See York v. Rush-Presbyterian-St. Luke's Medical Center, 854 N.E.2d 635 (2006).

180. Defendant Condell acted in a manner to lead Plaintiff to conclude that the Individual Defendants were its agents and/or employees.

181. Moreover, the Plaintiff was relying on Defendant Condell to provide Randall with appropriate and necessary medical care, including all support services.

182. Therefore, Defendants Condell is vicariously liable for the actions of the Individual Defendants who provided medical services in Defendant Condell.

183. Furthermore, Defendants Condell is vicariously liable for the actions of the Individual Defendants who were affiliated with it.

184. Pursuant to § 740 ILCS 180/2, Lydia seeks fair and just compensation, in excess of $50,000, for the pecuniary injuries resulting from Randall's death, including but not limited to damages for grief, sorrow, and mental suffering; loss of family advice, counsel, guidance, instruction, and training services; loss of household personal services; loss of family accompaniment services; and loss of consortium, society, love, support, and companionship; and litigation costs.

COUNT III

Plaintiff v. Defendants
Intentional Infliction of Emotional Distress

185. Paragraphs 18-184 are incorporated herein by reference.

186. To state a claim for intentional infliction of emotional distress, a Plaintiff must establish the following: (1) the Defendants' conduct must be extreme and outrageous, as measured by the sensibilities of the average member of the community; (2) the Defendant must either intend that his conduct cause severe emotional distress, or know that there is a high probability that the conduct will cause severe emotional distress; and (3) the resulting emotional distress must be so severe that no reasonable person could be expected to endure it.

187. The Defendants' conduct in knowingly violating state and federal law, and established standards and procedures in the medical profession, and purposefully causing Randall's untimely and unlawful death, is extreme and outrageous.

188. The Defendants knew that there was a high probability that ignoring Lydia's authority pursuant to the Illinois Health Care Surrogate Act and acting contrary to her stated medical direction thereby causing Randall's unlawful and untimely death would cause Lydia to suffer severe emotional distress.

189. The emotional distress associated with Lydia knowing that her son was being unlawfully killed so that his organs could be harvested, and that she was unable to prevent the Defendants from doing so, was so severe that no reasonable person could be expected to endure it.

190. Moreover, the Defendants did not provide Lydia with an opportunity to say goodbye to her son before they caused his untimely death.

191. Pursuant to § 740 ILCS 180/2, Lydia seeks fair and just compensation, in excess of $50,000, for the pecuniary injuries resulting from Randall's death, including but not limited to damages for grief, sorrow, and mental suffering; loss of family advice, counsel, guidance, instruction, and training services; loss of household personal services; loss of family accompaniment services; and loss of consortium, society, love, support, and companionship; and litigation costs.

WHEREFORE, Plaintiff respectfully requests that judgment be entered in her favor as follows:

A. That this Court declare that the Defendants' actions violated her statutory rights;

B. That this Court declare that the Defendants are jointly and severally liable for all damages;

C. Compensatory damages, including but not limited to all pecuniary injuries available pursuant to the Illinois Wrongful Death Act, including but not limited to grief, sorrow,

and mental suffering; loss of family advice, counsel, guidance, instruction, and training services; loss of household personal services; loss of family accompaniment services; and loss of consortium, society, love, support, and companionship;

D. Litigation costs;

E. Such other financial or equitable relief as is reasonable and just.

Jury Trial Demand

Plaintiff respectfully requests a trial by jury on all claims/issues in this matter that may be tried to a jury.

Respectfully Submitted,

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