

2026 IL App (2d) 250177-U
No. 2-25-0177
Order filed August 25, 2026

NOTICE: This order was filed under Illinois Supreme Court Rule 23(b) and is not precedential except in the limited circumstances allowed under Rule 23(e)(1).

IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

PHILIP DAVIS, Plaintiff-Appellant,

v.

ZEHRA HYDERI, a/k/a Hydari, AWN KHADEMI, FOOT AND ANKLE SPECIALISTS OF ILLINOIS, LTD., and SYED S. ASGHAR, Defendants-Appellees.

Appeal from the Circuit Court of Lake County.
Honorable Charles W. Smith, Judge, Presiding.
No. 22-L-8

JUSTICE JORGENSEN delivered the judgment of the court.
Presiding Justice Kennedy and Justice Birkett concurred in the judgment.

ORDER

¶ 1 *Held:* In this medical malpractice action, we affirm the jury's verdict and reject plaintiff's arguments that the trial court abused its discretion by: (1) allowing cumulative evidence from defendants' experts, (2) allowing expert testimony from unqualified witnesses, (3) barring plaintiff's evidence concerning his ability to afford a surgical shoe, (4) admitting evidence of plaintiff's alleged noncompliance with medical recommendations, and (5) not finding defendant's violations of an *in limine* order deprived plaintiff of a fair trial. Further, there was no cumulative error, and plaintiff forfeited his argument that the jury's verdict was against the manifest weight of the evidence. Affirmed.

¶ 2 In January 2020, plaintiff, Philip Davis, had surgery on his right great toe. He suffered an infection post-surgery, and the toe required amputation. Plaintiff filed a negligence suit against his doctors and a medical practice; specifically, defendants Dr. Zehra Hyderi (podiatrist and

surgeon), Dr. Shawn Khademi (podiatrist), Dr. Syed Asghar (internal medicine), and the Foot and Ankle Specialists of Illinois, Ltd. (Dr. Hyderi's practice group that employed Dr. Khademi). After trial, the jury returned a general verdict in defendants' favor. The court denied plaintiff's posttrial motion.

¶ 3 Plaintiff appeals, arguing: (1) the trial court erred by allowing cumulative evidence from defendants' experts; (2) two of the cumulative opinions were offered by doctors not qualified to give them; (3) the court erred in barring plaintiff from offering evidence that he could not afford a surgical shoe, to rebut the contention that he did not comply with his doctors' recommendations that he wear one; (4) the court erred by admitting evidence of plaintiff's alleged noncompliance with medical recommendations that were not causally linked by expert testimony; (5) defendants' repeated violations of court orders regarding plaintiff's prior medical conditions deprived him of a fair trial; (6) the cumulative effect of the errors deprived plaintiff of a fair trial; and (7) the jury's verdict was against the manifest weight of the evidence. For the following reasons, we affirm.

¶ 4 I. BACKGROUND

¶ 5 Plaintiff is a Type 2 diabetic. Measuring a diabetic's A1C level is a way to assess the patient's blood sugar levels over the prior 90-day period. Generally, a patient who has an A1C level higher than 8 is considered an uncontrolled diabetic. Further, diabetics are generally at higher risk for infections from open wounds.

¶ 6 In 2018, plaintiff was in an auto collision that resulted in a wound on the bottom of his right great toe. For more than one year, Dr. Hyderi treated plaintiff for the wound, performing multiple debridement procedures (during which the wound is cleaned and dead tissue is removed to encourage healing). Ultimately, on January 27, 2020, Dr. Hyderi performed a debridement, along with the application of a skin substitute (essentially, a piece of fish tissue) to close plaintiff's

wound. Prior to the surgery, plaintiff sought and obtained surgical clearance from Dr. Asghar, his primary care physician. On February 3, 2020, Dr. Khademi saw plaintiff for a post-surgical follow up and a dressing change. On February 10, 2020, when Dr. Khademi again saw plaintiff, he identified *new* wounds on plaintiff's foot that appeared infected. On February 18, 2020, Dr. Hyderi directly admitted plaintiff to the hospital, where plaintiff's toe was eventually amputated.

¶ 7 Plaintiff subsequently sued defendants. In short, plaintiff's overall theory of the case was that, because his A1C level on December 13, 2019, measured 11.7, reflecting that he was an uncontrolled diabetic, Dr. Asghar should not have cleared him for the surgery. For the same reason, Dr. Hyderi should not have performed the procedure, she should have continued conservative management, and, further, she failed post-surgery to provide him with a surgical shoe. Finally, plaintiff argued that Dr. Khademi was negligent, where he did not, (1) on February 3, 2020, provide plaintiff with a surgical shoe and a full dressing to his right foot; and (2) on February 10, 2020, after seeing new wounds on plaintiff's foot that showed signs of infection, admit plaintiff to the hospital, choosing instead to provide oral antibiotics.

¶ 8 Defendants responded, in sum, that plaintiff's December 13, 2019, A1C level was not a contraindication to the procedure performed, they did not deviate from their respective standards of care, and that plaintiff's noncompliance with their recommendations contributed to his injury.

¶ 9 A. Pretrial Motions

¶ 10 Prior to trial, the court ruled on various motions *in limine*. Relevant here, all parties moved generally to bar evidence of their wealth or poverty, with defendants asserting that such preclusion should include evidence that plaintiff could not afford a surgical shoe. Plaintiff's counsel argued that, because it was defendants' contention that plaintiff was contributorily negligent by failing to follow their recommendations, including wearing a surgical shoe, he should be allowed to rebut

that contention. However, plaintiff's counsel clarified, "it's not a matter of cost." Rather, when the surgical shoe was offered, plaintiff

"said he didn't have his wallet, not that he couldn't afford it, that he didn't have his wallet with him *** [s]o it's not a matter of how wealthy he was or how impoverished he was. He didn't have the physical ability to pay at that visit. *** [I]t's not that he couldn't afford it. It's not a wealth and poverty issue."

Plaintiff's counsel continued, "they should have given him a boot whether he had his wallet or he didn't have his wallet. It's an \$8 boot; give him a boot and you bill him later or whatever." Counsel reiterated, "[i]t has nothing to do with affording a boot." The court ruled that the cost of the boot would not be allowed, defendants could not state that they did not give plaintiff a boot because he could not pay for it, and one specific record reflecting that plaintiff could not afford the shoe required redaction. As to the redaction, plaintiff's counsel stated, "no problem."

¶ 11 In addition, plaintiff sought to bar cumulative expert testimony and to bar experts from testifying outside of their respective areas of expertise. The court ruled that, as the experts had different specialties, they would be required to "stay in their lane[s]" and testify from their own areas of expertise.

¶ 12 Finally, plaintiff sought to bar certain evidence of other injuries or medical conditions that he suffered (such as psychiatric conditions, prior surgeries to areas other than the foot, history of heart failure, atrial fibrillation, coronary artery disease, kidney disease, etc.). However, plaintiff's counsel acknowledged that his experts opined that the surgery should not have been performed due to plaintiff's diabetes and coronary artery disease. As such, the court ultimately ruled that, except for chronic kidney disease, edema, and coronary artery disease, defendants were barred from mentioning plaintiff's other health history or conditions.

¶ 13

B. Trial

¶ 14 Trial lasted over two weeks and included testimony from around 22 witnesses, generating a lengthy record. For the sake of relative brevity, we summarize each party's testimony, as well as that of any associated expert.¹

¶ 15

1. Plaintiff

¶ 16 Plaintiff testified that he followed his doctors' recommendations and instructions. He attended numerous appointments, tried to follow diet and exercise instructions, and worked to lose weight. He was aware of the importance of diet and exercise for diabetes management. Plaintiff relied on his primary care physician, Dr. Asghar, to manage his diabetes. Plaintiff testified that Dr. Asghar did not instruct him to see an endocrinologist.

¶ 17 From 2016 to 2018, plaintiff sought treatment from Dr. Hyderi for other wounds, which ultimately healed in November 2018. In 2019, after the auto collision, he returned to her care, seeing her approximately 25 to 30 times in one year. Plaintiff agreed to proceed with Dr. Hyderi's recommendation to undergo a skin substitute procedure in January 2020, because he trusted her. The surgery was performed at an outpatient surgical center. Plaintiff testified that, upon discharge from the procedure, he asked for a surgical shoe but was not provided one. Plaintiff agreed that, in 2017 and 2018, he possessed a surgical shoe, but he testified that he told Dr. Hyderi he no longer had it.

¶ 18 On February 3, 2020, plaintiff saw Dr. Khademi, who changed his post-surgical dressing to a smaller bandage. Plaintiff testified that he would have liked a larger bandage but did not have a shoe in which a larger bandage would fit. Further, although he requested a surgical shoe on

¹As the jury found in defendants' favor, we do not summarize the expert testimony concerning plaintiff's alleged pain syndrome and damages.

February 3, 2020, he was not given one because he had left his wallet in the car. Plaintiff did not recall Dr. Khademi recommending an ultrasound; if so, plaintiff would have had one.

¶ 19 On February 10, 2020, as instructed, plaintiff returned to Dr. Khademi. He was disappointed to see that, when the dressing was removed, there was drainage, peeling skin, and a bad odor. During that visit, he was provided with a surgical shoe. Dr. Khademi did not recommend that plaintiff go to the hospital; if he had, plaintiff would have done so. Plaintiff testified he took the antibiotics Dr. Khademi prescribed. He testified that he was not told to follow up in four days; rather, he was told to follow up in another week, which he did on February 18, 2020, with Dr. Hyderi. When Dr. Hyderi removed plaintiff's bandage, she told him he needed to immediately go to the hospital. Plaintiff remained in the hospital for 9 to 10 days, where he had two procedures, including the amputation.

¶ 20 2. Dr. Asghar (and experts Nelson, Gallagher, Pitchon, and Dubberke)

¶ 21 On February 21, 2018, Dr. Asghar, an internal medicine physician, treated plaintiff for the first time. Although not reflected in the written records, Dr. Asghar recalled, at that first visit, they discussed plaintiff's entire health history, and Dr. Asghar asked why plaintiff did not see an endocrinologist. Plaintiff was frustrated and explained that he had seen an endocrinologist but "they don't do anything" for him. Dr. Asghar testified that he helped plaintiff manage his diabetes and that the standard of care did not require him to refer plaintiff to an endocrinologist. Dr. Asghar also agreed that diabetics, particularly uncontrolled diabetics, are at risk of infection from surgery, and that a patient with an A1C level over 8 is considered an uncontrolled diabetic.

¶ 22 Dr. Asghar testified that plaintiff's December 3, 2019, A1C level was 11.7, but he did not condition surgical clearance on plaintiff lowering his A1C level. Plaintiff's A1C levels had both increased and decreased while Dr. Asghar treated him. There was no certainty that, if plaintiff

delayed surgery for three or six months, he would lower his A1C below 8, and Dr. Asghar did not give him a “chance” to do so before the surgery. Dr. Asghar explained that he was “very uncomfortable” waiting another period of three months, six months, or another year before clearing plaintiff for Dr. Hyderi’s recommended procedure, when plaintiff had an open foot wound that had persisted for more than one year. Dr. Asghar conceded that the wound had not been infected over that year of care. He noted that plaintiff was anxious to get the surgery. And because plaintiff’s December 13, 2019, A1C level would not reflect plaintiff’s glucose levels on the surgery date (as A1C tests only reflect the levels 90 days prior to the test), before clearing plaintiff for the surgery, Dr. Asghar ordered plaintiff on January 13, 2020, to monitor his glucose readings at home for one week and to bring the numbers back to Dr. Asghar for review. He testified that he told plaintiff,

“ ‘[W]e have to work hard to bring the sugar down. If your sugar stays high, your chance[] for infection is very high. If you can reduce the blood sugar down, less food for bacteria, less food for the viruses, less food for the fungus, and less chances for the infection.’ So, ‘Okay, Doc, I’ll do it.’ ”

¶ 23 Dr. Asghar agreed plaintiff did, in fact, lower his blood sugar. Indeed, on January 24, 2020, plaintiff returned to Dr. Asghar with his at-home glucose readings and, given plaintiff’s full history, Dr. Asghar found that most of the blood sugar levels reflected good control for plaintiff. Thus, Dr. Asghar believed that, as of January 24, 2020, plaintiff had achieved reasonable control over his glucose levels, and he anticipated that plaintiff would maintain good control until the surgery three days later. Therefore, based on plaintiff’s glucose numbers, Dr. Asghar cleared plaintiff for the procedure. Dr. Asghar agreed that plaintiff was a compliant patient “here and there” and participated in his own care, as reflected by his attending appointments, following instructions,

and reducing his A1C levels (1) in 2018, from 13.2 to 8.7 over three or four months; and (2) in 2019, from 10.4 to 7.5 over four months.

¶ 24 During plaintiff's examination of Dr. Asghar, plaintiff's counsel inadvertently displayed records that referenced some of plaintiff's prior medical conditions. Upon a motion by defendants, the court disagreed that plaintiff's disclosure of those records waived his request *in limine* to bar reference to prior medical conditions. The court noted that it had been paying attention to the displayed evidence and had barely noticed the exhibit before counsel removed it from view, the references were not the focus of plaintiff's questions or in the main body of the record, and it was not certain the jury was even exposed to it.

¶ 25 Two primary care experts were called. First, plaintiff's primary care expert, Dr. Kenneth Nelson, testified that Dr. Asghar deviated from the internal medicine standard of care by clearing plaintiff for the procedure and that the deviation led to plaintiff's infection and eventual amputation. He explained that the higher the A1C level, the higher the risk for infection. Nelson opined that Dr. Asghar should have postponed plaintiff's elective procedure until plaintiff's A1C was below 8 and his diabetes was under control. Further, Nelson opined that it was improper for Dr. Asghar to rely upon plaintiff's at-home glucose results, and instead he should have repeated the A1C test. According to Dr. Nelson, if Dr. Asghar felt that plaintiff was a noncompliant patient and would not listen to his recommendations, then he should not have cleared plaintiff for the procedure. Dr. Nelson agreed, however, that plaintiff's records reflected that, over five years and 16 A1C-level tests, plaintiff's A1C level was below an 8 on only one occasion. Further, he acknowledged the records from multiple providers documenting that plaintiff had a long history of noncompliance, was discharged from an endocrinology practice due to that noncompliance,

wanted to control his diabetes himself, and was “intermittently” compliant with his diabetes management.

¶ 26 In contrast, Dr. Asghar’s internal medicine expert, Dr. Thomas Gallagher, testified that Dr. Asghar’s treatment complied with the standard of care, which did not require delaying plaintiff’s procedure due to the elevated A1C level. He explained that factors an internist considers before clearing a patient for surgery include: the type of procedure being performed, whether the procedure is minor or major, whether anesthesia is involved, the length of the procedure, and the patient’s medical history. Dr. Gallagher explained that a debridement with skin substitute is a minor procedure. It does not require general anesthesia. Further, the record reflected that, when asked to clear plaintiff for the 2020 surgery, Dr. Asghar knew that (1) when he first saw plaintiff in February 2018, plaintiff already had a foot ulcer on the bottom of his right toe; and (2) plaintiff had successfully undergone multiple skin substitute procedures with Dr. Hyderi for those previous wounds. Dr. Gallagher opined that the standard of care did not require Dr. Asghar to postpone the procedure until plaintiff improved his A1C level, as plaintiff had an open wound at risk of infection and the medical conditions that put him at risk overall, would remain present for years after the January 2020 procedure. Dr. Gallagher testified that, while Dr. Asghar appropriately ordered lab tests (such as cholesterol) as part of plaintiff’s pre-operative testing, obtaining another A1C level would not have been helpful because it would not have changed the recommended management. Instead, Dr. Gallagher opined that (1) Dr. Asghar appropriately asked plaintiff to check and document his blood sugars at home, closer to the surgery; (2) plaintiff’s glucose numbers, when he returned them to Dr. Asghar, were reasonably controlled; and (3) it was appropriate for Dr. Asghar to clear plaintiff based on those numbers.

¶ 27 Although Dr. Gallagher agreed that plaintiff regularly attended doctor appointments and that weight loss can be challenging for a patient with foot pain and diabetic neuropathy, he testified that plaintiff's A1C records from 2014 through 2019 reflected that plaintiff's diabetes was not at all controlled. Overall, plaintiff was noncompliant with his diabetes-management recommendations, which contributed to his uncontrolled diabetes. He agreed that, because Dr. Asghar could manage plaintiff's diabetes, plaintiff did not need to see an endocrinologist. Further, he testified that the ultrasound that plaintiff cancelled in February 2020 would not have been a flow-limiting study that required intervention or surgery. When asked about plaintiff's other medical conditions, Dr. Gallagher mentioned plaintiff's history of cardiovascular disease and a bypass surgery. Plaintiff's objection to those references, based on his motion *in limine*, was sustained and the answer was stricken.

¶ 28 Two infectious disease experts were called. First, plaintiff called Dr. Howard Pitchon (an expert in both infectious disease and internal medicine), who testified that plaintiff's surgical wound developed into cellulitis, which eventually caused osteomyelitis (a bone infection) and required amputation. He opined that, if the surgery had not been performed (*i.e.*, implicating Dr. Hyderi), plaintiff would not have developed the infection and the amputation would not have been necessary. Dr. Pitchon opined that a reasonably careful internal medicine or primary care physician (*i.e.*, implicating Dr. Asghar) would not have cleared plaintiff for surgery. Dr. Pitchon agreed, however, that plaintiff had a history of noncompliance with medical instructions and that patients have a responsibility to follow their physicians' instructions.

¶ 29 Dr. Asghar, in turn, called his own infectious disease specialist, Dr. Erik Dubberke, who disagreed that plaintiff developed an infection and required amputation because Dr. Asghar cleared him for the procedure. Dr. Dubberke explained that, from an infectious disease perspective, the

A1C of 11.7 in December 2019 was not a contraindication for the skin substitute procedure in January 2020. He explained that no study suggested that a reduced A1C level lowered the risk for infection. Moreover, Dr. Dubberke testified that the infection did not develop at the surgical site, noting that there was no breakdown of the sutures or the wound at the surgical site itself. Rather, the infection developed when plaintiff developed a new ulcer on the ball of his foot. Dr. Dubberke opined that, even without the skin substitute procedure, plaintiff was more likely than not to develop an infection and was at very high risk for amputation because of his poorly controlled diabetes.

¶ 30 3. Dr. Hyderi (and experts Nirenberg, Armstrong, Kazlauskaite, and Williams)

¶ 31 By January 2020, Dr. Hyderi had been in practice for 22 years, had treated thousands of patients for diabetic foot ulcers, and had performed thousands of debridement-with-skin-substitute procedures on diabetic patients with open wounds. She owned Foot and Ankle Specialists, which she started in 2015, and she employed Dr. Khademi from 2019 to 2020. Dr. Hyderi had a long-standing relationship with plaintiff, as she began seeing him in 2016, and, over approximately four years, had 150 visits with him. In that period, she had observed “the ebbs and flows in terms of his healing, progression, and regression as it pertain[ed] to his right foot ulcers.” Specifically, Dr. Hyderi treated plaintiff starting in 2016 for a wound that eventually closed. For that wound, the record reflected that she performed on plaintiff 24 debridements with skin substitutes, including at a time when he was cleared with an A1C of 12 and his glucose measured 369. Plaintiff had a surgical shoe by early 2019, and Dr. Hyderi counseled him on how to properly use it.

¶ 32 In 2019, Dr. Hyderi began treating plaintiff for a new wound that would not close. Dr. Hyderi testified the wound was not small, in relation to its location under the right great toe, and was dangerous because it was on a weightbearing site. She testified that uncontrolled diabetes

may put a patient at greater risk for infection and post-operative complications, and plaintiff was at risk for infection when she performed the surgery because of his uncontrolled diabetes, microvascular disease, and chronic kidney issues. Although the ulcer persisted for about one year without infection, Dr. Hyderi had already performed around 24 debridements without a skin substitute, and the wound's healing had stalled. She wanted to close the wound. The procedure was elective and could have been delayed for possibly another month, but Dr. Hyderi considered it to be medically necessary. The procedure was minimally invasive and could be done in an office setting, but it was performed in a surgical center because the type of skin substitute (fish graft) was only available at the surgical center. The procedure took 14 minutes and required only local, not general, anesthesia. Dr. Hyderi explained that she was looking at a patient she had "known for four years, that wound is stalling, which is very dangerous, which means there's something going on that is not allowing the wound to heal. Therefore, I wanted to close it." Further, "I did a minimally invasive procedure on the bottom of his great toe to help the diabetic patient of mine to heal his wound as fast as possible. The wound had been present for a year. I wanted to close him."

¶ 33 Dr. Hyderi agreed that: in January 2020, plaintiff's diabetes was uncontrolled; as of December 13, 2019, he had an A1C level of 11.7; and, on the morning of the surgery, his glucose level was 217. She agreed that plaintiff's A1C at the time of surgery would most likely have been the same as it was on December 13, 2019. In Dr. Hyderi's opinion, however, for the type of procedure she was performing, the standard of care did not require plaintiff's A1C level to be below 8. Further, clearance from plaintiff's primary care physician was required by the surgical center. She testified that, although Dr. Asghar cleared plaintiff for surgery, it was her decision to perform the procedure. During the procedure, the wound was irrigated with antibiotics, and, after the procedure, Dr. Hyderi placed a large, sterile dressing on plaintiff's foot. The dressing would

not fit in a regular shoe, so, Dr. Hyderi instructed plaintiff to wear the surgical shoe that she had ordered for him during their previous treatments. Dr. Hyderi agreed that the standard of care required plaintiff to be provided with a surgical shoe, but explained that she did not provide one because she believed plaintiff already had one. When asked how she knew he had a surgical shoe, Dr. Hyderi responded, “[b]ecause I [had] been treating him for four years by that time.” She testified that she had seen plaintiff use the surgical shoe multiple times in 2019, and she also educated him, on at least 10 occasions, to keep wearing it to offload pressure, as reflected by several 2019 records in which she instructed him to wear the surgical shoe, at times with an offloading insert. “Why would I recommend to my patient to wear something he didn’t have?” Moreover, if plaintiff, for some reason, did not have his surgical shoe, Dr. Hyderi testified he also had a “CAM walker boot,” that extends mid-calf and offloads pressure with a rocker bottom.

¶ 34 Dr. Hyderi further testified that, when she saw plaintiff on February 18, 2020, the surgical site showed no sign of infection. The graft and stitches were intact, and she removed the stitches. However, other new wounds were infected (as described more below), and she directly admitted plaintiff to the hospital. Dr. Hyderi believed it was likely that plaintiff developed osteomyelitis at some point between February 10, and February 18, 2020. On February 24, 2020, Dr. Hyderi amputated plaintiff’s right great toe.

¶ 35 Plaintiff called Dr. Michael Nirenberg as a podiatry expert. Dr. Nirenberg testified that the standard of care is what a reasonably careful podiatrist would do under the same or similar circumstances. He testified that Dr. Hyderi deviated from the standard of care when she performed plaintiff’s surgery, because his blood sugar was too high, and the deviation from care started a cascade of events and contributed to cause plaintiff’s amputation. Dr. Nirenberg conceded that Dr. Hyderi had successfully performed “more than 20” debridements with skin substitutes on plaintiff

in 2017, when he was an uncontrolled diabetic with an A1C level *higher* than that measured in 2020 and achieved healing of those wounds.

¶ 36 In response, Dr. Hyderi called Dr. David Armstrong as a podiatry expert. Dr. Armstrong testified that, when treating plaintiff, both Dr. Hyderi and Dr. Khademi complied with the standard of care. He explained that a podiatrist's approach to treating a patient is highly personalized, and having a relationship with a patient and knowing what treatments have worked in the past serves to inform future treatment. Dr. Armstrong noted that debridements with skin substitutes may be performed in office without medical clearance or at a surgical center, which requires clearance because many kinds of surgeries are performed there. Dr. Armstrong testified that plaintiff's uncontrolled diabetes, along with the open wound on his toe, put him at great risk for infection; the procedure was medically necessary to reduce the risk of infection; and Dr. Hyderi complied with the standard of care in deciding to perform it, given her knowledge of the patient and that the wound had been open a long time and other treatments had not yet closed it. He explained that Dr. Hyderi engaged in close monitoring of plaintiff's wound:

“She monitored this patient on a regular basis as you saw. She debrided the wound appropriately. She worked to offload appropriately over a really long period of time, and she treated with advanced therapy, so-called skin substitutes, effectively initially for the one wound and then when it recurred, wanted to do the same for the wound in 2020.”

Dr. Armstrong disagreed that plaintiff's A1C level of 11.7 was a contraindication for the procedure and testified that waiting for plaintiff to reduce his A1C level was not a realistic option because there was no evidence that it ever lowered to a reasonable range for any prolonged period. Dr. Hyderi had advised plaintiff of the importance of lowering his blood sugar for healing, and prolonging the procedure would just put him a higher risk. Further, Dr. Armstrong explained that

the surgical site was not the source of infection; rather, the osteomyelitis and amputation resulted from *new* wounds plaintiff developed two weeks later. In sum, Dr. Armstrong did not believe that Dr. Hyderi caused plaintiff harm.

¶ 37 Dr. Rasa Kazlauskaite testified, over plaintiff’s objection and as an endocrinology expert, that neither plaintiff’s A1C level over 11, nor his blood sugar level of 217 on the day of surgery, was a contraindication to Dr. Hyderi performing a “minor surgical procedure” and, specifically, the debridement with skin substitute procedure.² She explained that the “cornerstone of diabetes care” is self-management, primarily through diet, and, because the doctor is not always there, the patient is “absolutely” responsible for management. Dr. Kazlauskaite testified that, over his 18 years with Type 2 diabetes, plaintiff was inconsistent in his management. Dr. Kazlauskaite volunteered that plaintiff previously had cardiac bypass surgery; plaintiff’s objection was sustained, but his request to bar her testimony and any anticipated motion for mistrial were denied. The court agreed that, although unintentional, the comment was problematic; yet, rather than draw more attention to it with a limiting instruction, it might instead instruct the jury at the end of the case about the proper comorbidity factors it could consider.

¶ 38 Finally, over plaintiff’s objection to the cumulative evidence concerning noncompliance and infection, Dr. Hyderi called Dr. Brett Williams to testify as an expert in infectious disease. Dr. Williams testified that plaintiff’s refusal to wear a larger dressing on his foot after surgery contributed to his risk of developing an infection, and the wounds leading to the amputation were

²Before Dr. Kazlauskaite offered her opinion, from an endocrinology standpoint, the court instructed the jury, “Ladies and Gentlemen, you are about to hear—The witness is about to give an opinion concerning clearing somebody for surgery with a A1C of 11.7 approximately 60 days prior to the surgery. That only goes—that opinion only applies to Dr. Hyderi and is limited to her case.”

more likely than not due to plaintiff's uncontrolled diabetes, not the surgery, as evidenced by the fact that the infection and osteomyelitis that led to the amputation did *not* originate in the surgical site (which showed no signs of redness, drainage, or the graft falling off), but, rather, from new wounds that developed from plaintiff's noncompliance and uncontrolled diabetes. He testified that the surgery had "no bearing" on the infection that developed later in a new wound. Dr. Williams testified that, as an infectious disease specialist, he "absolutely [did] not" see signs of an untreated infection that began on January 27, 2020, and continued through February 10, 2020. Further, he testified that, in his experience with infectious disease, a reasonably careful infectious disease specialist might not have even ordered antibiotics on February 10, 2020, as the record reflects the new wound was not clearly infected, and, accordingly, plaintiff did not require hospitalization or intravenous antibiotics on that date. Finally, Dr. Williams noted that plaintiff received home health care, and records from February 11, 13, and 14, 2020, each reflected that "the visiting nurse tried to go over the patient's medications with him to make sure he was taking them correctly as prescribed, and he refused to show her those medications." Dr. Williams opined, based on his experience, that plaintiff did not, between February 10, and 18, 2020, take the prescription oral antibiotics. He explained that plaintiff was prescribed antibiotics that are effective against the bacteria found in his new wounds and, if he took the antibiotics as instructed, the infection should have improved, not worsened. Dr. Williams acknowledged that no medical record reflected that plaintiff was not taking the antibiotics and, further, that plaintiff picked up the prescriptions when filled. Dr. Williams testified that, at some point, even without the January 27, 2020, surgery, plaintiff would likely have required a toe amputation.

¶ 39 4. Dr. Khademi (and experts Nirenberg, Armstrong, and Spinner)

¶ 40 Dr. Khademi testified that, from 2019 until 2021, he practiced as an associate podiatrist with Dr. Hyderi and Foot and Ankle Specialists. In January 2020, Dr. Khademi was just starting his career and had been a practicing podiatrist for around 5 months, while he knew Dr. Hyderi had practiced more than 20 years. Dr. Khademi agreed that the standard of care required a podiatrist to check the patient's A1C level prior to performing an elective surgical procedure and that a podiatrist "generally" should not perform an elective procedure before the patient's A1C is below 8. In his personal practice, he prefers an A1C level below 7. Dr. Khademi would consider plaintiff's A1C of 11.7 prior to surgery as reflecting uncontrolled diabetes. He testified that an A1C of 11.7 makes post-operative complications more likely, and, in his personal practice, which he believes complies with the standard of care, he would not put a skin graft on a wound at that level. However, Dr. Khademi explained that he has treated diabetic wounds that simply will not heal over time, and the decision on when to operate to close the wound is highly dependent on who is treating the patient, considering a variety of factors. Dr. Khademi had "no involvement" in the decision to perform the debridement with skin substitute on plaintiff. Dr. Khademi had not, at that point, ever performed that procedure. He assumed the decision was made to help plaintiff heal his longstanding wound, and, as it pertained to Dr. Hyderi's medical decisionmaking with respect to plaintiff's procedure, he deferred to her. He knew that Dr. Hyderi had been treating plaintiff for numerous years.

¶ 41 Dr. Khademi saw plaintiff only one time (and for the first time) prior to the surgery. Specifically, on January 21, 2020, he cared for plaintiff's wound, which was not infected, by debriding it and applying a sterile dressing.

¶ 42 Dr. Khademi next saw plaintiff on February 3, 2020, after the surgery. He saw that Dr. Hyderi's operative note recommended that plaintiff ambulate in a surgical shoe with an offloading insert to take pressure off the wound. However, plaintiff walked into the office on February 3, 2020, wearing no shoe on his right foot—*only* the surgical dressing. This concerned Dr. Khademi, not only because plaintiff was diabetic, but also,

“[m]ore importantly, he just had surgery. He had a graft placed on his toe and so now he was walking without any sort of offloading for his foot and so we have, you know, it's not clear as to the environment that his foot is in. Obviously he is barefoot. So we worry about germs getting in there. We worry about pressure being placed on an area that we don't want because of the fact that he was wasn't wearing a shoe.”

Dr. Khademi removed the dressing and examined the surgical site on the bottom of plaintiff's right great toe; the graft and stitches were intact, and there were no signs of infection. He noticed some redness on top of plaintiff's toe, which he “chalked up to some irritation from his bandage,” which is commonly seen. The skin on top of the toe, where there was some redness, was completely closed, and there was no drainage. Dr. Khademi testified that he wanted plaintiff to get a surgical shoe, which is like an open-toed sandal, that day, but plaintiff said he had left his wallet in the car and did not have it on him. The parking lot was 10 feet outside the front door. Although Dr. Khademi agreed that the standard of care required a podiatrist to give a high-risk patient a surgical shoe, even if he or she did not have a wallet, and bill them for it later, Dr. Khademi testified that plaintiff was “absolutely adamant” that he receive only a minimal dressing, smaller than the surgical dressing he had been wearing, that could fit inside a diabetic shoe. When plaintiff refused Dr. Khademi's recommendation to apply a robust dressing to protect the foot and skin, one that would also go around plaintiff's foot and ankle to anchor a dressing that encompassed the toe, Dr.

Khademi applied a minimal dressing (a layer of gauze on the toe with a wrap around the toe), and he dispensed to plaintiff a diabetic shoe. The fit of the diabetic shoe for plaintiff's foot was specifically assessed, as the shoe has extra depth and an insert made with plaintiff's measurements. The records reflected that plaintiff felt the diabetic shoe fit "fine," and there was no increased pressure on the toe within the toe box or any heel slippage. When Dr. Khademi was asked what could he do, given that he offered plaintiff a surgical shoe and plaintiff would not take it, Dr. Khademi responded, "well, do everything reasonable to, you know, give him something[,] which in this case was a diabetic shoe." When asked whether he did not give plaintiff a surgical shoe because he did not have his wallet, Dr. Khademi responded, "No. He didn't want it" and "he did not want the shoe because he wanted a minimal dressing on his toe and his diabetic shoe and he was adamant about that." Dr. Khademi advised plaintiff not to touch the sterile dressing, to ambulate only in the diabetic shoe, and to return in one week. Further, because Dr. Khademi did not feel a pulse in plaintiff's foot, he recommended that he have a vascular ultrasound to assess bloodflow. He testified that the records reflected that Dr. Hyderi entered the order for the ultrasound, but plaintiff cancelled it.

¶ 43 On February 10, 2020, Dr. Khademi again treated plaintiff. When he removed the dressing, new wounds had developed on the base of the great toe and side of the foot (the first metatarsal head). The new wounds were "weeping," such that there was clear drainage (not pus), but also a bad odor. Dr. Khademi diagnosed "cellulitis of the right toe," performed a wound culture, wherein he swabbed the drainage so the culture could be sent to a lab to identify the specific bacteria that was present, and then "copiously" debrided and flushed out the new wounds before applying a new sterile dressing. Plaintiff was "verbally very, very upset" and "irate." His angry demeanor concerned Dr. Khademi that he might not absorb and follow instructions or fully appreciate the

potential gravity of the situation. Thus, Dr. Khademi ordered home health care to visit plaintiff to oversee his care and to help him change his dressing. He also prescribed Bactrim, a broad-spectrum antibiotic, until the culture results were received and then modified the prescription to Augmentin, to specifically target the type of bacteria found. Dr. Khademi did not send plaintiff to the hospital that day. Dr. Khademi agreed that, sometimes with patients who have vascular issues and restricted bloodflow, oral medication does not always reach the necessary location. Although he was concerned plaintiff could lose his right toe, as with any patient suffering an infection, Dr. Khademi did not feel it was medically necessary to admit plaintiff to the hospital on February 10, 2020, or order intravenous antibiotics, as there was, at that point, only a local infection, isolated to the great toe, that he was comfortable treating with oral antibiotics. There were no signs of systemic infection. Dr. Khademi did not have an opinion on what caused the cellulitis and did not believe the February 3, 2020, dressing had been too tight; however, he testified that plaintiff had lower extremity swelling that could have caused the dressing to dig into the toe. On February 10, 2020, plaintiff left with a more robust dressing and a surgical shoe. Dr. Khademi's chart reflected that he wanted plaintiff to return in four days, on February 14, 2020, so he could reassess the wounds, monitor the infection, and ensure the antibiotics were effective. Plaintiff did not return that day, as recommended. No appointment log showed an appointment was entered for February 14, 2020, but plaintiff did have an appointment scheduled on February 18, 2020. Further, although his primary concern was managing the infection, Dr. Khademi reiterated that plaintiff should have a vascular ultrasound, since he could not detect a pulse in plaintiff's foot, and plaintiff had cancelled the last order.

¶ 44 Plaintiff's podiatry expert, Dr. Nirenberg, testified that Dr. Khademi deviated from the standard of care by using a diabetic shoe and failing to provide plaintiff with a surgical shoe on

February 3, 2020, and again on February 10, 2020, when he failed to admit him to the hospital. Those deviations, he opined, contributed to cause the infection, osteomyelitis, and amputation. Dr. Nirenberg acknowledged that Dr. Khademi tried to give plaintiff a surgical shoe. He added, “I know he said he didn’t have the money.” Defense counsel objected, based on the motion *in limine*, and the objection was sustained. Off the record, plaintiff’s counsel represented that he had instructed the witness about the *in limine* ruling, and the court, ultimately, preemptively denied any defense motion for a mistrial and instructed the jury to disregard the answer. Dr. Nirenberg also agreed that, on February 3, 2020, Dr. Khademi noted some redness on top of the toe (not near the surgical graft) but assessed that there was no infection, which Dr. Nirenberg agreed was “a reasonable analysis,” given that plaintiff had no fever, chills, nausea, vomiting, fatigue, swelling or drainage or other signs of systemic infection. Regarding the February 10, 2020, visit, Dr. Nirenberg agreed that Dr. Khademi noticed new wounds on plaintiff’s right great toe, along with odor and drainage, and that he: took a culture to see whether there was an infection and, if so what kind; cleaned the wounds; prescribed a broad-spectrum antibiotic; ordered home health care for plaintiff; later changed the antibiotic, based on the culture results; and recorded that plaintiff exhibited no fever, chills, nausea, vomiting, fatigue, or sign of systemic infection. Dr. Nirenberg acknowledged that plaintiff was described as “irate” at that visit, as well as the fact that the home health visit notes reflected that plaintiff refused to learn to change his dressing. He acknowledged that plaintiff was sometimes noncompliant during treatment, as well as the fact that records reflected that he had cancelled the ultrasound Dr. Khademi had recommended and did not return to see Dr. Khademi on February 14, 2020. However, Dr. Nirenberg testified that plaintiff’s noncompliant nature was relevant to his opinion that he should have been admitted to the hospital

on February 10, 2020, because, if a patient is historically not willing to care for himself, then he cannot be trusted and should be admitted to the hospital.

¶ 45 As to Dr. Khademi, Dr. David Armstrong (again, called by Dr. Hyderi as a podiatry expert) testified that, when treating plaintiff on February 3, and 10, 2020, Dr. Khademi complied with the standard of care. He noted that the records reflected that, on February 3, 2020, the surgical graft was intact and there were no signs of infection. Per plaintiff's request, Dr. Khademi replaced the surgical bandage with a minimal, standard dressing. Dr. Armstrong noted that, on February 10, 2020, plaintiff had developed two new wounds on his foot, but the surgical site was not infected and the stitches remained intact. Thus, on February 10, 2020, Dr. Khademi complied with the standard of care by taking a culture of the new wounds and prescribing an antibiotic; plaintiff did not need to be admitted to the hospital to manage the infection, as "the infection was not severe enough, [] this was a mild infection[,] and [it] could be managed as an outpatient." Moreover, when the culture returned on February 12, 2020, Dr. Khademi complied with the standard of care by switching plaintiff's broad-spectrum antibiotic to one that would address the discovered bacteria, but there was no need to admit plaintiff to the hospital or switch to intravenous antibiotics, as there was no evidence the infection was worsening. Dr. Khademi's records reflected that he also asked plaintiff to return on February 14, 2020, to monitor the infection, but it did not appear that plaintiff followed up that day. In sum, Dr. Armstrong did not believe that Dr. Khademi caused plaintiff harm.

¶ 46 Finally, Dr. Khademi's podiatry expert, Dr. Steven Spinner, testified, in sum, that Dr. Khademi's treatment of plaintiff complied with the standard of care. He explained that Dr. Khademi played an interim role, covering for Dr. Hyderi, who was the primary treating podiatrist. Although a surgical shoe would have been ideal, Dr. Spinner did not agree the standard of care

required that plaintiff be given a surgical shoe; rather, the standard of care required that he be placed in a shoe that was not occlusive or causing additional pressure to the foot. Dr. Spinner further explained that plaintiff's demeanor was irate and angry, making communication difficult, and, further, that it is "difficult to get an irate and combative patient to follow medical instructions." Dr. Spinner testified that plaintiff's diabetes was never really controlled, particularly since 2018, and that multiple records over time reflected that plaintiff had a "long history of noncompliance" with physician recommendations that caused or contributed to his outcome.

¶ 47 Dr. Spinner also referenced plaintiff's multiyear history of uncontrolled diabetes, multiple records reflecting plaintiff's noncompliance with checking his blood sugar, plaintiff's refusal at one point to see an endocrinologist because he could "do a better job" than the endocrinologist, as well as plaintiff's morbid obesity, vascular disease, and uncontrolled diabetes "that is basically sedentary," all of which contributed to his poor outcome. Dr. Spinner opined,

"[T]he outcome that occurred, which was the amputation of the big toe, was not the result of something that occurred on February 10th or did not occur.

This is the result of 20 years of a patient not taking care of himself *** not controlling his blood sugar, not following his doctor's instructions. That ultimately is what wound up being the precipitating cause for all of the complications which occurred."

According to Dr. Spinner, however, the amputation was ultimately required because of acute shutdown of blood to the right great toe, as opposed to anything that plaintiff did between February 3, and February 17, 2020.

¶ 48 C. Motion for Directed Verdict, Closing Argument, Verdict, and Posttrial Motion

¶ 49 At the close of all the evidence, plaintiff moved for a directed verdict against all defendants. The court denied the motion, finding that the evidence presented disputed issues of fact, since the

opinions offered by some experts were then refuted or countered by others. Given the controverted evidence, the court found “the issues were well presented by both [the] defense and plaintiff, and it’s up to the jury to decide these conflicts.”

¶ 50 In between closing arguments, outside the jury’s presence, plaintiff’s counsel noted for the court that, in Dr. Khademi’s argument, his counsel had emphasized to the jury that contemporaneous records reflected that plaintiff adamantly refused the surgical shoe. However, in light of the *in limine* ruling, that same record had been redacted, eliminating the rest of the notation reflecting that plaintiff refused the shoe because he could not afford it. Plaintiff’s counsel argued that the door was now open to enter the full note into evidence, reflecting that he refused the shoe because he could not afford it. After argument, the court denied plaintiff’s request, noting it would not, after a two-week trial, allow a party to introduce evidence during closing arguments, particularly where the case was tried in compliance with the court’s ruling that no evidence of the cost of the shoe would come in. Plaintiff’s counsel reiterated that it was not new evidence, because the note did not reflect the cost of the shoe; rather, it simply reflected that he could not afford it, “which is actually consistent with the evidence that he didn’t have his wallet.” The court responded, “true.” Counsel then continued, “This isn’t a cost issue. This isn’t the shoe cost eight bucks or 20 bucks or 50 bucks. *** It just says I can’t afford it. I think that’s consistent with evidence that has come in thus far.” Nevertheless, the court denied plaintiff’s request, again noting that it had redacted the statement that plaintiff now wanted to introduce, and to allow plaintiff’s request “would be essentially reversing myself not in the middle but almost at the end of closing arguments.”

¶ 51 After closing arguments, the jury was instructed and provided three verdict forms: (1) form A, to use if it found for plaintiff and against one or more defendants and that plaintiff was not

contributorily negligent; (2) form B, to use if it found for plaintiff and against one or more defendants and that plaintiff's contributory negligence was 50% or less of the total proximate cause of the injury or damage; or (3) form C, to use if it found in favor of all defendants or that plaintiff's contributory negligence was more than 50 percent of the proximate cause of the injury or damage. Specifically, form C provided, "We the jury find in favor of the defendants [listing their names] against the plaintiff [his name]." On November 18, 2024, the jury returned form C, thus, reflecting a general verdict in defendants' favor.

¶ 52 In his posttrial motion, plaintiff raised four overarching issues, arguing: (1) the court abused its discretion by allowing excessive cumulative evidence regarding the standard of care and plaintiff's alleged noncompliance with instructions; (2) the court abused its discretion and the rule of completeness by allowing evidence that plaintiff refused a surgical shoe while barring the reason for plaintiff's refusal; (3) he was denied a fair trial, due to defendants' repeated violations of the court's *in limine* orders concerning plaintiff's comorbidities; and (4) the court abused its discretion by admitting evidence about plaintiff's alleged noncompliance that was not causally connected to the ultimate outcome. Plaintiff did not raise an argument that the jury's verdict was against the manifest weight of the evidence.

¶ 53 On April 1, 2025, the court denied plaintiff's motion. The court noted that the trial was one of the "finest" with which it had ever been involved in nearly 50 years as an attorney and judge and that both sides were well represented and presented in advance well-researched legal issues, made cogent arguments, and, while a difficult case, "it was presented in accordance with the highest standards of our profession." Regarding plaintiff's arguments, the court, in sum, did not find the experts' testimonies cumulative, explaining that each defendant had a right to put on his or her own defense and that barring the witnesses would have reflected an abuse of discretion.

Relevant on appeal, the court noted that Dr. Williams refuted Dr. Pitchon's assertion that plaintiff's infection required hospitalization, while Dr. Kazlauskaite's specialization in diabetes and endocrinology was "particularly relevant," necessary, and helpful to the jury. The court also found the challenged expert testimony was not cumulative, and spoke to causation, not the standard of care. In addition, the court noted that the jury was not overwhelmed by the volume of evidence, and it was a "wonderful jury," an engaged group that was alert throughout all of the testimony from both sides. Further, the court did not find significant the "shoe issue," noting that it had ruled that evidence concerning the cost of the shoe or the wealth or poverty of any party was not allowed, but plaintiff successfully introduced testimony that he should have been given a surgical shoe and did not receive one because his wallet was in the car. The court found that the challenged portion of the statement was not relevant and, even if the rule of completeness was not adhered to, plaintiff was not prejudiced. Next, the court noted that *both* sides violated the *in limine* ruling about comorbidities, but plaintiff did not demonstrate prejudice from the mistakes, which were quickly rectified, and the court was "strongly of the opinion that these references did not factor into the jury's decision on medical malpractice or causation." It noted that the law does not direct that every violation of an *in limine* order must result in a new trial and that it tried to balance enforcement of its orders with the fact that litigants are not entitled to perfect trials, only fair ones. Finally, the court disagreed that defendants introduced evidence of noncompliance not causally connected to his outcome; specifically, both Dr. Williams and Dr. Dubberke testified that plaintiff's noncompliance contributed to his infection and amputation, while Dr. Spinner testified that plaintiff's failure to control his blood sugar levels and follow medical instructions contributed to his eventual amputation. The court stated it

“rejects the argument that the defendants used plaintiff’s noncompliance to paint him in a nonfavorable light in front of the jury. Defendant’s [*sic*] counsel would have been remiss in their obligations to represent their client if they did not bring out the plaintiff’s noncompliance *** with medical recommendations and that that caused or contributed to his injury.”

¶ 54 Plaintiff timely appeals.

¶ 55 II. ANALYSIS

¶ 56 We first address and reject defendants’ argument that the general verdict rule precludes granting plaintiff a new trial.³ Namely, defendants note that section 2-1201(d) of the Code of Civil Procedure precludes a plaintiff from establishing reversible error, where two or more theories are presented to the jury and sufficient evidence supported at least one of those theories and was free from prejudicial error. 735 ILCS 5/2-1201(d) (West 2024); *Perez v. St. Alexius Medical Center*, 2022 IL App (1st) 181887, ¶¶ 64, 69. Defendants assert that the general verdict here raised a presumption that the jury found in their favor on every defense raised, including lack of proximate cause. See *Steed v. Rezin Orthopedics & Sports Medicine, S.C.*, 2021 IL 125150, ¶ 36. On appeal, defendants contend, plaintiff does not raise a claim of error regarding the evidence that the surgical site did not suffer from infection and the skin replacement procedure had *no bearing* on the development of the *new* wounds that formed and, ultimately, led to the amputation (specifically, testimony from Dr. Williams and Dr. Dubberke). Defendants thus contend that plaintiff raises issues implicating only the standard of care, not the jury’s proximate-cause determination. As there exists an independent and untainted basis to support the general verdict, namely, one

³We note that defendants filed separate appellee briefs, but Dr. Hyderi/Foot and Ankle Specialists and Dr. Asghar expressly adopt and incorporate the arguments contained in their codefendants’ briefs.

reflecting that plaintiff failed to prove the causal link between defendants' alleged negligence and his injuries, defendants contend we must presume the jury found in their favor on proximate cause. Defendants conclude that, on this basis alone, we should affirm the jury's verdict.

¶ 57 We disagree. Critically, the issues plaintiff raises on appeal are ones he contends affected the entire trial such that, if successful in his appeal, there would be no theory presented to the jury that would have been free from prejudicial error. Further, plaintiff argued at trial that, even if new wounds were the source of infection, those wounds would not have developed had the surgery not been performed and had defendants properly dispensed both a surgical shoe and a dressing that did not dig into plaintiff's toe. Therefore, we disagree with defendants' assertion that the evidence that only new wounds became infected was necessarily divorced from plaintiff's theory of proximate cause. Moreover, we note that, on appeal, plaintiff challenges Dr. Williams' testimony, he argues that the experts presented cumulative evidence, and he attacks as incomplete the evidence pertaining to his lack of a surgical shoe, all of which arguably relate to his theory that defendants' actions proximately caused the infection. If successful, those arguments could, theoretically, demonstrate that no theory or defense was free from prejudicial error. Accordingly, we disagree that we must affirm the verdict based upon the general-verdict theory, and we address each of plaintiff's arguments, in turn.

¶ 58 A. Cumulative Evidence

¶ 59 Plaintiff argues first that the trial court abused its discretion by allowing cumulative evidence from defendants' experts. Specifically, plaintiff argues that the court allowed four defense experts (Drs. Gallagher, Kazlauskaite, Dubberke, and Armstrong) to offer echoing opinions on Drs. Hyderi's and Asghar's compliance with the standard of care. Plaintiff contends that Illinois Rule of Evidence 403 (eff. Jan. 1, 2011) precludes expert testimony when its probative

value is substantially outweighed by undue prejudice, including the needless presentation of cumulative evidence. Here, plaintiff contends, with each additional piece of cumulative evidence, the probative value of that evidence diminished, increasing the danger of unfair prejudice through repetition. Plaintiff asserts that his primary allegations included that Dr. Asghar cleared him for surgery that was contraindicated due to his elevated A1C level and that Dr. Hyderi performed the contraindicated surgery.⁴ Defendants then presented four witnesses who were “all allowed to offer the exact same opinion,” *i.e.*, that plaintiff’s A1C level was not a contraindication to the procedure performed and, thus, “essentially, that Dr. Asghar and Dr. Hyderi complied with the standard of care because there was no contraindication to surgery.” Plaintiff argues that the court abused its discretion in allowing this “battle of the experts to turn into a numbers game through a cacophony of repeating opinions that overwhelmed those of the [p]laintiff’s experts,” as the jury might have mistaken the imbalance in expert testimony as authoritativeness. Plaintiff contends that he was prejudiced because, to the jury, it appeared that “four out of five” doctors agreed with defendants and put him at a disadvantage that was impossible to overcome. “In this case, numerosity became a substitute for persuasiveness and medical reasoning.” We disagree.

¶ 60 The decision whether to admit expert testimony lies within the trial court’s sound discretion and will not be reversed unless it is unreasonable. *Seymour v. Collins*, 2015 IL 118432, ¶ 41; *Snelson v. Kamm*, 204 Ill. 2d 1, 24 (2003). “Expert testimony is admissible if the proffered expert is qualified by knowledge, skill, experience, training, or education, and the testimony will assist the trier of fact in understanding the evidence.” *Id.* However, even relevant evidence “may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice,

⁴Plaintiff appears to direct this argument solely against Drs. Asghar and Hyderi, but our analysis remains the same, even if Dr. Khademi is included.

confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or *needless* presentation of cumulative evidence.” (Emphasis added.) Ill. R. Evid. 403 (eff. Jan. 1, 2011). Evidence is cumulative if it adds nothing to what was already presented to the jury. *People v. Ortiz*, 235 Ill. 2d 319, 335 (2009). Generally, the probative value of identical evidence decreases as it is repeated, and, due to diminishing returns, there may be a point where additional evidence provides almost no value. *People v. Maya*, 2017 IL App (3d) 150079, ¶ 70.

¶ 61 The court’s finding here that the challenged evidence was not “needlessly presented,” that it retained value, and that it was not, therefore, unduly prejudicial was not unreasonable. Plaintiff likens this case to a criminal one, where some evidence of the defendant’s prior crimes was relevant to the voluntariness of his confession, but the detail and repetitive presentation of the prior crimes greatly exceeded what was required to accomplish this purpose. See *People v. Nunley*, 271 Ill. App. 3d 427, 432 (2005). We disagree that *Nunley* (or criminal caselaw) holds much persuasive value here. There, the court found that the excessive cumulative evidence created a mini trial over conduct far more “grotesque” than that at issue. *Id.* Here, however, the challenged evidence spoke directly to the issues plaintiff himself raised; namely, whether his A1C and glucose levels were a contraindication to clearing him for surgery (Dr. Asghar) or performing the surgery (Dr. Hyderi). We disagree that the experts’ opinions on that specific question, presented from the perspective of their specialties, is the same as opining that the doctors complied with their respective standards of care or equated to improper and cumulative standard-of-care testimony.

¶ 62 Plaintiff further references a “battle of the experts,” a “numbers game,” and a “cacophony” of repetition, such that the jury could have mistaken the imbalance in testimony for authoritativeness. Again, we disagree with plaintiff’s characterization of the evidence. It is certainly true that several experts testified over numerous days. However, plaintiff also sued three

doctors, each of whom was legally entitled to present a defense and witnesses to rebut those that plaintiff presented against them. See *Taylor v. County of Cook*, 2011 IL App (1st) 093085, ¶¶ 36-41 (citing *Tsoukas v. Lapid*, 315 Ill. App. 3d 372, 383 (2000)) (finding no abuse of discretion and rejecting argument that, in a multi-defendant malpractice case, the defense presented improper cumulative evidence; the court noted that each defendant was entitled to testify on his or her own behalf, as well as to present expert testimony, even if that testimony might overlap or benefit the codefendants; “three doctors are named as defendants, and each defendant doctor has the right to present a defense”); see also *Gulino v. Zurawski*, 2015 IL App (1st) 131587, ¶ 83 (although the opinions were the same, each malpractice defendant was entitled to present its own expert to rebut the plaintiff’s expert).

¶ 63 Here, we similarly find no abuse of discretion regarding the number of experts. Indeed, both sides presented multiple experts as follows:

Number of Experts	Plaintiff	Dr. Asghar (Internal Medicine)	Dr. Hyderi (Podiatrist and Surgeon)	Dr. Khademi (Podiatrist)
1	Dr. Nelson (Internal medicine as to Dr. Asghar)	Dr. Gallagher (Internal medicine)	Dr. Kazlauskaitė (Endocrinology)	Dr. Spinner (Podiatry)
2	Dr. Pitchon (Infectious disease and internal medicine as to Dr. Asghar and Dr. Hyderi)	Dr. Dubberke (Infectious disease)	Dr. Williams (Infectious disease)	
3	Dr. Nirenberg (Podiatry as to both Dr. Hyderi and Dr. Khademi)		Dr. Armstrong (Podiatry) *Also opined as to Dr. Khademi	

¶ 64 On balance, it is evident that defendants Asghar and Hyderi presented five experts *combined* to counter the opinions of plaintiff’s experts, but they did not “overwhelm” plaintiff’s experts. In fact, each defendant essentially presented only one expert to directly counter the

opinions offered by plaintiff's experts in those *exact* same fields. The sole outlier was Dr. Kazlauskaite, an endocrinologist, but the court found her testimony both relevant and helpful to the jury, where her expertise in diabetes management was responsive to plaintiff's claim that plaintiff's A1C level and glucose numbers on the day of surgery were a contraindication for a "minor surgical procedure." The court's finding was not unreasonable. See *Cetera v. DiFilippo*, 404 Ill. App. 3d 20, 45-46 (2010) (no cumulative testimony or abuse of discretion, where experts testified from differing areas of expertise regarding causation, standard of care, or as a treating physician); *Dahan v. UHS of Bethesda, Inc.*, 295 Ill. App. 3d 770, 781 (1998) (rejecting argument that expert testimony was cumulative, where the three physicians testified from the perspective of their varying areas of expertise). In addition, the record simply does not support plaintiff's concern that the jury may have been overwhelmed or could have mistaken the purported imbalance in testimony for authoritativeness. Again, we disagree that there existed an imbalance, certainly not an unreasonable one, and the court's determination that the jury was *not* overwhelmed by the volume of evidence and that it was attentive, engaged, and followed instructions was not erroneous. In sum, the court did not abuse its discretion by admitting cumulative expert testimony.

¶ 65

B. Unqualified Opinions

¶ 66 Plaintiff next argues that the prejudicial effect of the cumulative testimony was compounded by the fact that two of the cumulative opinions were offered by doctors not qualified to give them. Specifically, he contends that the question whether the procedure Dr. Hyderi performed on plaintiff was contraindicated is a podiatry issue. As neither Dr. Kazlauskaite nor Dr. Dubberke are podiatrists, plaintiff argues, any opinion about whether the surgery was contraindicated was outside of their areas of expertise and should not have been introduced. Plaintiff urges that, to testify as an expert on the standard of care in a particular school of medicine,

the expert must be licensed therein. He asserts that, because Drs. Kazlauskaite and Dubberke are not podiatrists, they were “automatically incompetent” to testify to issues pertaining to the standard of care for a podiatrist. Plaintiff further disagrees that the experts offered only causation testimony, asserting that, although thinly disguised as causation testimony, in fact, testimony that the procedure was not contraindicated necessarily implies that Drs. Asghar and Hyderi did nothing wrong. Plaintiff asserts that the central standard-of-care issue was whether it was appropriate for the procedure to have proceeded when it did, which is a podiatry judgment and, thus, whether the procedure was contraindicated was standard of care, not causation, testimony. “The decision to proceed with surgery is purely a podiatric one.” We disagree.

¶ 67 Plaintiff presents this issue as a legal one, *i.e.*, allowing a witness from another “school of medicine” to opine without qualification to the standard of care in effect for a different discipline, thereby rendering appropriate *de novo* review. However, as discussed further below, neither physician opined on the podiatry standard of care and, thus, we review the court’s admission of the expert testimony for an abuse of discretion. *Snelson*, 204 Ill. 2d at 24.

¶ 68 The trial court did not abuse its discretion in allowing the testimony from Drs. Kazlauskaite or Dubberke. Neither doctor, when testifying that plaintiff’s A1C level was not a contraindication to the procedure, offered an opinion regarding the standard of care for a podiatrist. The record reflects that the parties and court were extremely diligent about keeping each expert in his or her own “lane.” Indeed, plaintiff and each defendant had their own sets of attorneys who were active in monitoring and objecting to evidence. As such, more often than not, there were objections and sidebars during expert witness testimony, with the court resolving issues as they arose and ensuring that each testifying expert stayed in his or her own “lane.” As a result, questions posed often began with the limitation that the answer should be confined *only* to the expert’s experience within his or

her field, and many answers were qualified as being given from the perspective of the witness's specialty. Accordingly, Dr. Kazlauskaite, who specializes in treating patients with diabetes, was instructed to confine her opinions to the field of endocrinology, and she expressly testified that her opinion regarding the significance of plaintiff's A1C and glucose levels came from her "purview" within endocrinology. Similarly, Dr. Dubberke testified from an infectious disease perspective. Namely, he testified that no study suggests that a reduced A1C level lowers the risk for infection. Thus, because plaintiff's A1C level was not a contraindication for the procedure, the infection was not caused by Dr. Asghar's decision to clear him for it. Neither physician commented on the standard of care for podiatry. Moreover, it is worth noting that these experts were directly responding to testimony from plaintiff's experts in infectious disease and internal medicine (thus, schools of medicine other than podiatry) that plaintiff's A1C levels *were* a contraindication for the procedure. Those experts, Drs. Nelson and Pitchon, limited their opinions to internal medicine and infectious disease, respectively, and (since he called them) plaintiff did not view those opinions as infringing upon the podiatry standard of care.

¶ 69 In sum, the court reasonably served as an active gatekeeper, limiting opinions to only the expert's field. We disagree that Dr. Kazlauskaite or Dr. Dubberke improperly rendered podiatry standard-of-care opinions.

¶ 70 C. Plaintiff's Ability to Afford Surgical Shoe

¶ 71 Next, plaintiff argues that the court erred in barring evidence that he could not afford a surgical shoe, as the evidence would have rebutted the contention that he was offered a surgical shoe by Dr. Khademi and refused it. Specifically, plaintiff asserts that Dr. Khademi's note from the February 3, 2020, visit reflected that plaintiff was informed that he needed to wear a surgical shoe on his right foot, but that he could not afford one and would purchase one when he was able.

Plaintiff contends that the court erred, where it allowed admission of only the portion reflecting that he was told to wear the surgical shoe. Plaintiff disagrees that the evidence would have improperly commented on the wealth or poverty of the parties, as his inability to afford the shoe would not have been offered to evoke sympathy from the jury but, rather, to refute defendants' contention that he was contributorily negligent by refusing it. Where contributory negligence requires an assessment of whether plaintiff acted reasonably, he contends, it was for the jury to determine whether his refusal of the shoe was reasonable, considering the reasons surrounding it. Plaintiff asserts that courts have repeatedly allowed admission of evidence about a patient's inability to pay for medical treatment to rebut a contention that the plaintiff simply refused treatment and, further, that admitting only part of the medical record violated the rule of completeness. Plaintiff argues that the improper exclusion of evidence that he could not afford to pay for the shoe: (1) left him unable to rebut defendants' arguments that he refused it; (2) allowed defendants to use plaintiff's refusal of the shoe as their rebuttal to his contention that they deviated from their standard of care in not providing him with one; and (3) allowed defendants to contend, without full context, that his refusal of the shoe caused his own infection and need for amputation. Again, we disagree.

¶ 72 The court did not abuse its discretion in excluding the portion of one medical record reflecting that he refused the shoe and could not afford it but would get one later. See *Herron v. Anderson*, 254 Ill. App. 3d 365, 375 (1993) (“[i]t is within the sound discretion of the trial court to permit, in the interests of justice, the omitted part of a statement to explain or refute an alleged inference”). First, admission of evidence concerning the parties' financial circumstances is generally improper, if it appeals to a jury's passion and prejudice. See, e.g., *Panelle v. Chicago Transit Authority*, 31 Ill. 2d 560, 561 (1964); *Lorenz v. Siano*, 248 Ill. App. 3d 946, 953 (1993).

As such, the court reasonably found that evidence about the parties' finances was not relevant. Tellingly, plaintiff did not disagree with the court's *in limine* ruling concerning exclusion of any evidence concerning the wealth or poverty of the parties. In fact, plaintiff filed his own *motion* to "bar reference to wealth of the plaintiff or poverty of the parties." Indeed, in pretrial argument on the motions, plaintiff's attorney specifically emphasized that plaintiff did *not* claim that he could not afford the shoe, repeatedly representing to the court that the issue was *not* one of affordability. Rather, plaintiff argued, to rebut the argument that he simply did not follow his physicians' recommendations, he wished to explain to the jury that he left his wallet in the car and, in any event, defendants should have nevertheless provided the shoe.

¶ 73 Second, in rejecting plaintiff's argument, raised during closing arguments and in his posttrial motion, that the unredacted record should be introduced, the court reasonably and correctly determined that the expressed purpose for which plaintiff wanted the full record introduced was achieved through other means, as he had explained to the jury that he left his wallet in the car. Plaintiff now disagrees there was no prejudice, asserting,

"leaving one's wallet in the car implies that the ability to *afford* the shoe is not an issue, which could lead to the conclusion that the failure to purchase the shoe once plaintiff was reunited with his wallet was not an exercise of reasonable care. On the other hand, the entire inability to *afford* the shoe reasonably explains plaintiff not obtaining the shoe not only that day, but over the course of the following days and weeks."

However, before trial, plaintiff repeatedly explained that the issue was *not* whether plaintiff could afford it but, rather, that his wallet was in the car. Indeed, he expressed that his inability to leave with the shoe was a physical one, *i.e.*, he did not have his wallet, not one involving affordability. Further, we simply disagree that there was prejudice. Namely, plaintiff testified that, although he

requested a surgical shoe on February 3, 2020, he was not given one because he had left his wallet in the car. Further, Dr. Khademi agreed that, when he offered plaintiff the surgical shoe, plaintiff explained that he did not have his wallet on him, and he had left it in the car. In addition, Dr. Khademi agreed that there exist mechanisms for later billing a patient for a surgical shoe, if they really need one, and that he would not deny a patient the ability to properly offload a wound simply because he did not have his wallet with him. Thus, plaintiff's desire to rebut the notion that he simply refused the shoe was achieved, where the jury learned that (1) plaintiff had a reason for leaving without the shoe, *i.e.*, his wallet was in the car; and (2) that Dr. Khademi could have given plaintiff the shoe *anyway*. The court did not abuse its discretion in finding it unnecessary to also add that plaintiff could not afford the shoe, which, based upon plaintiff's arguments before trial, was not necessarily accurate. We note that there was no offer of proof made to establish that, in fact, plaintiff could not afford the shoe.

¶ 74 Plaintiff's cited cases are unavailing, as they involved admitting evidence that the patients did not discontinue or avoid medical treatment because their conditions had resolved but rather because they *in fact* lacked health insurance or were financially unable to pay for it. See *Bruntjen v. Bethalto Pizza, LLC*, 2014 IL App (5th) 120245, ¶ 147 (affirming the court's admission of the evidence); *Klingelhoets v. Charlton-Perrin*, 2013 IL App (1st) 112412, ¶¶ 62-63 (affirming the court's admission of the evidence); *Vanoosting v. Sellars*, 2012 IL App (5th) 110365, ¶¶ 22-25 (reversing the court's omission of the evidence in a trial on damages only and where the evidence was relevant to whether the plaintiff stopped treatment because she lacked pain and suffering). Here, again, the issue was not whether plaintiff did not accept the shoe because his condition had resolved, nor did plaintiff or his counsel ever frame his refusal as an affordability one.

¶ 75 Third, we note that we disagree with plaintiff that introducing his alleged inability to pay would not have been for the purpose of evoking sympathy and, instead, the exclusion simply implicated the rule of completeness. The rule of completeness allows for the admission of additional portions of a statement in order to put the statement into proper context, to clarify the meaning of evidence already received, or to avoid misleading the trier of fact. See *Herron*, 254 Ill. App. 3d at 375; *People v. Craigen*, 2013 IL App (2d) 111300, ¶ 45. However, the opposite is also true, and there is “ ‘no right to introduce portions of a statement which are not necessary to enable the jury to properly evaluate the portions [already] introduced.’ ” *Craigen*, 2013 IL App (2d) 11300, ¶ 45 (quoting *People v. Caffey*, 205 Ill. 2d 52, 91 (2001)). Here, there was no confusion or risk that the jury was being misled. Again, although the entire record was not introduced, other evidence reflected that plaintiff had a reason, short of outright refusal, for leaving without the shoe on February 3, 2020, *i.e.*, his wallet was in the car. Finally, we note that when, before trial, the court ordered the record be redacted to exclude reference to plaintiff’s inability to afford the shoe, plaintiff’s counsel responded, “no problem.” While the parties here do not develop or argue the concept of “invited error,” (see, *e.g.*, *Oldenstedt v. Marshall Erdman & Associates, Inc.*, 381 Ill. App. 3d 1, 14 (2008) (parties generally cannot complain of error that they invited)), we note that, at a minimum, plaintiff’s position pretrial was not consistent with his present one. In short, the court did not abuse its discretion in refusing to admit evidence that plaintiff could not afford the surgical shoe.

¶ 76 D. Noncompliance with Recommendations

¶ 77 Plaintiff also argues that the court erred in admitting evidence of plaintiff’s alleged noncompliance with medical recommendations that were not causally linked by expert testimony. He notes that defendants cast him as a “habitually noncompliant patient who was so generally

unhealthy that an injury like his was bound to happen at some point.” Plaintiff contends it was inappropriate to allow defendants to establish a pattern of his noncompliance and use it as propensity evidence, since evidence of prior bad acts is inadmissible for the purpose of establishing a person acted in the same manner on a subsequent occasion. Specifically, plaintiff argues that that Illinois Rule of Evidence 404(a)-(b) (eff. Jan. 1, 2011) disallows admission of prior wrongs or alleged bad acts to show the character of a person or to show action in conformity therewith. Plaintiff contends that admission of this evidence was especially problematic in this medical malpractice case, given that patients have autonomy over their own medical decisions and the right to refuse any offered treatment. He notes that a patient’s lifestyle choices that cause the need for medical treatment do not constitute contributory negligence, as a defendant doctor takes his or her patient as they are. Finally, plaintiff argues that, here, there was no causal connection established between many of the alleged prior incidents of noncompliance and the infection that resulted in the amputation. Although defendants criticized his diet and exercise regimen, wound care, failure to undergo a post-operative ultrasound, and general attitude toward medical treatment, none of the alleged noncompliance was causally linked to plaintiff’s outcome through appropriate expert testimony. Plaintiff summarizes that the prejudice was manifest and that we should reverse, as defendants’ attempt to cast him as a habitually noncompliant patient who therefore must not have complied with postoperative recommendations and must have caused his own infection and need for amputation “confused the issues and distracted the jury from the true issue in the case—whether defendants deviated from the standard of care and whether those deviations caused the infection and amputation.” We disagree.

¶ 78 Again, the court’s evidentiary rulings are reviewed for an abuse of discretion. *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 109 (2004).

¶ 79 Here, the court reasonably found that defendants did not introduce evidence of his noncompliance that was not causally connected to his outcome. As noted by the court, both Dr. Williams and Dr. Dubberke testified that plaintiff's noncompliance contributed to his infection and amputation, while Dr. Spinner testified that plaintiff's failure to control his blood sugar levels and follow medical instructions contributed to his eventual amputation. All three of *plaintiff's* own expert witnesses, Drs. Nelson, Pitchon, and Nirenberg, conceded that plaintiff's records reflected a history of noncompliance with medical instructions and that patients have a responsibility to follow their physicians' instructions. The contested evidence clearly related to plaintiff's conduct during care and whether that conduct contributed to his infection. Although plaintiff cites *Goad v. Evans*, 191 Ill. App. 3d 283, 302 (1989), a wrongful death action, for its statement, "evidence of prior actions is inadmissible for the purpose of establishing a person acted in the same manner on a subsequent occasion," *Goad* was *affirming* the circuit court's discretionary decision to exclude evidence it deemed irrelevant. Similarly, plaintiff cites another wrongful death action, *Powell v. Dean Foods Co.*, 2013 IL App (1st) 082513-B, ¶ 88, for its statement, "[i]t is axiomatic that evidence of prior bad acts *unrelated to a material issue* is prohibited." (Emphasis added.) In *Powell*, the court explained that the prohibition of prior bad acts or character to establish propensity is well-established in criminal law, but similar rules apply in civil cases, and the admission of such evidence is a determination that remains within the trial court's sound discretion after weighing the evidence's probative value against undue prejudice. *Id.*, ¶¶ 88-90. The court in *Powell* ultimately found the circuit court abused its discretion in admitting prior bad acts but did so, in part, on the basis that the acts (prior speeding, tickets, violations of federal trucking regulations) were not offered for any admissible purpose other than propensity, given the claims and defenses at issue. *Id.*, ¶¶ 100-108, 116-17.

¶ 80 Here, unlike cases where evidence of prior bad acts was improperly admitted because it was unrelated to a material issue, plaintiff's medical-malpractice claims sought to hold defendants responsible for a result that *he* (defendants alleged) might have caused or exacerbated. Contrary to plaintiff's assertion, the "true issue" in this case was not merely whether defendants deviated from the standard of care and whether that deviation proximately caused the infection and amputation; rather, also at issue was whether plaintiff's action *contributed* to cause the infection and amputation. As plaintiff notes, contributory negligence is assessed by whether a party acted reasonably. See *Long v. City of New Boston*, 91 Ill. 2d 456, 463-64 (1982) (noting "[c]ontributory negligence is lack of due care for one's safety as measured by the objective reasonable-man standard" and "[i]n other words, the plaintiff is required to exercise that care which the reasonably prudent person would take to avoid injury in like circumstances"). Citing *Witherell v. Weimer*, 118 Ill. 2d 321 (1987), plaintiff in fact agrees that evidence concerning a patient's failure to follow a doctor's orders may constitute contributory negligence. And, indeed, the jury here was instructed that plaintiff had a duty to use ordinary care for his own safety, and that he was contributorily negligent if he failed to use ordinary care that proximately caused or contributed to cause his injury. Although plaintiff is correct that patients have a right to refuse treatment, doing so is certainly relevant to contributory negligence. The jury could have reasonably considered that plaintiff's history of deciding which recommendations he would follow rendered it more likely than not that he decided not to follow recommendations and that ultimately contributed to his infection and amputation.

¶ 81 For example, plaintiff points out that defendants tried to establish that he did not complete a postsurgical ultrasound, as recommended by Dr. Khademi, but witnesses testified that the ultrasound would not likely have shown anything new or prevented his outcome. Similarly, he

contends that the evidence that he did not see an endocrinologist in the preoperative period was irrelevant, as experts also opined that he did not need to do so because Dr. Asghar could manage plaintiff's diabetes. This does not mean, however, such evidence was irrelevant or unduly prejudicial. For example, the jury could have reasonably considered that plaintiff's cancellation of his ultrasound or his assessment of which type of doctor to see to manage his diabetes rendered credible, for example, Dr. Khademi's testimony that he wished to see plaintiff again on February 14, 2020, so he could monitor the infection, but plaintiff did not return, or that plaintiff chose a minimal dressing and a diabetes shoe over the recommended surgical dressing and shoe. The court was not unreasonable in finding that defendants' counsel would have been remiss in their obligations to represent their clients if they did not introduce evidence to support their defense that plaintiff's noncompliance with medical recommendations caused or contributed to his injury.

¶ 82 Candidly, we are not persuaded that evidence of plaintiff's noncompliance with medical recommendations is even akin to evidence of prior bad acts or character, improperly introduced to establish propensity. Certainly, defendants did not introduce evidence that might be traditionally considered as reflecting "bad acts" or character, as they did not seek to establish, for example, that plaintiff was dishonest, had a bad reputation in the community, or previously committed crimes or tortious conduct. Rather, they introduced evidence that spoke to their physician-patient relationship with him over the course of treatment and his decisions to accept or reject their recommendations. In his reply brief, plaintiff contends that whether this evidence attacked his character is "a matter of interpretation" and the notion that bad acts must be criminal, tortious, or wrongful conduct to be precluded as propensity evidence "is not the law." But he provides no citation for either proposition. Moreover, and as *plaintiff* notes, a patient is free to accept or refuse treatment, which may even be reasonable in certain circumstances. Thus, it is not clear that simply

exercising that agency would fall within the realm of conduct traditionally considered “prior bad acts” or character evidence.

¶ 83 Plaintiff cites *Holton v. Memorial Hospital*, 176 Ill. 2d 95, 120 (1997), for the proposition, “disallowing tort recovery in medical malpractice actions on the theory that a patient was already too ill to survive or recover may operate as a disincentive on the part of health care providers to administer quality medical care to critically ill or injured patients[.] *** That is why doctors treat all patients, not just those with better than even odds.” *Id.*

He reiterates that defendant doctors take their patients in the condition they find them, such that defendants may still be liable for injuries they caused, even though the injuries may not have occurred but for the preexisting weaknesses of the injured person. He contends that a patient’s lifestyle choices that cause the need for medical treatment do not constitute contributory negligence under Illinois law. No one disputes these concepts, but we disagree that these concepts apply here. Defendants did not refuse to provide plaintiff with care on the basis that he was too ill or unlikely to recover, nor did they argue that they should not be held liable *because* of his overall poor health or that he was contributorily negligent *because* he has diabetes. To the contrary, the evidence reflected that *despite* plaintiff’s overall health, defendants treated his foot wound, performed the skin substitute procedure, and treated him post-operatively, too. Defendants argued that they were not liable because they did not deviate from their standards of care and that plaintiff’s conduct, not preexisting conditions, contributed to his result. Although Dr. Skinner opined that the infection and amputation was the result of 20 years of plaintiff not taking care of himself, the broader context of the evidence reflected that plaintiff’s inability to control his

diabetes or consistently maintain a lower A1C level over a sustained period was a consideration in his overall care and sequence of events that led to the amputation.

¶ 84 Finally, plaintiff asserts that casting him as someone who was virtually always resistant to medical treatment is inconsistent with the record, which reflects, for example, that he: visited his podiatrists numerous times; agreed to undergo the procedure at issue; presented to Dr. Asghar for preoperative clearance; monitored his own glucose at home, recorded the readings, and brought them to his doctors; was able to reduce his A1C level significantly on two occasions; was active in his own care; and ultimately agreed to the amputation of his toe. We agree that this evidence, reflecting the numerous times that plaintiff *was* a compliant patient, was properly presented to the jury and was relevant to the contributory negligence defense. But then, so was the countering evidence. Moreover, and as testified to by plaintiff's own witnesses (Drs. Nelson and Nirenberg), defendants' evidence reflecting that plaintiff was a noncompliant patient could easily have worked in his *favor* at trial. Namely, given that the doctors knew that plaintiff often did not follow their instructions for care, the jury could have found it unreasonable that they nevertheless cleared him for the procedure, performed the procedure, failed to insist that he wear a surgical shoe, and/or did not send him to the hospital at the first sign of infection. Ultimately, it was for the jury to weigh the evidence and resolve conflicts therein. Therefore, we disagree that the court abused its discretion in allowing evidence about plaintiff's noncompliance with medical recommendations.

¶ 85 E. Evidence of Plaintiff's Medical Conditions

¶ 86 Plaintiff argues next that defendants' repeated violations of court orders regarding his prior medical conditions deprived him of a fair trial. He contends that, despite the court's order *in limine* that certain aspects of his medical history were inadmissible, defendants elicited evidence of that history throughout trial. Most significantly, he notes: (1) Drs. Gallagher and Kazlauskaite testified

that plaintiff had cardiac bypass surgery, and (2) defense counsel displayed a record containing plaintiff's history of chronic fatigue and a record indicating that plaintiff had a defibrillator. Plaintiff argues that these health conditions were irrelevant and, further, that no expert connected his prior bypass surgery, defibrillator, or chronic fatigue to any relevant issue. The error, he argues, was prejudicial and deprived him of a fair trial, because it was part of the narrative to cast him as generally unhealthy and noncompliant. He disagrees that his counsel opened the door to evidence of prior unrelated medical conditions, as his counsel only inadvertently displayed a record while discussing a different portion of the note, and the court found it unlikely the jury noticed the mistakenly displayed portion of the record. In contrast, plaintiff argues, defendants' experts explicitly testified about his unrelated health issues on multiple occasions, and it appeared that defense counsel did not properly instruct Dr. Kazlauskaite on the court's prior rulings. After the defibrillator placement was displayed in a record, plaintiff notes, even the trial court commented, "I'm getting tired of hearing it was unintentional. You had plenty of time to go through these records."

¶ 87 We conclude that the court did not abuse its discretion in denying plaintiff's motion for a new trial based on the *in limine* order violations. See *Obszanski v. Foster Wheeler Construction, Inc.*, 328 Ill. App. 3d 550, 554 (2002) (we review for an abuse of discretion the trial court's decision to deny a motion for a new trial).

¶ 88 Again, this was a lengthy trial with voluminous evidence, including numerous medical records that apparently referenced multiple conditions but also had redactions. In the grand scheme of the evidence, these violations were minimal. Further, each time a violation occurred, the court took corrective action as it deemed appropriate and proportionate to the situation, at times admonishing the jury to disregard an answer, striking an answer, discussing with counsel, and

instructing the jury that, if it found for plaintiff on the liability question, it could not consider his comorbidities to limit damages.⁵ Generally, sustaining objections and instructing the jury to disregard the error is sufficient to cure any prejudice. See, e.g., *Clayton v. County of Cook*, 346 Ill. App. 3d 367, 383 (2003).

¶ 89 Plaintiff cites cases that reflect, overall, courts properly exercised discretion in barring testimony regarding prior conditions. See, e.g., *Hawkes v. Casino Queen, Inc.*, 336 Ill. App. 3d 994, 1006-08 (2003) (court did not abuse its discretion where it excluded evidence of a prior injury that was not established to be causally related to current injury); *Wingo v. Rockford Memorial Hospital*, 292 Ill. App. 3d 896, 913 (1997) (court did not abuse its discretion where it excluded evidence that a pregnant mother's smoking was a possible cause of fetal brain damage). The court here also granted plaintiff's motion *in limine* to exclude evidence of most comorbidities. However, there were simply incidental violations of that order, when, for example, witnesses volunteered unsolicited answers or records were displayed that were not fully redacted. Notably, no witness here testified during these "slips" that plaintiff's toe infection was caused by, for example, his coronary bypass surgery or chronic fatigue. Indeed, the court noted that violations happened from *both* sides, but expressly found the jury was not influenced by the violations and, in fact, might not have noticed some of them. In denying plaintiff's motion for a new trial on this basis, the court expressed that it was "strongly of the opinion that these references did not factor into the jury's decision on medical malpractice or causation." See *White v. Garlock Sealing Techs., LLC*, 373 Ill. App. 3d 309, 329 (2007) ("[t]he trial court is in the best position to determine to what extent the

⁵Specifically, the jury was instructed, "If you decide for the plaintiff on the question of liability, you may not deny or limit the plaintiff's right to damages resulting from this occurrence because any injury resulted from a pre-existing condition which rendered the plaintiff more susceptible to injury."

improper evidence may have affected the decisions of the jury”). The court further noted that the law does not direct that every violation of a motion *in limine* must result in a new trial and that it tried to balance enforcement of its orders with the fact that litigants are not entitled to perfect trials, only fair ones. We agree. Having reviewed the record, we cannot say that the court abused its discretion in (1) how it chose to handle the violations or (2) its assessment that, in the context of the entire record, the violations did not influence the jury’s verdict.

¶ 90

F. Cumulative Error

¶ 91 Plaintiff next asserts that the cumulative effect of the foregoing errors requires a new trial. Even if none of the issues warrants reversal on its own, plaintiff contends, the verdict may have been affected by the (1) cumulative standard-of-care opinions, (2) admission of improper expert opinions offered from incorrect specialties, (3) attack on plaintiff’s lifestyle decisions and history of noncompliance, and (4) improperly elicited evidence of his prior medical history. Plaintiff argues that the foregoing errors cumulatively created a cascade of improper evidence that could not be fairly overcome, warranting a new trial. We disagree.

¶ 92 It is true that a new trial may be necessary when the cumulative effect of trial errors might have affected the verdict and, thus, deprived a party of a fair trial. *Mueller v. Phar-Mor, Inc.*, 336 Ill. App. 3d 659, 670 (2000). Here, however, there was no error that affected the verdict. As previously discussed, each of the evidentiary decisions plaintiff challenges on appeal was well within the court’s discretion, such that there was no error, let alone cumulative error, and “logic necessarily dictates that a new trial is not required.” *Cetera*, 404 Ill. App. 3d at 47. Moreover, “[r]eviewing courts are not concerned that parties receive an error-free trial; rather, our concern is that plaintiffs receive a fair trial, one free of substantial prejudice.” *Id.* Here, plaintiff received a

fair trial and he has failed to show that any error, let alone multiple errors, substantially prejudiced his case, warranting a new one. Therefore, we reject plaintiff's cumulative error argument.

¶ 93

G. Jury's Verdict

¶ 94 Finally, plaintiff contends that the jury's verdict was against the manifest weight of the evidence. Plaintiff asserts that the overwhelming evidence established that Dr. Asghar should not have cleared him for surgery and Dr. Hyderi should not have performed the surgery "unless and until" his A1C levels were better controlled. Plaintiff contends that, without the improper errors that permeated the trial, the only reasonable verdict would have been one in his favor. As the jury's verdict was not based on competent evidence, plaintiff argues, it should be reversed.

¶ 95 Notably, plaintiff does not dispute that he did not raise this issue in a posttrial motion and, therefore, it is forfeited. See, e.g., *State Farm Mutual Auto Insurance Co. v. Plough*, 2017 IL App (2d) 160307, ¶ 4 (2017). However, he contends that forfeiture is a limitation on the parties, not the courts, and that we may choose to address the issue to obtain a just result. While that is true (see, e.g., *Pinske v. Allstate Property and Casualty Insurance Co.*, 2015 IL App (1st) 150537, ¶ 19), we honor the forfeiture here. Before and during trial, plaintiff raised numerous objections and was represented by counsel. Then, after a lengthy trial, plaintiff filed, briefed, and argued a multi-issue posttrial motion. Despite ample opportunity to raise an extremely common issue, i.e., that the verdict was against the manifest weight of the evidence, plaintiff did not do so, an omission that was not likely inadvertent. The failure to raise the issue, however, deprived the trial court of any opportunity to correct any error, a central purpose of the requirement that each argument must first be raised below. See *Brown v. Decatur Memorial Hospital*, 83 Ill. 2d 344, 349 (1980). We see no justification or basis for excusing the forfeiture here.

¶ 96 Nevertheless, we may confidently note that, if we addressed this issue, we would reject it. As the trier of fact, it is the jury's role to weigh the evidence, make credibility determinations, and to resolve conflicts in expert testimony. *Gulino*, 2015 IL App (1st) 131587, ¶ 74. We will not disturb the verdict unless it is against the manifest weight of the evidence, *i.e.*, unless the opposite conclusion is clearly apparent or where the jury's findings were not based on the evidence. *Id.* Here, the jury heard testimony from the parties and numerous qualified experts who provided their opinions about plaintiff's treatment. Given the verdict, the jury evidently found defendants' witnesses and experts more credible. "The mere fact that the jury resolved the conflicting testimony against [plaintiff] does not render the verdict in this case against the manifest weight of the evidence." *Id.*, ¶ 75; see also *Snelson*, 204 Ill. 2d at 35-36 (verdict not against the manifest weight of the evidence where it concerned a "classic battle of the experts" in which the jury resolved the discrepant testimony in favor of one side); *Sottile v. Carney*, 230 Ill. App. 3d 1023, 1031 (1992) (verdict not against the manifest weight of the evidence where the "medical expert testimony [was] merely conflicting"). Ultimately, even if it were not forfeited, it is evident that the jury's verdict was not against the manifest weight of the evidence.

¶ 97

III. CONCLUSION

¶ 98 For the reasons stated, we affirm the judgment of the circuit court of Lake County.

¶ 99 Affirmed.