2012 IL App (2d) 110147-U
No. 2-11-0147
Order filed May 16, 2012

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

MARILYN ALEVRAS, Special Adm'r of the Estate of Anthony P. Alevras, Deceased, Plaintiff-Appellant, v. RAFA ADI, Defendant-Appellee (Anthony Bekkerman and Condell Medical Center, Defendants).	)	Appeal from the Circuit Court of Lake County. No. 09-L-699 Honorable Christopher C. Starck, Judge, Presiding.

JUSTICE BOWMAN delivered the judgment of the court.
Justices Burke and Hudson concurred in the judgment.

ORDER

Held: The trial court properly allowed testimony of the pathologist regarding the decedent's cause of death and testimony of treating physicians regarding the decedent's prior condition and opinions as to his life expectancy and cause of death. Therefore, a new trial was not warranted, and the judgment of the circuit court was affirmed.

¶ 1 Plaintiff, Marilyn Alevras, special administrator of the Estate of Anthony P. Alevras, filed a medical negligence claim against defendant, Dr. Rafa Adi, alleging that Dr. Adi failed to place Anthony on a cardiac monitor upon admission to the hospital which would have prevented his death

from sudden cardiac arrhythmia. A jury found in favor of defendant, and plaintiff appeals, arguing that the trial court erred in allowing: (1) the pathologist to testify about his conclusion that Anthony died from sudden and unexpected cardiac arrhythmia; and (2) Anthony's treating physicians to testify regarding his prior health condition and to give opinions as to his life expectancy and cause of death. Plaintiff further argues that even if the individual errors do not warrant a new trial, the cumulative effect of these evidentiary errors was so prejudicial a new trial is required. We affirm.

¶ 2 I. BACKGROUND

¶ 3 Plaintiff's complaint alleged the following against Dr. Adi. On and prior to July 3, 2003, Dr. Adi was Anthony's internal medicine physician. On July 3, 2003, Dr. Adi treated Anthony, diagnosing him with a pulled muscle in his left buttock. She advised him to follow-up with her in two or three days. On July 5, 2003, Anthony went to the Condell Medical Center emergency room complaining of shortness of breath and pain in the left buttock. The triage examination showed that his skin was pale, cool and moist. He also had cellulitis in his left buttock and an abscess on his left upper arm. Dr. Anthony Bekkerman treated Anthony in the emergency room, and he ordered blood tests, blood cultures, an EKG, and administered antibiotics. Dr. Bekkerman spoke to Dr. Adi regarding Anthony's condition and reported that he presented with cellulitis, an abscess, a normal EKG, and that antibiotics and pain medications were being administered. Dr. Bekkerman recommended admission to the hospital and a surgical consultation for a possible incision and drainage of the abscess. Dr. Adi agreed and approved Anthony's admission to the hospital. Anthony was admitted to Condell and sent to a general medicine room. Anthony was never connected to a cardiac monitor.

¶ 4 According to the complaint, Dr. Adi breached the standard of care of an internist by failing to admit Anthony to either a telemetry unit or a cardiac intensive care unit, given Anthony's health condition. Anthony had a history of diabetes, a blood sugar of 451, a BUN of 47, a sodium level of 122, an anion gap of 22.5, and a white blood cell count of 23,900. All of those numbers were very abnormal, indicating uncontrolled diabetes and an overwhelming infection.

¶ 5 The complaint alleged that Dr. Adi was negligent in the following ways: (1) failing to ask Dr. Bekkerman for a report of Anthony's lab work, EKG findings, and complaints in the emergency room; (2) failing to order that Anthony be admitted to a telemetry unit, cardiac intensive care, or an intensive care unit; and (3) failing to admit or transfer Anthony to a telemetry, cardiac intensive care, or intensive care unit upon receipt of his lab results. As a direct and proximate result of Dr. Adi's negligence, plaintiff alleged that Anthony's cardiac rhythm was not continuously monitored, and he lost the opportunity of any chance to survive his ultimate cardiac arrhythmia event. As such, Anthony died on July 5, 2003, as a result of a cardiac arrhythmia.

¶ 6 Among the many pretrial motions, plaintiff moved to bar Dr. Adi's witness, Dr. Michael Kaufman, from testifying regarding his autopsy report, arguing that the cause of death was not at issue and his opinions as to the cause of Anthony's death would be cumulative to Dr. Adi's expert witness. Plaintiff also moved to bar the testimony of Anthony's treating physicians, Dr. Robert Koch and Dr. Fahd Jajeh, regarding their testimony as to Anthony's prior health conditions and noncompliance with medical recommendations made to him. The trial court denied the motion to bar Dr. Kaufman's testimony. Numerous motions *in limine* were filed by both parties.

¶ 7 The trial commenced on August 23, 2010. Dr. Bekkerman testified that Anthony was admitted around 2:30 a.m. on July 5, complaining of pain in his left buttock and left leg area.

Anthony also complained of shortness of breath. Dr. Bekkerman examined Anthony and testified that he was obese, his oxygen level was normal, his breath sounds were normal, his heart rate was normal, his abdomen was not tender, and that the left buttock area was tender. Dr. Bekkerman learned Anthony's medical history included cardiac disease and diabetes. Dr. Bekkerman testified that diabetic patients with infections tended to not respond as well to antibiotics and had more complications. He ordered blood tests and blood cultures and administered antibiotics and pain medications. He also ordered an EKG. Anthony's EKG showed that he did not have an arrhythmia while in the emergency room. In the emergency room, Anthony's blood pressure, temperature, pulse, and pulse oximetry were all normal. The pulse oximetry measures one's concentration of oxygen in his blood; so despite Anthony's complaint of shortness of breath, he was getting sufficient oxygen through his system. Dr. Bekkerman spoke with Dr. Adi at 5:20 a.m. on July 5 to request that Anthony be admitted so that he could be further treated with antibiotics for the left buttock cellulitis and a left arm abscess. Dr. Bekkerman was still waiting for the blood culture results and reported the blood count results to Dr. Adi. Anthony's white blood cell count was extremely high, indicating an infection was present, which Dr. Bekkerman believed was evidenced by the cellulitis and abscess he observed. Although the blood culture results were not back yet, those results would identify the type of bacteria and only assist the physician in deciding which antibiotic to administer. Dr. Bekkerman testified that the plan to admit Anthony was to treat him with intravenous antibiotics and obtain a surgical consult on the abscess. Because of Anthony's uncontrolled diabetes, Dr. Bekkerman believed it was necessary to aggressively treat the infections. Regarding whether to place Anthony on a cardiac monitor, Dr. Bekkerman did not believe that was necessary since his EKG was normal and was unchanged since his last EKG, which was in his file. Once Anthony left

the emergency room, Dr. Bekkerman had no role in his care. Dr. Bekkerman signed off on the medications he prescribed, and Anthony was sent to a general medicine bed. Dr. Bekkerman did not decide which bed to admit Anthony at the hospital.

¶ 8 Rita Halle, plaintiff's sister, testified that she knew Anthony had a heart condition, was an insulin-dependent diabetic, and suffered a heart attack in the past. On July 5, 2003, plaintiff was in Greece. Rita received a call from plaintiff on the evening of July 4, alerting her to the fact that Anthony was ill. Plaintiff asked Rita to check on him. Rita did so and found that Anthony was short of breath and had tremendous pain in his left buttock. She took Anthony to the hospital, bringing with her a list of his physicians and medications. Rita provided the list to the emergency room nurse and provided some information to Dr. Bekkerman. Once it was decided that Anthony would be admitted, Rita left the hospital. She attempted to call him the next day but Anthony did not answer. Rita called the nurse's station and asked if someone could check on him because he was not answering the phone. After being unable to speak to him by phone, Rita returned to the hospital and learned Anthony had died.

¶ 9 Plaintiff testified that her husband, Anthony, was diagnosed with type 2 diabetes in 1992 and suffered a heart attack in 1994. He was 39 years old at the time of his heart attack. In 2001, Anthony had a second heart attack. Dr. Adi was Anthony's attending physician at that time because his regular internist, Dr. Mira Kupisek was out of the country. He was also seen by two cardiologists, Dr. Koch and Dr. Jajeh. In July 2003, plaintiff was in Greece. She spoke to Anthony, who complained of pain in his leg. He first went to the emergency room on July 1. Because he did not seem any better after that visit, plaintiff told him to see Dr. Adi. Anthony saw Dr. Adi in the office on July 3. After that, plaintiff asked Rita to check on him. Upon learning of her husband's

death, plaintiff returned home and went to the hospital. She asked Dr. Adi why Anthony was not being monitored. Dr. Adi explained that the nature of his symptoms did not warrant monitoring.

¶ 10 Maria Alevras-Chen, Anthony's daughter, testified that she saw Anthony in the hospital hours before he died. He said he was tired and asked she return later. Maria spoke to his nurses, and they advised that he had a pinched nerve and had undergone all of the tests that he needed. Maria returned later and found out her father had died.

¶ 11 Dr. Sheldon Schwartz, plaintiff's expert internist witness, testified that it was his opinion that Dr. Adi deviated from the standard of medical care in her handling of Anthony's admission. Dr. Schwartz believed that Dr. Adi should have advised Dr. Bekkerman to keep Anthony in the ER until he had his comprehensive metabolic profile lab work back. According to Dr. Schwartz, because Anthony complained of shortness of breath and his cardiac history, he should have been admitted to the ICU and immediately evaluated to see if he had suffered a heart attack. Even though Dr. Bekkerman determined that Anthony's shortness of breath was due to the intense pain of the infections, Dr. Schwartz nevertheless believed that Dr. Adi should have had Anthony admitted to the ICU. If not the ICU, Dr. Schwartz believed that Anthony should have been placed on a cardiac monitor or a telemetry unit, where he would be monitored. He believed Anthony's potassium level caused his cardiac arrest, and a cardiac monitor would have picked up on electrical wave changes in his heart earlier, which would have prompted doctors to get his potassium level down faster. Dr. Schwartz opined that had Anthony been placed on a cardiac monitor or in a telemetry or ICU unit, his chances of being alive would have been much better.

¶ 12 On cross-examination, Dr. Schwartz admitted that Dr. Bekkerman did order an EKG and compared it to Anthony's prior EKG, noting that no changes had occurred and no abnormalities were

noted. He agreed with Dr. Bekkerman that Anthony's EKG showed no change from his June 2003 EKG. He admitted that Dr. Bekkerman ruled out a cardiac-related cause for Anthony's shortness of breath and determined that it was due to the extreme pain he was in, which was ameliorated by pain medication. Dr. Schwartz also admitted that the EKG would likely not show an abnormality given Anthony's potassium level.

¶ 13 Dr. Dennis Caralis, a cardiologist, testified as an expert witness for plaintiff as follows. In Dr. Caralis's opinion, Anthony should have been connected to a cardiac monitor and admitted to an ICU room where a nurse would be attending to the critically ill patient. Because Anthony was not monitored, his chance of survival or recovery was decreased. Dr. Caralis admitted that Anthony's EKG upon admission was normal but accelerated, called sinus tachycardia. He believed that had Anthony been monitored before he flatlined, an appropriate intervention could have saved his life. Specifically, Dr. Caralis believed that Anthony would have had a coronary angiogram until he stabilized and then bypass surgery. He admitted that a "crash cart," which responds to a "code blue" in an ICU floor is the same as a crash cart on a general medicine floor and that an ER physician reports to a code blue event no matter where it occurs in the hospital. He further admitted that a cardiac monitor cannot prevent a sudden asystole but it will show an evolution of a steady, normal rhythm to the asystole. Dr. Caralis admitted that a heart can go from a normal rhythm to asystole but that was not the case of Anthony.

¶ 14 Dr. Adi testified that she saw Anthony on July 3, 2003, and that he was morbidly obese, complaining of pain in the left buttock. She told him to follow-up with Dr. Kupisek, his regular internist, in two to three days. She did not observe any signs of infection at the time of the visit, and his heart rate and blood pressure were normal. Dr. Adi knew that Anthony had an elevated blood

sugar but did not know the exact number. She did not know the EKG findings from the emergency room, and admitted she did not order cardiac monitoring. Dr. Adi testified Anthony's presentation upon admission to the hospital did not indicate the need for cardiac monitoring. According to Dr. Adi, Anthony's EKG was normal and his potassium was not high enough. Based on the bloodwork, Dr. Adi opined that Anthony was possibly dehydrated. She testified that the results were not so terrible that cardiac monitoring was necessary. She admitted that it was always possible Anthony's heart rate could be disturbed, but that was true of anyone. She testified anyone at any time could have a heart attack. But based on his symptoms, his EKG, and his lab work, Dr. Adi did not deem it necessary to place Anthony on a cardiac monitor. Based on her conversation with Dr. Bekkerman, Dr. Adi understood Anthony to have cellulitis of the left buttock and an abscess on his arm, and treatment focused on the infection. The blood culture came back negative, which Dr. Adi testified meant his infection was localized. Regarding cardiac monitoring, a sudden cardiac arrhythmia is unpredictable and may or may not be picked up by a monitor in time for any intervention.

¶ 15 Dr. Joseph Messer testified as an expert witness for defendant. Dr. Messer, a cardiologist, testified that Dr. Adi's conduct did not cause the outcome in this case. He testified that Anthony would not have had a greater chance of survival had Dr. Adi admitted him to an intensive care unit room instead of a general medicine room. Dr. Messer explained that the cause of death was a sudden cardiac standstill and the environment in which such an event occurs does not affect the outcome. Cardiac standstill is the condition in which the heart simply stops; it is also called asystole. Unlike cardiac arrests due to ventricular fibrillation or ventricular tachycardia where there is a warning that the heart is irritated or beating irregularly, asystole occurs suddenly within a beat or two. Dr. Messer testified that it is very difficult to resuscitate a patient with asystole. A cardiac monitor would not

provide any lead time to forewarn medical personnel that the asystole was coming. Asystole is depicted on a monitor with a "straight line," indicating cardiac activity has ceased. Within a minute or seconds, the heart stops, and the patient becomes lethargic and quickly loses consciousness. When a patient is on a monitor, nurses are typically not watching the monitor at all times. Rather, an abnormality usually sounds an alarm to alert medical professionals. Dr. Messer testified that asystole was consistent with the nurse's deposition that Anthony became pale and passed out while she was starting his new IV.

¶ 16 Dr. Messer knew Anthony died from asystole by reviewing the records. According to the records, the nurse went into Anthony's room and noticed his IV was dislodged. She got another nurse to assist her in starting a new intravenous line. While they were working on Anthony, he suddenly became pale, stopped breathing, and arrested. They called a code blue, and the appropriate personnel responded. The first EKG was done very quickly because Anthony's room was right outside the nursing station, and it showed asystole. Dr. Messer testified that a code blue situation is not run any differently in an intensive care unit than it is on a general medicine floor. The presence of a cardiac monitor would also not change the way a code blue is run.

¶ 17 Further, Dr. Messer testified that he did not believe that Anthony's asystole was triggered by a complete metabolic abnormality. Even if his metabolic abnormalities contributed, Dr. Messer opined that he was being treated in the same way as he would have been treated in an intensive care unit, with insulin and fluids. He also opined that Anthony's potassium was not at a level that is deleterious to the heart. Anthony's EKG would have shown evidence of hyperkalemia (high potassium) if his potassium level was affecting his heart. Similarly, Dr. Messer noted that Anthony had mildly high liver enzyme levels and liver function tests, which may have been caused by the

infection or his dehydration, and he was receiving the same treatment (antibiotics and fluids) regardless of the type of hospital unit he was in.

¶ 18 In reviewing the medical records, Dr. Messer noted that Anthony's medical challenges included obesity, high blood pressure, uncontrolled diabetes, a history of deep venous thrombosis that was treated with Coumadin but not well-monitored, a 1994 heart attack, and a 2001 heart attack. After the 2001 heart attack, it was recommended that Anthony have bypass surgery but he opted to have a stent put in. Dr. Messer opined that Anthony's history of coronary artery disease contributed to the asystole. Dr. Messer testified that Anthony's heart had scars and aneurysms from his past heart attacks, which interfere with the normal electrical conduct of the heart and can cause the heart to stop suddenly. Finally, Dr. Messer testified that based on Anthony's history as of July 2003, he believed that Anthony had a life expectancy of less than five years.

¶ 19 Irene Pochtarev, Anthony's attending nurse, testified that on July 5, 2003, around 1:00 p.m., she went to Anthony's room to take his vitals and his blood sugar. Anthony was sleeping when she went into his room. Irene noticed his IV had dislodged, and she woke him and asked him to turn on his back so she could restart an IV line. She could not find a vein, and went out in the hall and asked another nurse, Toni, to assist. They returned to Anthony and began trying to start the new IV line. Irene saw Anthony turn pale, and they immediately called the code blue.

¶ 20 Dr. Avery Hart testified for defendant regarding the standard of care for internal medicine physicians. He testified that in his opinion, Dr. Adi complied with the standard of care required of an internist faced with Anthony's presentation at the emergency room. Dr. Hart based this opinion on a review of the records, which indicated that Dr. Bekkerman saw no changes in Anthony's EKG, determined the shortness of breath was resolved with treatment for pain associated with his buttock,

and diagnosed Anthony with the abscess and cellulitis. Dr. Hart testified that Anthony's blood sugar of 451 did not require intensive care treatment. The fact that Dr. Adi did not remember at the time of Dr. Bekkerman's call that she saw Anthony in June 2001 when he was admitted for a heart attack, again covering for Anthony's regular physician, did not violate the standard of care for an internist. Regardless, the prior cardiac history did not require admission to an intensive care unit because the treatment Anthony needed-insulin, antibiotics, and fluids-did not need to be administered in such a unit. Dr. Hart testified that none of Anthony's lab results rose to a level that required ICU care.

¶ 21 Dr. Hart testified that the treatment provided to Anthony was appropriate and did not need to be provided in an ICU setting. Anthony was given pain medications because cellulitis, a soft tissue infection, is very painful. He was also given antibiotics, which would be given whether the infection was localized or generalized. He was also given fluids and insulin to bring his blood sugar down, his potassium down, and his sodium level up. Dr. Hart testified that based on the lab work, it did not appear that Anthony's infection had escalated into sepsis, a more generalized infection of the blood.

¶ 22 The following videotaped evidence depositions were also admitted, which we summarize using the transcripts of those depositions. Dr. Fahd Jajeh, Anthony's cardiologist, testified that he first treated Anthony in 1994, when he performed an angioplasty procedure on him after he had a heart attack. He then saw Anthony again in 2001 after he had another heart attack, at which time he discussed options with Anthony because he had so many more blocked arteries. Dr. Jajeh recommended bypass surgery but also offered another angioplasty procedure. Anthony opted for the angioplasty. Dr. Jajeh also observed ankle edema in 2001, indicating heart failure. Anthony returned in 2002, complaining of shortness of breath. Dr. Jajeh believed he was developing

congestive heart failure. Because of the diminished heart function and progressive heart failure, Dr. Jajeh opined that Anthony was at high risk for sudden, potentially fatal cardiac arrhythmia. Dr. Jajeh noted in Anthony's chart that he did not take his medications regularly and was still overweight.

¶ 23 Dr. Michael Kaufman, the supervising pathologist who handled Anthony's autopsy, testified that he did not perform the gross examination of the organs but worked with his attending pathologist on the final report. Dr. Kouzov, the attending pathologist, performed the incisions and gross examination of the organs. Dr. Kaufman reviewed the microscopic tissue slides with him and worked on the final conclusions. The final autopsy report listed the immediate cause of death as sudden and unexpected cardiac death secondary to a presumed cardiac arrhythmia. Dr. Kaufman testified that Anthony's main disease was severe hypertensive and arteriosclerotic cardiovascular disease. Dr. Kaufman explained that in pathology terms, "sudden and unexpected" events occur where an individual dies not due to a longstanding illness and their death is not necessarily expected. In this case, it was due to an abnormal fatal heart rhythm. He explained that it was not a situation where Anthony showed signs over the course of days that an arrhythmia was impending. Dr. Kaufman explained that Anthony had obvious risk factors that made asystole more likely than in another person. However, based on what had occurred, where Anthony presented with a skin infection and uncontrolled diabetes and then suddenly became unresponsive in the presence of the nurse, his cardiac arrest was "sudden and unexpected." Dr. Kaufman acknowledged that the preliminary autopsy report indicated that the cause of death was subacute myocardial infarction of the lateral wall of the left ventricle of the heart. Dr. Kaufman explained that preliminary reports recorded one's first impressions after gross examination of the organs. Preliminary reports did not factor in tissue slides or toxicology or other microbiological tests. He testified that the final report

did not indicate subacute myocardial infarction because there was no evidence of any subacute or acute myocardial infarction in that location after he reviewed the tissue slides. Evidence of acute or subacute myocardial infarction would show in the slides as dead muscle tissue but Anthony's slides showed only scar tissue, which indicated evidence of older heart attacks, not recent ones.

¶ 24 Dr. Robert Koch, another cardiologist who treated Anthony, testified that he saw Anthony on June 24, 2003, after he had an emergency room visit for angina-like symptoms. Dr. Koch was not Anthony's primary cardiologist but noted that he had previously declined open heart bypass surgery. He testified that this meant to him that the patient had already decided to live life with the possibility of future heart attacks and angina because he had chosen to open one artery instead of having all the arteries benefit from a bypass. His stress test exam in June 2003 showed that Anthony was not suffering from an acute heart attack and the only ischemia, or reduced blood flow, was from that of the dead muscle area from the prior heart attacks. Dr. Koch noted that Anthony's June 2003 EKG was unchanged from his prior one, and that his heart muscle was weakened but not much more than after his last heart attack. He recommended that Anthony take a blood pressure medication and follow up with Dr. Jajeh after he have a follow-up stress test. Dr. Koch believed that Anthony was at risk for some cardiac event in the future when he last saw him in June 2003. Dr. Koch believed he was at risk of a fatal cardiac arrhythmia. Dr. Koch testified that had he been consulted upon Anthony's admission, he would not have had him in a monitored bed because he was not having cardiac symptoms. He would not have had the stress test done in-patient because Anthony was not having cardiac symptoms. The shortness of breath that Anthony reported would not have prompted Dr. Koch to give any cardiac orders or to place Anthony in a telemetry unit.

¶ 25 Finally, Dr. Mira Kupisek, Anthony's regular internist, testified that Anthony had insulin-dependent diabetes, high cholesterol, obesity, high blood pressure, coronary artery disease, history of two heart attacks, and deep vein thrombosis. He also had a history of recurrent abscesses. Dr. Kupisek testified that Anthony's diabetes was usually uncontrolled because of his poor compliance with diet, medications, blood glucose monitoring, and exercise. All of these factors also contributed to his coronary artery disease. Dr. Kupisek testified that she believed Anthony's life expectancy was not more than five years as of June 2003, and believed it was actually successful that he lived so long after the last heart attack with a heart that was so poor.

¶ 26 The jury found in favor of defendant on August 30, 2010. Plaintiff filed a motion for a new trial, which was denied on January 18, 2011. Plaintiff timely appealed.

¶ 27 II. ANALYSIS

¶ 28 Plaintiff argues that she is entitled to a new trial because of the cumulative errors caused by the trial court in allowing: (1) Dr. Kaufman to characterize the "official" cause of death as being "unexpected" cardiac arrhythmia; and (2) Dr. Jajeh, Dr. Koch, and Dr. Kupisek to testify regarding Anthony's life expectancy. We disagree.

¶ 29 Plaintiff argues first that Dr. Kaufman should not have been allowed to testify about the cause of death in the final autopsy report because the cause of death was not disputed and the terminology "sudden and unexpected" were terms of art, not based on his expertise as a pathologist. Further, plaintiff argues that she requested a physician outside of Condell to perform the autopsy so results were not "fudged." Dr. Kaufman testified that no such conversation took place; plaintiff testified to the opposite.

¶ 30 The trial court is in the best position to make decisions regarding the admission of evidence. *Gauger v. Hendle*, 2011 IL App. (2d) 100316,¶ 98. We review evidentiary decisions under an abuse of discretion standard. *Id.* A trial court abuses its discretion where no reasonable person would take the view adopted by the trial court. *Id.* Here, Dr. Kaufman testified regarding the contents of his autopsy report. Plaintiff's complaints about Dr. Kaufman's testimony do not affect the admissibility of his testimony, but rather the weight to be assigned to his opinions. *Moller v. Lipov*, 368 Ill. App. 3d 333, 344 (2006). Plaintiff argues that Dr. Kaufman should not have been allowed to testify as to the cause of death because Dr. Messer and Dr. Caralis agreed that Anthony died of a cardiac arrhythmia. Dr. Kaufman, however, testified further that the tissue slides did not show evidence of a recent heart attack and therefore, the death was due to a sudden and unexpected asystole event.[1] Further, plaintiff complains that Dr. Kaufman did not have proper authorization to perform the autopsy. However, this information was brought in inadvertently by the defense, and the court allowed plaintiff to testify in rebuttal on that point to correct the error. Finally, plaintiff argues that Dr. Kaufman's terminology was a term of art and differed from the preliminary autopsy report's results. Again, Dr. Kaufman was cross-examined on these points, and he explained what he meant by "sudden and unexpected" and the differences between preliminary and final autopsy reports. The arguments that plaintiff raises go to the weight the jury should place on Dr. Kaufman's testimony, not its admissibility. Contrary to plaintiff's argument, the fact that Dr. Kaufman was allowed to

[1] Plaintiff makes a conclusory allegation in her brief that Dr. Kaufman was not qualified to characterize Anthony's arrhythmia as sudden or unexpected. The record demonstrates otherwise; Dr. Kaufman testified as the pathologist who reviewed the microscopic tissue slides and explained his conclusions in terms of his experience and knowledge as a pathologist. Regardless, plaintiff's argument is undeveloped and unsupported by legal authority and forfeited on that basis. Ill. Sup. Ct. R. 341(h) (eff. July 1, 2008). Similarly forfeited is plaintiff's undeveloped and unsupported statement that Dr. Kaufman's testimony was exacerbated by defense counsel's statements in opening and closing arguments that the cause of death was sudden and unexpected.

testify regarding the difference between a preliminary and final autopsy report did not remove from the jury's province the credibility or the weight to be afforded in his cause-of-death opinion. Therefore, we reject plaintiff's argument that the trial court abused its discretion in letting Dr. Kaufman testify as to his autopsy report.

¶ 31 Next, plaintiff argues that the testimony of Dr. Koch, Dr. Jajeh, and Dr. Kupisek further prejudiced her case. Plaintiff argues that these non-treating physicians should not have been allowed to provide expert testimony when they did not treat Anthony during his last admission to Condell. First, these physicians were allowed to testify as independent experts pursuant to Illinois Supreme Court Rule 213(f)(2) (eff. Sept 1, 2008). The trial court allowed these witnesses to testify regarding their treatment of Anthony's ailments prior to his final admission to Condell. The trial court barred these witnesses from testifying that Anthony's failure to comply with their recommendations caused his own death, but the court allowed them to opine as to his life expectancy and their opinion as to what may have caused his death.

¶ 32 In *Geers v. Brichta*, 248 Ill. App. 3d 398, 407 (1993), the defendants argued that the trial court improperly admitted the deposition testimony of treating physicians because both testified that it was only possible that the plaintiff's neck problems were caused by the collision. The court stated that a physician may testify to what might or could have caused an injury despite any objection that the testimony is inconclusive. *Id.* "Such testimony is but the opinion of the witness given on facts assumed to be true." *Id.* The trier of fact still has the duty to determine the facts and the inferences to be drawn from those facts. *Id.* In that case, the doctors had testified that based upon their examinations and treatment of the plaintiff's neck injury, they believed it was possible the injury stemmed from the automobile collision. *Id.* at 408.

¶ 33 Likewise, Anthony's doctors testified regarding the treatment they provided to Anthony prior to his final admission to Condell. They also provided their opinion as to his life expectancy given the state of Anthony's health during their last encounters. Contrary to plaintiff's argument, these witnesses did not testify as to the standard of care that applied to Dr. Adi. Dr. Jajeh was asked whether he had hospitalized Anthony on certain occasions, and he answered that he did not. Dr. Koch was asked whether he would have ordered any tests or ordered a cardiac monitor if he had been consulted upon Anthony's final hospital admission; he did not opine that Dr. Adi breached her duties to Anthony. Both Dr. Jajeh and Dr. Koch provided information regarding the condition of Anthony's heart as of his last visits with them. Dr. Kupisek testified that in her opinion, Anthony's failure to monitor his diabetes and other conditions contributed to his ultimate heart attack. All of the doctors believed Anthony was at high risk for a sudden heart attack because of his damaged heart, uncontrolled diabetes, high blood pressure, obesity, and other ailments. Their opinions did not address whether Dr. Adi violated the standard of care applicable to an internal medicine physician in failing to admit Anthony to a cardiac intensive care unit or otherwise having him on a cardiac monitor based on the symptoms he presented with in the emergency room. While defendant sought to admit this evidence to support her argument that Anthony came to the hospital with a higher risk of suffering a heart attack seeking treatment for his muscle pain and infection, this testimony could have been construed by the jury in plaintiff's favor as they argued because of his prior health conditions, he should have been on a cardiac monitor. We do not know how the jury construed the information. Regardless of how the jury weighed the evidence, we reject plaintiff's argument that the trial court abused its discretion in admitting this testimony because it was not cumulative of the standard-of-care issue.

¶ 34 III. CONCLUSION

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

¶ 36 Affirmed.