2011 IL App (1st) 101297-U

FOURTH DIVISION
December 8, 2011

No. 1-10-1297

IN THE APPELLATE COURT
OF ILLINOIS
FIRST JUDICIAL DISTRICT

ANDREW WAGNER and JULIE WAGNER,	)	Appeal from the
	)	Circuit Court of
Plaintiffs-Appellants,	)	Cook County
	)	
v.	)	No. 06 L 280
	)	
MITCHELL SHEINKOP, M.D.,	)	Honorable
	)	Cheryl A. Starks,
Defendant-Appellee.	)	Judge Presiding.

JUSTICE STERBA delivered the judgment of the court.
Justice Lavin and Justice Pucinski concurred in the judgment.

ORDER

¶ *1* *HELD*: The circuit court did not abuse its discretion in denying the motion for a new trial where there was support in the record for the jury's verdict. Moreover, the circuit court did not abuse its discretion in excluding evidence of prior medical negligence actions where the evidence had limited probative value and was highly prejudicial. Finally, the arguments regarding evidence related to the suspension of plaintiffs' expert from an organization for orthopedic surgeons were waived where no objections were made at trial and no offer of proof was made regarding the reasons for the suspension.

¶ 2 The present appeal arises out of a judgment entered on a jury verdict in favor of

defendant-appellee Mitchell Sheinkop, M.D., and against plaintiffs-appellants Andrew and Julie Wagner in a medical malpractice action. The Wagners contend that the trial court erred in entering judgment on the jury verdict because: (1) the verdict was against the manifest weight of the evidence; (2) plaintiffs should have been permitted to cross-examine defendant regarding the number of times he had been sued for malpractice; (3) defendant should not have been permitted to question plaintiffs' expert regarding his suspension from the American Academy of Orthopaedic Surgeons; and (4) if questions regarding the suspension were allowed, plaintiffs should have been given an opportunity to explain the suspension. For the following reasons, we affirm the judgment of the trial court.

¶ 3 BACKGROUND

While the Wagners were on vacation in the spring of 2004, Andrew experienced pain in his left hip and consulted a doctor. The doctor advised him that he would probably need a hip replacement. When the Wagners returned home, Andrew saw Dr. Sheinkop. Following an examination and x-rays, Dr. Sheinkop determined that Andrew had severe arthritis in both hips and a total loss of articular cartilage. The options available to Andrew were bilateral hip replacement or wheelchair confinement. With hip replacements, the objective is to reproduce the smooth gliding mechanism of a healthy ball and socket joint. A metallic shell, lined with a plastic or polyethylene liner, is implanted into the acetabulum (the socket) in the pelvis and secured with screws. The femoral head (the ball) of the bone is removed, a portion of the bone marrow is "reamed" out, and an artificial stem with a ball on top is implanted into the marrow cavity of the bone, recreating the anatomical ball and socket joint.

¶ 4 Dr. Sheinkop initially scheduled a bilateral hip replacement for Andrew on April 28, 2004. However, only the left hip was replaced during the April 28 surgery. The next day, Andrew dislocated his left hip. Dr. Sheinkop performed a closed reduction on the hip. A closed reduction is a manual repositioning of the ball portion in the ball and socket hip joint without performing surgery. The closed reduction was not successful and on May 1, 2004, Dr. Sheinkop performed an open reduction on Andrew's left hip, replacing the original polyethylene liner with a constrained liner and repositioning the femoral head. An open reduction is performed by operating on the hip itself to reposition the ball into the socket. After a second dislocation to the same hip on May 10, Dr. Sheinkop performed a revision on Andrew's left hip on May 11, 2004, replacing both the acetabular liner and femoral head. During a revision, the hardware is completely removed and replaced with new components.

¶ 5 Dr. Sheinkop performed the hip replacement on Andrew's right hip on October 6, 2004. On October 30, 2004, Andrew dislocated his right hip in his shower at home. Dr. Sheinkop successfully performed a closed reduction on the right hip and Andrew was given a brace with instructions to wear it 24 hours a day. On November 29, 2004, Andrew again dislocated his right hip. Dr. Sheinkop performed another closed reduction on Andrew's right hip. On December 4, 2004, Andrew's right hip dislocated again. Dr. Sheinkop performed an open reduction on Andrew's right hip on December 6, 2004, replacing the femoral head and adjusting the position of the cup.

¶ 6 The Wagners initially brought suit against Dr. Sheinkop in 2005, but voluntarily dismissed pursuant to Section 2-1009 of the Illinois Code of Civil Procedure. 735 ILCS 5/2-

1009 (West 2004). The Wagners refiled in January 2006, alleging one count of medical malpractice for Dr. Sheinkop's replacement of the left hip, one count of medical malpractice for Dr. Sheinkop's replacement of the right hip, and one count for loss of consortium (on behalf of Julie Wagner, Andrew's wife).

¶ 7 During the discovery phase of the litigation, Dr. Sheinkop was served with the following interrogatory: "Have you ever been named as a defendant in a lawsuit arising from alleged malpractice or professional negligence? If so, state the court, the caption and the case number for each lawsuit." Dr. Sheinkop responded: "Yes. Lawsuits in which I have been named as a defendant are a matter of public record. I do not keep a list." At Dr. Sheinkop's deposition, he was asked how many medical malpractice lawsuits he had been involved in as a defendant. Dr. Sheinkop estimated that he had been involved in 10 to 15 lawsuits.

¶ 8 After the case was assigned for trial, Dr. Sheinkop filed a motion *in limine* to preclude any reference, testimony or argument before the jury at trial related to any other medical negligence lawsuit in which he may have been named as a party. At the hearing on the motion, counsel for the plaintiffs stated that although Dr. Sheinkop testified in his deposition that he had been named as a defendant in approximately 10 to 15 medical negligence lawsuits, in fact, Dr. Sheinkop had been involved in 34 lawsuits. The court said that it would allow counsel to *voir dire* Dr. Sheinkop on the question before he testified at trial in order to determine whether he actually thought there had been that many lawsuits or if he was simply mistaken. In the meantime, the court ruled that testimony relating to other medical malpractice lawsuits would be overly prejudicial and granted the motion.

¶ 9 During Dr. Sheinkop's testimony at trial, the court allowed plaintiffs to make an offer of proof related to the number of times he had been named as a defendant in medical malpractice suits. Plaintiffs produced a list of more than 30 lawsuits and questioned Dr. Sheinkop about his deposition testimony. Dr. Sheinkop testified that the total on plaintiffs' list included cases that were filed against residents in which he was named as the chief of the residency training program, refilings of previously filed cases that had been withdrawn, and cases that involved members of his family that had nothing to do with medical malpractice and thus, the actual number was significantly less than 30. The court upheld its ruling that the probative value of the evidence was outweighed by its prejudicial effect.

¶ 10 At trial, Dr. Sheinkop testified that when he examined Andrew in 2004, he was incapacitated by pain and was dependent upon a walker, cane or wheelchair for mobility. Moreover, Andrew had no hip motion at the time on the left side and very little hip motion on the right side. After x-rays were taken, Dr. Sheinkop discovered that Andrew had lost all articular cartilage in both hips. Dr. Sheinkop testified that he did not perform both hip replacement surgeries at the same time because of a combination of Andrew's size and the fact that he experienced more blood loss than anticipated during the first operation. Dr. Sheinkop stated that with larger and heavier patients, the technical aspects of the surgical procedure are more difficult, there is a greater potential for complications, and the patient is likely to experience greater blood loss.

¶ 11 In his postoperative report, Dr. Sheinkop noted that postoperative instability was a concern due to Andrew's obesity and general size, and he testified that the risk of dislocation,

while inherent in any hip replacement surgery, increases exponentially in a larger and heavier patient. Dr. Sheinkop stated that some of the factors involved in the initial dislocation were: (1) the inherent risk in all hip replacements, (2) Andrew's weight at the time of surgery, and (3) the size of the largest replacement femoral head that was available at that time. He explained that stability is based upon the contact points of the femoral head and that a larger femoral head has more contact, and thus, more inherent constraint.

¶ 12 Dr. Sheinkop testified that with Andrew's initial dislocation, he was not able to achieve a successful closed reduction because of Andrew's size and a prior knee replacement procedure. He explained that because of the pressure that would have been required to perform the closed reduction, there was a risk that the knee prosthesis would be destroyed. On May 1, an open reduction was performed on Andrew's left hip. Dr. Sheinkop testified that he replaced the original liner with what is known as a constrained liner. He explained that the thinner liner he originally inserted is more commonly used because it lasts longer, does not wear, and there is less chance of it pulling loose. However, because of the dislocation, he replaced the original liner with a thicker, constrained liner in which the ball is snapped into the socket to provide a rigid fixation with less propensity to dislocate.

¶ 13 The postoperative report from the open reduction procedure indicated that the positioning of the acetabulum was less than optimal. Dr. Sheinkop explained that this notation did not mean that the component had been misplaced originally. He said that after the initial hip replacement surgery, he tested the joint by pushing, pulling, and twisting it, and was satisfied with its stability at that point. However, when the x-ray was taken on May 1st following the dislocation, he was

not satisfied with the position of the cup at that time.

¶ 14 Dr. Sheinkop testified that the May 10 dislocation occurred because the constrained liner that was implanted on May 1 was defective and caused the prosthesis to come out of position. He stated that the manufacturer subsequently recalled the defective constrained liners and constrained liners are no longer commonly used because there are now larger femoral heads available. On May 11, Dr. Sheinkop performed a revision in which he replaced both the femoral head and the acetabular liner.

¶ 15 Dr. Sheinkop testified that following the October 6 right hip replacement, Andrew dislocated the right hip when he slipped in the shower. Dr. Sheinkop performed a closed reduction on October 30, and placed Andrew in an abduction brace for 24 hours every day, 7 days per week, for 6 weeks. However, he stated that Andrew did not follow his instructions but removed the brace when he dressed. An abduction brace allows a patient to walk, but restricts the movement of the joint, permitting the soft tissues surrounding the joint to heal. Dr. Sheinkop explained that the abduction of the acetabular cup refers to the angle at which the cup is positioned. He stated that an abduction of 45 degrees is optimal, but that an abduction in the range of 30 to 70 degrees is acceptable.

¶ 16 Dr. Sheinkop demonstrated that neutral placement of the acetabular cup is when the socket faces straight out to the side, anteversion is when it is tilted so that the front is less prominent, and retroversion is when the front is more prominent. He testified that any degree of retroversion is improper if it leads to instability, and that retroversion "might or could" lead to instability. Dr. Sheinkop stated that when Andrew dislocated his right hip again on November

29, he was again able to successfully perform a closed reduction. Finally, on December 6 after another dislocation, he performed a final operation to correct the right hip. Dr. Sheinkop further testified that the sciatic notch was not penetrated by the protruding screw seen on the December 6 x-ray, but that the screw penetrated the ilium instead, that the end of the screw was protected by a mass of muscle, and that approximately 40 percent of cases exhibit a screw protruding in this manner.

¶ 17 Dr. Sheinkop was asked about a surgery report he prepared describing an open reduction that was performed on Andrew's right hip that was dated November 29. He testified that he did not, in fact, perform that procedure on November 29 but rather on December 6. On November 29, he performed a closed reduction. He explained that the report was dictated on January 6, 2005, at which time he was informed that he was delinquent in preparing the report for November 29 and would lose his privileges to proceed with his next surgery if he did not dictate the November 29 procedure. He stated that his memory did not serve him accurately and he dictated a procedure that had been done on December 6 instead of the procedure that was actually done on November 29. He further explained that because of laws governing medical records, he was unable to alter a medical record in any way and had to live with the administrative error.

¶ 18 Dr. Graboff testified as an expert for the plaintiffs. Plaintiffs' counsel filed a motion *in limine* immediately prior to his testimony to prevent the defendant from questioning Dr. Graboff about his recent suspension from the American Academy of Orthopaedic Surgeons (Academy). Dr. Graboff was suspended from the Academy for two years based on violations of the organization's standards on expert witness testimony. Plaintiffs' counsel argued that the

suspension was not probative of Dr. Graboff's qualifications or anything else because the Academy is a voluntary organization and the standards were adopted long after Dr. Graboff became a member of the organization. The trial court agreed that the suspension had nothing to do with Dr. Graboff's license to practice medicine, but stated that it was relevant to show that he had not adhered to "those standards which are expected of an expert witness." After additional argument by both sides, the trial court stated that it thought the prejudicial effect far outweighed the probative value of the suspension. Defense counsel agreed that it was very prejudicial but argued that it went directly to the issue of the expert's credibility, the primary issue in the case. The trial court stated that it was "really a close call" and then ruled that defense counsel could bring up the suspension in terms of background, but would not be allowed to discuss the reasons for the suspension.

¶ 19 At trial, Dr. Graboff explained that the ball and socket were not inserted correctly in the initial surgery on April 28, resulting in the instability in Andrew's hip which caused the dislocations. Dr. Graboff testified that the cup itself was improperly abducted, being in an "almost horizontal" position, and that the proper standard of care for insertion of the cup is an abduction of approximately 35 degrees. Dr. Graboff also testified that Dr. Sheinkop had left a bone spur at the top of the socket, and as a result, the cup was not completely inserted into the socket. According to Dr. Graboff, the standard of care for a hip replacement required all bone spurs to be removed prior to insertion of the cup. Finally, Dr. Graboff testified that when the prosthesis is inserted into the shaft of the bone, the flange or collar should be resting on a piece of the bone for stability, but in Andrew's surgery, there was a space between the flange and the

bone.

¶ 20 Dr. Graboff stated that the acetabular cup was positioned correctly when it was replaced during the May 1 surgery, after which the abduction was about 35 or 40 degrees. However, Dr. Graboff testified that even though Dr. Sheinkop put in a thicker liner, and thus the ball would not have been as deeply in the cup, it still should have been inside the cup instead of floating outside the cup as the x-ray showed. Dr. Graboff stated that the radiology report following the May 1 surgery supported his view that the ball was incorrectly positioned outside of the acetabular cup. Moreover, Dr. Graboff opined that the incorrect placement caused the dislocation of the hip on May 10. He noted that the x-ray taken after the May 11 surgery showed the femoral head to be correctly positioned within the acetabular cup. Dr. Graboff further testified that during the May 1 surgery, Dr. Sheinkop installed the acetabular cup in a retroverted position. Dr. Graboff testified that while there are acceptable ranges of anteversion, there is no acceptable retroverted position. He stated that the May 11 surgery also corrected the retroversion problem.

¶ 21 Turning to the hip replacement surgery on Andrew's right hip on October 6, Dr. Graboff testified that the acetabular cup was inserted in a neutral position when it should have been placed in an anteverted position. Dr. Graboff opined that the right hip dislocated multiple times because of the neutral position of the acetabular cup. Moreover, during the corrective surgery on December 6, Dr. Graboff testified that one of the screws affixing the acetabular cup to the pelvis penetrated through the bone to the sciatic notch, creating the possibility of a potentially catastrophic vascular injury if the screw should puncture the sciatic nerve or a major vein or artery. Finally, Dr. Graboff testified that in his opinion, the multiple dislocations of Andrew's

hips resulted in soft tissue damage, causing severe, incapacitating pain that could have been avoided if the surgeries had been performed correctly.

¶ 22 Dr. Graboff stated that it was his opinion, within a reasonable degree of medical certainty, that Dr. Sheinkop deviated from the standard of care in performing surgical procedures on the left hip on April 28 and May 1, and in performing surgical procedures on the right hip on October 6 and December 6. Dr. Graboff opined that the hip replacement components were incorrectly positioned on April 28 because of excessive abduction, and on May 1 because of retroversion. He further opined that on October 6, the acetabular cup was inserted in a neutral position and following the surgery on December 6, one of the screws protruded into the sciatic notch.

¶ 23 During cross examination, Dr. Graboff testified that he advertised his services as an expert witness on the internet, and stated online that he was a board certified orthopedic surgeon, and a fellow of the Academy. Dr. Graboff testified that the Academy was a prestigious national organization for orthopedic surgeons and that he had been a member of the Academy for 20 years. He confirmed that he had recently been suspended from the Academy for a period of two years. Dr. Graboff stated that he had not performed surgeries of any kind since January 1, 2005, that he devoted roughly 20-25% of his practice to joint replacement surgery between 1994 and 2004, and that 60% of the surgeries he performed during that time were hip replacement surgeries.

¶ 24 Dr. Graboff also testified that component or prosthesis failures are recognized complications with hip replacement surgeries, and that when dislocations occur, the cause cannot

always be determined and in many cases is multifactorial. Finally, Dr Graboff stated that he did not believe that Andrew fell in the shower on October 30. He was asked about the ambulance report, surgical summary, and emergency triage notes which all indicated Andrew had fallen in the shower, but maintained that he did not believe Andrew had fallen. On redirect examination, Dr. Graboff explained that in his experience, he could not remember a case of a patient having a traumatic dislocation from falling. Instead, because of some instability in the socket, a patient could be in the act of sitting down and the joint could pop out, causing the fall. He stated that he believed that in Andrew's case, his hip became dislocated first and then he fell.

¶ 25 Dr. Nelson testified as an expert for the defendant. He stated that he had reviewed Andrew's medical records and x-rays as well as the depositions in the case and formed an opinion, within a reasonable degree of medical certainty, that Dr. Sheinkop complied with the standard of care. Dr. Nelson testified that he had been performing hip replacement surgeries for 25 years and continued to perform such surgeries. In Dr. Nelson's opinion, the initial left hip replacement surgery complied with the basic standards of orthopedic surgery. He testified that the acetabular cup placement in the initial surgery was not optimal, but stated that it was within the standard of the acceptable margin of error. Dr. Nelson stated that cup position was not the sole factor in stability and that the primary factor was muscle strength. He testified that the ideal placement of the acetabular cup should be 45 degrees from horizontal but that variables such as the size of the patient and the depth of the surgical wound can affect the placement of the cup.

¶ 26 Dr. Nelson testified that Dr. Sheinkop's decision to halt the attempted closed reduction on April 29 because of the risk to Andrew's knee prosthesis and perform an open reduction instead

was the appropriate action following the initial dislocation of the left hip. In Dr. Nelson's opinion, Dr. Sheinkop complied with the standard of care in performing the open reduction on May 1 in which the polyethylene liner was replaced with a constrained liner. He stated that the explanation that the cup was defective, causing the dislocation that led to the May 11 surgery, was plausible, and that the records indicated that Andrew was doing well after the May 11 left hip surgery.

¶ 27 Dr. Nelson opined that the October 6 right hip replacement surgery was performed correctly and that the medical records indicated that the dislocation on October 30 was caused by a fall in the shower. Dr. Nelson explained that a fall would be considered a traumatic dislocation, which can cause injury to the soft tissues. He explained that during a traumatic dislocation, the femoral head would tear the surrounding muscles and that could lead to additional episodes of instability. In Andrew's case, Dr. Nelson testified that the traumatic dislocation did in fact lead to additional instability. He stated that performing a closed reduction following the dislocation complied with the standard of care. He further testified that placing Andrew in a brace following the procedure was the correct action to help control the position of the soft tissue during the healing process. In Dr. Nelson's opinion, Dr. Sheinkop complied with the standard of care and dealt with the complication in a professional and correct manner.

¶ 28 Dr. Nelson noted that the two components in the open reduction procedure performed by Dr. Sheinkop on December 6 that led to increased stability were increasing the anteversion of the cup and increasing the size of the femoral head. Dr. Nelson testified that on anterior-posterior x-rays such as those shown at trial, you cannot determine whether the cup is antroverted or

retroverted. Finally, Dr. Nelson testified that the protruding screw following the December 6 procedure did not penetrate the sciatic notch. He explained that the sciatic notch is the curvature that was above the screw in the x-ray, and that it is located behind the acetabulum. Also, if the screw had gone behind the acetabulum, it would actually look short and like a circle on the x-ray, instead of visualized in full length. Based on the technical factors of how to read an x-ray, Dr. Nelson stated it was clear that the screw was not protruding into the sciatic notch.

¶ 29 On cross examination, Dr. Nelson agreed that the screw used on December 6 was longer than it needed to be, but that the length was still within the standard of care. Dr. Nelson stated that the bone spur did not, in his opinion, contribute to the incorrect positioning during the April 28 surgery. He stated that the variability of the positioning depended on the size of the patient and the position of the pelvis on the table, not on whether there was a bone spur at the edge of the socket. Dr. Nelson also testified that it was his opinion that the femoral head was fully seated in the constrained liner after the May 1 surgery. He explained that the additional thickness of the constrained liner made it appear on the x-ray as if the femoral head was farther away from the shell. Finally, Dr. Nelson stated that in order to interpret references to retroversion in medical reports, you need to know the standard baseline measuring that was used by the creator of the report. He explained that the goal for placement of the acetabular cup is 25 to 30 degrees of anteversion. A surgeon may say that a position at 20 degrees of anteversion is slightly retroverted, meaning it is retroverted from the optimal position of 25 to 30 degrees, not from zero. Therefore, he could not state definitively what was meant just by reading a reference to retroversion in a report.

¶ 30 The jury returned a verdict in favor of Dr. Sheinkop and against the Wagners, and the trial court entered judgment on the verdict. The Wagners' motion for a new trial was denied and this appeal was timely filed.

¶ 31 ANALYSIS

¶ 32 The Wagners raise four issues on appeal. First, they contend that the jury verdict was against the manifest weight of the evidence and thus, the trial court abused its discretion in denying the motion for a new trial. Second, the Wagners contend that it was an abuse of the trial court's discretion not to allow cross-examination regarding the apparent inconsistency in the actual number of lawsuits filed against Dr. Sheinkop and the number that he gave in his deposition. Next, the Wagners contend that it was an abuse of the trial court's discretion to permit the defendant to cross-examine Dr. Graboff about his suspension from the Academy. Finally, the Wagners argue that the trial court abused its discretion in not permittng Dr. Graboff to explain his suspension.

¶ 33 We first address the issue of whether the trial court erred in denying the motion for a new trial. In ruling on a motion for a new trial, the trial court will weigh the evidence and only order a new trial if the verdict is contrary to the manifest weight of the evidence. *Maple v. Gustafson*, 151 Ill.2d 445, 454 (1992). In order for a jury verdict to be against the manifest weight of the evidence, the opposite conclusion must be "clearly evident," or the jury's findings must be "unreasonable, arbitrary, and not based upon any of the evidence." *Id*. On review, a trial court's ruling on a motion for a new trial will not be reversed unless it is affirmatively shown that the trial court abused its discretion. *Id*. at 455. In making this determination, the reviewing court

should consider "whether the jury's verdict was supported by the evidence and whether the losing party was denied a fair trial," keeping in mind that the trial court had the benefit of observing the witnesses, their manner in testifying, and the circumstances surrounding credibility determinations. *Id*. at 455-56. "[W]here there is sufficient evidence to support the verdict of the jury, it constitutes an abuse of discretion for the trial court to grant a motion for a new trial." *Id*. at 456.

¶ 34 Appellants contend that the only reasonable conclusion that can be drawn from the evidence presented at trial is that Andrew's multiple hip dislocations, closed reductions, and surgical procedures were the direct result of Dr. Sheinkop's failure to adhere to the standard of care required by these procedures. In support of this contention, appellants make the following assertions: (1) both experts agree that the April 28 surgery caused the initial left hip dislocation, (2) both experts agree that retroversion is never acceptable and retroversion was present here, and (3) both experts agree that an unnecessarily long screw was used and that this screw penetrated Andrew's pelvis either in or near the sciatic notch. Appellants further contend that Dr. Sheinkop admittedly abandoned "usual and customary practice" during the May 1 surgery. We disagree with these characterizations of the testimony at trial.

¶ 35 Our review of the record discloses that there was almost no agreement between the two experts, and certainly no agreement regarding the issue of whether Dr. Sheinkop complied with the standard of care. Dr. Nelson testified that while the position of the acetabular cup during the April 28 surgery was not optimal, it was within the acceptable margin of error. He further testified that variables such as the patient's size and position of the pelvis on the operating table

affect the placement of the cup and that the primary factor in stability is muscle strength, not cup position. Dr. Nelson also stated that anteversion and retroversion cannot be measured on an anterior-posterior x-ray, so there would be no way to determine whether the cup was retroverted simply by viewing the x-ray. When questioned regarding notes on a surgical report that indicated the cup was retroverted, Dr. Nelson explained that the interpretation of the notes depended on the basis for the measurement, whether it was from zero or whether it was being measured in relation to the optimal position. Finally, while Dr. Nelson did agree that the screw was longer than necessary, he did not agree that it penetrated the sciatic notch, nor that the use of the longer screw constituted a deviation from the standard of care. He explained that if the screw had gone behind the acetabulum, it would actually look short and like a circle on the x-ray, instead of visualized in full length, thus, it was clear that the screw was not protruding into the sciatic notch.

¶ 36 The argument that Dr. Sheinkop admittedly abandoned "usual and customary practice" during the May 1 surgery is also not supported by the record. Appellants argue that because Dr. Sheinkop used a thick constrained liner during the May 1 surgery instead of the thinner customary alternative, he abandoned the usual and customary practice and, as a direct result of the thick liner, the cup holding the joint socket together wiggled loose. In fact, Dr. Sheinkop testified that although the thinner liner is more commonly used, there is less propensity for dislocation with the thicker liner. He explained that he used the thicker liner on May 1 because the left hip dislocated when he originally used the thinner liner. Moreover, neither of the experts testified that the cup holding the joint socket together wiggled loose as a direct result of the thicker liner. Dr. Graboff testified that the dislocation on May 10 was a result of the incorrect

placement of the ball. He stated that even though a thicker liner was used, the ball still should have been positioned inside the cup and instead the x-ray showed that it was floating outside the cup. He further opined that the acetabular cup was inserted in a retroverted position on May 1, causing the May 10 dislocation. Dr. Nelson testified that he found to be plausible Dr. Sheinkop's explanation that the dislocation on May 10 was the result of a defective component that was subsequently recalled by the manufacturer. He further stated that Dr. Sheinkop complied with the standard of care in performing the May 1 procedure in which he replaced the original liner with a thicker constrained liner.

¶ 37 Because the experts presented opposing opinions on the issue of whether Dr. Sheinkop complied with the standard of care, and because both experts explained the basis for their conclusions, the jury's verdict ultimately turned on the credibility of the experts and resolving the conflicts in their testimony. It is well settled that it is "the province of the jury to resolve conflicts in the evidence, to pass upon the credibility of the witnesses, and to decide what weight should be given to the witnesses' testimony." *Maple*, 151 Ill. 2d at 452. The trial court cannot set aside a verdict merely because the jury could have drawn different inferences or conclusions; "[l]ikewise, the appellate court should not usurp the function of the jury and substitute its judgment on questions of fact fairly submitted, tried, and determined from the evidence which did not greatly preponderate either way." *Id*. at 452-53.

¶ 38 The jury in this case heard conflicting testimony regarding what caused the various dislocations and whether the procedures performed by Dr. Sheinkop complied with the standard of care. Both experts relied on x-rays and medical reports, as well as their own expertise in the

field, to support their conclusions. The jury also heard testimony from Dr. Sheinkop himself, who explained that the reasons for the dislocations were multifactorial and included Andrew's size, a component that turned out to be defective, and Andrew's failure to follow instructions. The jury weighed the evidence, resolved the conflicts, and found the testimony of Dr. Nelson and possibly that of Dr. Sheinkop to be more credible than the testimony of Dr. Graboff. Dr. Nelson explained the basis for his opinion that Dr. Sheinkop adhered to the standard of care and both he and Dr. Sheinkop offered alternative reasons for the various dislocations that, if believed by the jury, adequately supported the verdict. Therefore, we conclude that the trial court did not abuse its discretion in concluding that there was sufficient evidence to support the verdict and thus, denying the motion for a new trial.

¶ 39 Appellants' remaining arguments relate to the admission or exclusion of evidence at trial. It is well settled that determinations on the admissibility of evidence are within the trial court's discretion and will not be reversed unless the record clearly demonstrates the court abused its discretion. *People v. Harris*, 231 Ill. 2d 582, 588 (2008). An abuse of discretion is found only where the decision is "arbitrary, fanciful or unreasonable" (*People v. Illgen*, 145 Ill. 2d 353, 364 (1991)) or "where no reasonable person would agree with the position adopted by the trial court" (*Schwartz v. Cortelloni*, 177 Ill. 2d 166, 176 (1997)).

¶ 40 We first address appellants' argument that the trial court's exclusion of evidence concerning Dr. Sheinkop's deposition testimony relating to the number of times he had been named as a defendant in a medical negligence action constituted an abuse of discretion. A determination that the probative value of the evidence is outweighed by its prejudicial effect is a

matter left to the sound discretion of the trial court. *Illgen*, 145 Ill. 2d at 375. Evidence of prior wrongs or acts may be admissible if offered for a reason other than to show a person's propensity to act in a particular way. *Wernowsky v. Economy Fire & Casualty Co.,* 106 Ill.2d 49, 53 (1985).

¶ 41 Appellants argue that they sought to introduce this evidence to impeach Dr. Sheinkop and not to show a propensity to commit malpractice. The trial court explained that it was not allowing the evidence because of the danger that a juror may be inclined to think that because Dr. Sheinkop had previously been sued for malpractice, he probably committed malpractice in the case at bar. After hearing appellants' offer of proof, the trial court upheld its earlier ruling. The trial court did not abuse its discretion in determining that the prejudicial effect of the evidence outweighed its probative value. The evidence appears to have very little value even for its purported use of challenging Dr. Sheinkop's credibility. It was apparent during the offer of proof that Dr. Sheinkop's admitted estimate was not nearly as wide of the mark as appellants argued, given that not all of the lawsuits on the list were filed against Dr. Sheinkop directly and some were refilings of previous suits. The dubious potential value of this evidence to challenge Dr. Sheinkop's credibility falls far short of outweighing the likelihood that it would unfairly prejudice the jurors. Thus, the trial court did not err in excluding evidence related to Dr. Sheinkop's deposition testimony about the number of prior malpractice claims against him.

¶ 42 Finally, appellants raise the related arguments that it was an abuse of the trial court's discretion to permit the defendant to cross-examine Dr. Graboff regarding his suspension from the Academy, and that, having allowed the cross-examination, it was a further abuse of discretion not to permit an explanation of the suspension. Dr. Sheinkop notes that the Wagners have

waived the objection to evidence regarding the suspension by failing to object to this line of questioning during cross-examination.

¶ 43 This court has noted that Illinois case law is clear; when a motion *in limine* is denied, "[an] objection must be made when the evidence is offered at trial or the right to raise this issue on appeal is waived." *Chubb/Home Insurance Cos. v. Outboard Marine Corp.*, 238 Ill. App. 3d 558, 567 (1992). Because orders *in limine* are interlocutory in nature and thus subject to reconsideration throughout the trial, proper and timely objections allow the trial court to interpret and make any necessary corrections to its prior order during trial, and also allow a reviewing court to benefit from the trial court's interpretation of its order. *Id*. at 567-68. Objections become even more critical where, as here, the trial court's prior ruling was a "close call." Appellants' counsel did not object when Dr. Graboff was questioned at trial about his suspension from the Academy, therefore, this issue has been waived and the trial court's ruling allowing the admission of evidence that Dr. Graboff was suspended from the Academy will stand.

¶ 44 Appellants' final argument related to evidence of the suspension is that the trial court abused its discretion by not allowing any explanation of the suspension. Appellants argue that the trial court refused to allow "any supposedly relevant explanatory facts about [the] suspension into evidence." However, appellants do not articulate any of the "relevant explanatory facts," nor do they cite to any portion of the record to support their argument. Rather, they cite to the transcript of the hearing on the motion to exclude evidence of the suspension during which the only party who sought to introduce evidence of the reasons for the suspension was the defendant.

¶ 45 Dr. Sheinkop argues that this argument has also been waived because the Wagners made

no offer of proof concerning Dr. Graboff's suspension. We agree. An offer of proof serves to inform the trial judge and opposing counsel of the nature of the offered evidence, and to enable the reviewing court to determine whether the evidence should have been excluded. *Chicago Park District v. Richardson*, 220 Ill. App. 3d 696, 701 (1991). "Thus, a party claiming he has not been given the opportunity to prove his case must provide a reviewing court with an adequate offer of proof of what the excluded evidence would have been. [Citation.] In the absence of an offer of proof, the issue of whether evidence was improperly excluded will be deemed waived." *Id*. at 701-02.

¶ 46 At the hearing on the motion to bar evidence of the suspension, the trial court prohibited defense counsel from going into the reasons why Dr. Graboff was suspended. Defense counsel argued that evidence that Dr. Graboff was suspended from the Academy because the organization determined that he was giving untruthful testimony as an expert witness should be admissible. The trial court agreed that the suspension itself could come in as part of the expert's background information, but ruled that it would be more prejudicial than probative for defense counsel to introduce evidence of the reasons for the suspension. At no point during the hearing did plaintiffs' counsel argue that the reasons for the suspension should be admitted into evidence. As previously noted, no objections were made when Dr. Graboff was asked about his suspension from the Academy on cross-examination. No questions regarding the reasons for the suspension were asked during redirect examination. No offer of proof was made as to what Dr. Graboff would testify to regarding the reasons for his suspension. In fact, there is no evidence in the record that appellants attempted to introduce any evidence whatsoever of the reasons for the

suspension. Thus, this issue has been waived and the trial court's ruling prohibiting defense counsel from introducing evidence regarding the reasons for Dr. Graboff's suspension from the Academy will stand.

¶ 47 For the foregoing reasons, we hold that the trial court did not abuse its discretion in denying the motion for a new trial, where there was evidence in the record to support the jury's verdict. Moreover, the trial court did not abuse its discretion in excluding evidence concerning the number of times Dr. Sheinkop had been named as a defendant in a medical negligence action where the evidence had almost no probative value and was highly prejudicial. Finally, appellants' arguments regarding evidence related to Dr. Graboff's suspension from the Academy have been waived where no objection was made when the evidence was introduced at trial, and no offer of proof was made regarding the reasons for the suspension.

¶ 48 Affirmed.