FIRST DIVISION
FILED: February 27, 2012

No. 1-10-2578

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

WILLIAM W. MALAK, Special Administrator of the Estate of CRYSTAL A. MALAK, Deceased,	)	APPEAL FROM THE CIRCUIT COURT OF COOK COUNTY.
Plaintiff-Appellant,	)	
v.	)	No. 05 L 08842
ADVANCED PAIN & ANESTHESIA CONSULTANTS, P.C., INC., a corporation, APAC CENTERS FOR PAIN MANAGEMENT, a corporation, and NARAYAN S. TATA, M.D.,	)	
Defendants-Appellees,	)	
and	)	
MIDWEST ANESTHESIOLOGISTS, LTD., a corporation, and DAVID J. BIRD, D.O.,	)	HONORABLE LAWRENCE O'GARA,
Defendants.	)	JUDGE PRESIDING.

PRESIDING JUSTICE HOFFMAN delivered the judgment of the court.
Justices Hall and Karnezis concurred in the judgment.

ORDER

¶ 1 Held: The judgment of the circuit court is affirmed where the jury's verdict is not against the manifest weight of the evidence nor inconsistent with the verdict against another defendant and where the circuit court did not abuse its discretion in making evidentiary rulings, in denying the plaintiff's request to postpone opening statements, or in limiting the amount of time for his closing argument.

¶ 2 The plaintiff, William W. Malak, as special administrator of the estate of Crystal A. Malak, deceased, brought this action against Narayan S. Tata, M.D., and his employer, Advanced Pain & Anesthesia Consultants, P.C., Inc., (collectively, Dr. Tata), alleging that Dr. Tata's medical negligence resulted in the death of the plaintiff's wife (Mrs. Malak). The jury returned a verdict in favor of Dr. Tata, and the plaintiff has appealed. For the reasons that follow, we affirm the judgment of the circuit court.

¶ 3 The record reflects the following relevant facts. On March 4, 2005, Mrs. Malak underwent an epidural steroid injection in her cervical spine to relieve pain in her neck and left arm. Dr. Tata performed the injection at the Tinley Woods Surgery Center, and Dr. Bird administered the anesthetic. The procedure was commenced at 11:40 a.m. and concluded at 11:55 a.m. Immediately following the procedure, Mrs. Malak was in stable condition and was able to converse with the doctors and nurses while being taken to the recovery room. She was left unattended in the recovery room for approximately five minutes. During that time, Mrs. Malak suffered a cardiopulmonary arrest, and, when a nurse checked on her at 12:05 p.m., she was unresponsive, did not have a pulse, was not breathing, and was cyanotic. Several members of the medical staff, including Dr. Bird, attempted to resuscitate Mrs. Malak, and Dr. Bird inserted an endotracheal tube to aid her respiration. Following the insertion of the tube, Mrs. Malak's blood pressure, heart rate, and heart

rhythm were normal, but her color remained cyanotic, indicating that her blood was not receiving oxygen. Mrs. Malak was transferred by ambulance to St. James Hospital, where hospital personnel determined that the endotracheal tube had been inserted into her esophagus, rather than her trachea. After the tube was repositioned into her trachea, Mrs. Malak's skin color returned to normal, and she retained a normal blood pressure, heart rate, and rhythm. The results of MRI scans revealed that Mrs. Malak had suffered severe edema of the brain, consistent with hypoxic brain injury. She was pronounced brain dead, and her family decided to terminate life support the following day.

¶ 4 The plaintiff brought this medical malpractice action against Dr. Tata, Dr. Bird, and the medical corporations employing them at the time of the procedure.[1] The plaintiff's complaint, as finally amended, alleged that Dr. Tata failed to properly place the needle for the epidural steroid injection, punctured Mrs. Malak's dura, and negligently injected lidocaine, an anesthetic, into her cervical spine. The amended complaint also asserted that Dr. Tata's negligence could be proven under the theory of res ipsa loquitur. Dr. Tata denied that he had negligently injected lidocaine into Mrs. Malak's spine, and his theory of defense was that she died of a heart attack caused by cardiac arrhythmia, which was unrelated to the steroid injection procedure. The claims against Dr. Bird were predicated on allegations that, following Mrs. Malak's cardiac arrest, he improperly placed an endotracheal tube in her esophagus, rather than in her trachea, and that he failed to ensure proper positioning post-intubation.

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[1] The plaintiff's original complaint also asserted claims against several other medical professionals, all of whom either settled or were voluntarily dismissed from the action and are not parties to this appeal.

¶ 5 Prior to trial, Dr. Tata filed a motion seeking to bar testimony by the plaintiff's expert, Dr. Stephen Pyles, that the injection of lidocaine into Mrs. Malak's cervical spine caused or contributed to her death. This motion was premised on the fact that, during his discovery deposition, Dr. Pyles stated that he could only speculate that Dr. Tata somehow had switched syringes and mistakenly injected anesthetic through a hole in the dura and into the high spinal area. Dr. Tata argued that, considering this deposition testimony, there was no competent evidence that lidocaine had been injected into Mrs. Malak's cervical spine. The trial court granted the motion in limine and rejected the plaintiff's argument that he could rely on the doctrine of res ipsa loquitur to provide a factual basis for Dr. Pyles' testimony regarding the inadvertent injection of lidocaine.

¶ 6 Two days later, and after the jury had been empaneled, the plaintiff sought reconsideration of the ruling on Dr. Tata's motion in limine. The trial court denied the plaintiff's request for reconsideration because Dr. Pyles' deposition testimony indicating that Dr. Tata might have somehow injected lidocaine into the subdural space was based on speculation. During this discussion, the plaintiff's counsel acknowledged that the medical examiner's office had not tested the cerebral spinal fluid, and, as a consequence, the toxicology report contained no evidence that lidocaine had been injected into Mrs. Malak's cervical spine. Later that afternoon, the plaintiff again sought reconsideration of the trial court's in limine ruling. The court addressed and rejected the plaintiff's argument for the third time and also denied the plaintiff's request to postpone the opening statements so counsel could revise his remarks to reflect the court's ruling. In refusing to grant a continuance, the trial court observed that the plaintiff had known of the pretrial ruling for two days and could present an opening statement that described the case in a professional and purposeful way

without addressing the excluded evidence.

¶ 7 At trial, Dr. Tata testified, on adverse examination by the plaintiff's attorney, regarding his qualifications as an expert, as well as his treatment of Mrs. Malak. Dr. Tata stated that he evaluated Mrs. Malak on March 2, 2005, and obtained a medical history, which revealed that she smoked cigarettes and took medication for hypertension. In addition, she had a family history of coronary heart disease, which included the death of her sister at age 48, as a result of a heart attack and kidney disease, and the death of her mother in her 60s, as a result of congestive heart failure.

¶ 8 According to Dr. Tata, Mrs. Malak complained of persistent pain in her neck, which radiated down her left arm. He performed a physical examination and noted that she had a regular heart rhythm and normal lung function at that time. Based on the results of the physical examination and further diagnostic testing, Dr. Tata determined that Mrs. Malak suffered from degenerative disk disease, which was most prevalent at the C6-C7 level, and spondylosis. He advised Mrs. Malak of the possible treatment options, including an epidural steroid injection, and Mrs. Malak agreed to undergo the injection, which was performed on March 4, 2005, at the Tinley Woods Surgery Center.

¶ 9 Dr. Tata described in detail the medical procedure followed during the epidural injection. In particular, he stated that, after the anesthesia was administered, he drew eight centiliters of lidocaine, a local anesthetic, and two centiliters of sodium bicarbonate, both of which are clear substances, into a 10-centiliter syringe. Using a small needle, he created a "skin wheel" to deaden the skin at the site of the injection prior to inserting the larger Tuohy needle through the skin, subcutaneous fat and ligaments. Dr. Tata explained that, because the insertion of the Tuohy needle can be painful, a local anesthetic is used on the surface of the injection site.

¶ 10 Dr. Tata further stated that, after creating the "skin wheel" by injecting two centiliters of the lidocaine-sodium-bicarbonate solution, he emptied the 10-centiliter syringe by evacuating the remainder of the solution into a reservoir on the procedure kit. He then inserted the Tuohy needle into the location of the "skin wheel" and determined that it was properly placed by feeling for resistance and by viewing live fluoroscopy. When he reached dense tissue, he inserted the needle into the epidural space where the steroid should be injected. Using a three-centiliter syringe, he injected Isovue, a contrast material, to make sure that the needle was placed in the epidural space and did not reach the spinal cord or the dura, which coats the spinal cord. After he confirmed the correct placement of the needle, the assisting nurse provided him with Kenalog, a white, viscous steroid, which he injected into Mrs. Malak's cervical spine. Finally, he drew a clear saline solution into the empty three-centiliter syringe and injected it through the Tuohy needle, in order to ensure adequate flow of the Kenalog over the nerves. When the procedure was complete, the needles, syringes, and any excess liquids were discarded.

¶ 11 Dr. Tata testified that he did not observe any signs of a problem during the procedure, and Mrs. Malak was stable and was sitting up in a wheelchair when Dr. Bird and a nurse escorted her to the recovery area. According to Dr. Tata, he left the operating room at 11:55 a.m. and dictated a note concerning the procedure. While completing this dictation in the nurse's station, he saw Mrs. Malak in the recovery area and spoke with her briefly, and he saw no sign of any problem at that time.

¶ 12 Dr. Tata stated that he was preparing another patient in the operating room when he heard an emergency page, and he left that patient with someone else as soon as he learned that Mrs. Malak was the subject of the page. When he reached the recovery area, Dr. Bird, other anesthesiologists,

and the nursing staff already were resuscitating Mrs. Malak. Dr. Tata testified that he remained in the room with Mrs. Malak until the ambulance arrived to transport her to St. James Hospital. Though he had no further involvement in Mrs. Malak's care, he was in contact with the physicians at the hospital to check on her through that night and to offer information and assistance.

¶ 13 Dr. Tata further testified that he spoke with the medical examiner who had performed the autopsy and learned that Mrs. Malak had an enlarged heart and that there was a small needle puncture in the dura as a result of the steroid injection. Yet, Dr. Tata explained that a small needle puncture in the dura did not constitute a deviation from the standard of care and that the puncture could not have caused Mrs. Malak's death. He further testified that he met the standard of care in performing the procedure and would not have done anything differently.

¶ 14 Dr. Mitra Kalelkar, the deputy chief medical examiner of Cook County who performed the autopsy, testified that Mrs. Malak died as a result of anoxic encephalopathy, meaning that her brain did not receive enough oxygen due to hypoxia. Dr. Kalelkar stated that, though Mrs. Malak had a somewhat enlarged heart and a history of hypertension, there was no evidence of a heart attack. She further noted that Mrs. Malak suffered a cardiopulmonary arrest shortly after the procedure and that her heart later started beating again. The autopsy revealed a small needle puncture in the dura, but Dr. Kalelkar concluded that the puncture did not cause Mrs. Malak's death. Dr. Kalelkar testified that the cause of Mrs. Malak's death was related to the epidural injection, but she could not rule out cardiac arrhythmia as the cause of the cardiopulmonary arrest.

¶ 15 Over Dr. Tata's objection, the trial court then conducted voir dire of Dr. Kalelkar and Dr. Steven Pyles, the plaintiff's expert. Based on the voir dire testimony of these two witnesses, the trial

court modified its prior decision on Dr. Tata's motion in limine. The court ruled that Dr. Pyles was precluded from testifying that lidocaine was actually injected, but he would be permitted to testify that Mrs. Malak's symptomology was consistent with a mistaken injection of lidocaine. The trial court overruled Dr. Tata's objection that such testimony was not relevant because there was no evidence that an inadvertent injection of lidocaine had occurred.

¶ 16 Dr. Pyles, an anesthesiologist, was called by the plaintiff as an expert witness with regard to the standard of care and causation. Dr. Pyles stated that, in forming his expert opinions, he relied on two medical journal articles relating to the inadvertent subdural injection of anesthetic. The first article was authored by Dr. Timothy Lubenow and published in 1987, and the second article was authored by Dr. Hoftman and published in 2009. Dr. Pyles further stated that, if anesthetic were injected in the subdural space, it would have a direct effect on the spinal cord within a period of approximately ten minutes. According to Dr. Pyles, the failure to recognize that the dura had been punctured and the unintentional injection of material into the subdural space constitutes a breach of the standard of care. However, Dr. Pyles acknowledged that a small puncture in the dura, resulting from an epidural injection, will seal itself without any ill effects and does not constitute a breach of the standard of care.

¶ 17 In testifying as to his theory of causation, Dr. Pyles stated that, if Dr. Tata had inadvertently injected lidocaine into the intrathecal space, Mrs. Malak would not be able to breathe and that deviation from the standard of care would have caused or contributed to her death. He further testified that such a result is unusual and does not ordinarily occur in the absence of negligence. Yet, Dr. Pyles acknowledged that the medical records reflected that only Isovue, Kenalog, and saline were

injected into the cervical spine through the Tuohy needle. He also acknowledged that the injection of those three substances through a puncture in the dura would not have caused Mrs. Malak's death, and he conceded that Mrs. Malak could have had a cardiac arrhythmia while she was unattended in the recovery room. In addition, Dr. Pyles admitted that he was "just speculating" as to whether or how Dr. Tata could have possibly injected lidocaine into the Tuohy needle. He further testified that, if Dr. Bird had placed the endotracheal tube correctly in Mrs. Malak's trachea, she likely would not have experienced any significant brain injury and would not have died.

¶ 18 The trial court then allowed the plaintiff to recall Dr. Tata for further adverse examination. Dr. Tata agreed that injecting an anesthetic agent through a hole in the dura would constitute a high spinal anesthetic that would cause the patient to stop breathing immediately. According to Dr. Tata, there would not be a delayed response to the anesthetic if it were administered in the cervical spine. The plaintiff's counsel then asked Dr. Tata whether he agreed or disagreed with certain statements contained in the medical journal article authored by Dr. Lubenow, which indicated that patients who had received subdural injection of anesthesia experienced a delay of 5 to 30 minutes in the onset of symptoms. In response to this questioning, Dr. Tata stated that he disagreed and explained that the article had no bearing on this case because the injection in those studies were administered in the lumbar spine, as opposed to the cervical spine. The plaintiff's attorney objected to the explanatory remarks on the ground that they were volunteered, but the objection was overruled.

¶ 19 During examination by his own counsel, Dr. Tata denied that he had injected any anesthetic in the epidural or any area other than the location of the local anesthetic for the skin wheel, and he further stated that the anesthetic did not go into the Tuohy needle at all. Dr. Tata agreed that an

anesthetic injected into the subdural space will cause a high spinal effect, causing the patient to stop breathing, but he stated that the effect would be immediate if the injection were in the cervical spine. Dr. Tata clarified that he did not disagree with the statements contained in the Lubenow article as they related to a delay in symptoms following injections in the lumbar spine. He further explained the anatomical difference in such injections: because lumbar spine is much lower than the cervical spine, an anesthetic injected in the subdural space in the lumbar area would have to travel "north" to the cervical centers to affect breathing. Due to the location of a lumbar injection, its effect would be delayed because of the time it would take for the anesthetic to travel up to the cervical region. According to Dr. Tata, the injection of an anesthetic in the cervical spine, such as at C6-C7, would cause the patient to stop breathing immediately.

¶ 20 The plaintiff also called Dr. Mary Case, a pathologist, who testified that, based upon her review of the autopsy report and the medical records, she concluded that "something about [the epidural injection procedure] created a problem with *** [Mrs. Malak's] heart and lungs." Dr. Case further testified that Mrs. Malak's death was not caused by coronary artery disease and that, if she had not undergone the epidural injection, she would not have died. She acknowledged, however, that she did not know what, in particular, had caused the hypoxia, and there was no way to determine whether there had been a cardiac arrhythmia prior to her death. In addition, Dr. Case also acknowledged that Mrs. Malak had a pre-existing heart condition that could have caused her death and that cardiac arrhythmia secondary to hypertensive cardiovascular disease was a possible cause of Mrs. Malak's death.

¶ 21 Dr. Tata called two expert witnesses who testified regarding the standard of care and the

causation of Mrs. Malak's death. Dr. Kevin Pauza testified that Dr. Tata met and exceeded the standard of care in his treatment of Mrs. Malak. Dr. Pauza stated that, in his opinion, the still images of the fluoroscopy taken during the injection procedure plainly establish that the needle was appropriately placed in the epidural space. Dr. Pauza found no sign of complications during the procedure, and he stated that the hole in the dura, which was discovered during the autopsy, does not indicate that Dr. Tata was negligent. Dr. Pauza explained that a puncture in the dura is a common occurrence and may be attributable to anatomical differences from one individual to another. He further stated that the dura heals itself after being punctured, and a needle puncture of the dura did not harm Mrs. Malak.

¶ 22 According to Dr. Pauza, the epidural steroid injection did not cause Mrs. Malak's death, and the record contained no evidence that lidocaine caused or contributed to Mrs. Malak's death. He noted that neither the fluoroscopy nor the pathology report indicated that Dr. Tata had injected any medications through the hole in the dura. Dr. Pauza also stated that the lidocaine used to numb the skin could not have harmed Mrs. Malak, and none of the substances that were injected through the Tuohy needle would have caused Mrs. Malak's death, even if they had been injected into the intrathecal space.

¶ 23 Dr. Pauza further testified to his expert opinion that, if an anesthetic had been injected intrathecally at the cervical spine level, it would have would have bathed the spinal cord in the location where breathing and respiration are controlled and would have caused an immediate respiratory arrest, which did not occur in this case. Based on the autopsy findings, Dr. Pauza ruled out all potential spinal complications. Dr. Pauza noted that Mrs. Malak's enlarged heart was an

abnormal condition for a person of her age, and he related her death to a sudden cardiac arrhythmia. According to Dr. Pauza, the epidural steroid injection did not cause Mrs. Malak's death.

¶ 24 Dr. Shaku Teas, a clinical and forensic pathologist, testified to her expert opinion that Mrs. Malak died as a result of a cardiac arrhythmia, secondary to hypotensive cardiovascular disease. After reviewing the autopsy report, Dr. Teas found no evidence that Dr. Tata had injected medication of any kind into Mrs. Malak's intrathecal space, and she perceived no problem in the area of the spine, the brain, or the vessels surrounding the spinal cord that could explain Mrs. Malak's death. Based in all of the information available, Dr. Teas concluded that Mrs. Malak died from hypoxia that arose from cardiac arrhythmia. According to Dr. Teas, Mrs. Malak recovered from the spinal epidural injection procedure and then suddenly had a cardiac arrest in the recovery room while she was unattended. Dr. Teas stated that, in her professional opinion, the epidural injection procedure was excluded as a cause of Mrs. Malak's death.

¶ 25 In rebuttal, the plaintiff called Dr. Kerber, who testified to his expert opinion that Mrs. Malak's death was not related to a sudden cardiac arrhythmia, but rather from a non-cardiac problem. Dr. Kerber explained Mrs. Malak was a low risk for cardiac arrhythmia because there was nothing in her family history or medical records suggested that she ever had any kind of heart rhythm disturbance. He further testified that 80% to 90% of sudden cardiac deaths result from severe coronary artery disease, but Mrs. Malak's coronary condition was mild and was not severe enough to cause any problem. Dr. Kerber stated that there was no evidence that Mrs. Malak had a sudden cardiac arrhythmia and that she had an EKG on in the recovery room, in the ambulance, and at the hospital, but none of them indicated the type of heart rhythm that is associated with a sudden cardiac

death. Dr. Kerber acknowledged, however, that no medication can prevent all cardiac arrhythmia, and that 10% to 20% of people who suffer fatal cardiac arrhythmia do so for no apparent reason. He also acknowledged that it was not possible to completely rule out a cardiac arrhythmia as a primary cause of death.

¶ 26 The jury returned a verdict in favor of Dr. Tata and against the plaintiff. However, the jury found that Dr. Bird was liable for Mrs. Malak's death and returned a verdict of $2,910,000 against him.[2] The plaintiff filed a post-trial motion seeking a new trial on his claims against Dr. Tata. In denying this motion, the trial court observed that the plaintiff's theory that lidocaine had been injected into Mrs. Malak's cervical spine based on speculation and was not supported by any competent evidence. The trial court further stated that it had erred in reversing its original decision on Dr. Tata's motion in limine regarding Dr. Pyles' testimony, and the court concluded that all of the parties had received a fair trial. This appeal followed.

¶ 27 The plaintiff initially contends that the trial court erred in denying his motion for a new trial because the jury's verdict was against the manifest weight of the evidence. We cannot agree.

¶ 28 In considering an appeal from a jury verdict, a reviewing court may not simply reweigh the evidence and substitute its judgment for that of the jury. *Snelson v. Kamm*, 204 Ill. 2d 1, 35, 787 N.E.2d 796 (2003). A new trial should be granted only when the verdict is contrary to the manifest weight of the evidence. *York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill. 2d 147, 178-79, 854 N.E.2d 635 (2006). A verdict is contrary to the manifest weight of the evidence when the opposite conclusion is clearly evident or when the jury's findings are unreasonable, arbitrary and not

[2] Dr. Bird has not challenged the verdict against him, and he is not a party to this appeal.

based upon any of the evidence. *York*, 222 Ill. 2d at 179. A court of review will not reverse a circuit court's decision with respect to a motion for a new trial unless it finds that the circuit court abused its discretion, and reviewing courts "are mindful that credibility determinations and the resolution of inconsistencies and conflicts in testimony are for the jury." York, 222 Ill. 2d at 179. An abuse of discretion occurs only if "no reasonable person would take the view adopted by the trial court." Dawdy v. Union Pacific R.R. Co., 207 Ill. 2d 167, 177, 797 N.E.2d 687 (2003).

¶ 29 In a medical negligence case, the plaintiff must prove: (1) the standard of care by which the physician's treatment is measured, (2) that the physician deviated from the standard of care, and (3) that the deviation proximately caused injury to the plaintiff. *Purtill v. Hess*, 111 Ill. 2d 229, 241-42, 489 N.E.2d 867 (1986); *Johnson v. Ingalls Memorial Hospital*, 402 Ill. App. 3d 830, 843, 931 N.E.2d 835 (2010). To establish proximate cause, the plaintiff must provide expert testimony to a reasonable degree of medical certainty that the deviation caused his injury, and the causal connection must not be " 'contingent, speculative, or merely possible.' " *Johnson*, 402 Ill. App. 3d at 843 (quoting *Ayala v. Murad*, 367 Ill. App. 3d 591, 601, 855 N.E.2d 261 (2006)). The opinion of an expert is only as valid as the basis and reasons upon which it is premised. *Johnson*, 402 Ill. App. 3d at 843. "A medical expert witness may not base his opinion on guess, conjecture, or speculation." Soto v. Gaytan, 313 Ill. App. 3d 137, 146, 728 N.E.2d 1126 (2000). Conclusory opinions that are based on unsubstantiated speculation are not relevant. Johnson, 402 Ill. App. 3d at 843.

¶ 30 In this case, Dr. Tata testified that he did not switch the syringes and mistakenly inject lidocaine into the subdural space of Mrs. Malak's cervical spine. He explained that, after creating the skin wheel, he evacuated the lidocaine-sodium-bicarbonate solution and discarded the 10-

centiliter syringe before using a three-centiliter syringe to inject the Isovue and that he also used a three-centiliter syringe to inject both the Kenalog and the saline solution. In addition, Dr. Tata testified as a treating expert that, if he had accidentally injected lidocaine into Mrs. Malak's cervical spine, the effect on her cardiopulmonary function would have been immediate and that the onset of those symptoms would not have been delayed by five or ten minutes. Thus, Dr. Tata presented direct evidence that he had not inadvertently injected an anesthetic into the intrathecal space and that his conduct could not have caused or contributed to Mrs. Malak's death. In addition, Dr. Tata presented the expert testimony of Dr. Kevin Pauza and Dr. Shaku Teas, both of whom testified that the medical record indicated that Mrs. Malak's death was related to cardiac arrhythmia. Dr. Pauza also testified that the effect of an anesthetic subdural injection in the cervical spine would have been instantaneous.

¶ 31 To counter this evidence, the plaintiff relied primarily on the expert opinion of Dr. Stephen Pyles, who stated that the injection of an anesthetic in the subdural space of the cervical spine would affect the spinal cord within approximately ten minutes and that, if Dr. Tata had inadvertently injected lidocaine into the intrathecal space, Mrs. Malak would not be able to breathe. However, on cross-examination, Dr. Pyles acknowledged that he was "just speculating" as to whether or how Dr. Tata could have possibly injected lidocaine into the Tuohy needle. Contrary to the plaintiff's assertion on appeal, we believe that, when considered in the context of his entire testimony, this testimony indicates that Dr. Pyles' conclusions as to breach of the standard of care and causation were based upon the mere possibility that Dr. Tata had mixed up the syringes in the operating room and inadvertently injected lidocaine into the subdural space of Mrs. Malak's cervical spine. Thus,

Dr. Pyles' expert opinion that the epidural injection caused or contributed to Mrs. Malak's death was predicated on speculation. Therefore, the expert testimony supporting the plaintiff's theory of liability against Dr. Tata was premised on an assumption that was refuted by Dr. Tata.

¶ 32 Moreover, even if Dr. Pyles' testimony is considered to be based on competent evidence and non-speculative, the jury certainly could have found the testimony of Dr. Tata and his expert witnesses to be more credible and more persuasive than the witnesses who testified on behalf of the plaintiff. See Maple v. Gustafson, 151 Ill. 2d 445, 452, 603 N.E.2d 508 (1992) (holding that the credibility of the witnesses, the weight to be given their testimony, and the resolution of conflicts in the evidence are matters that fall peculiarly within the province of the jury). Based on the record presented, we cannot say that the jury's verdict in favor of Dr. Tata was against the manifest weight of the evidence. In reaching this conclusion, we do not agree with the assertion in the plaintiff's reply brief that this case involves an issue of first impression requiring this court to define the term "speculation."

¶ 33 We also reject the plaintiff's contention that the verdict in favor or Dr. Tata must be reversed because it is inconsistent with the verdict against Dr. Bird. Where verdicts returned in a single action are legally inconsistent, such verdicts must be set aside and a new trial granted. Mrowca v. Chicago Transit Authority, 317 Ill. App. 3d 784, 786, 740 N.E.2d 372 (2000) (citing Kumorek v. Moyers, 203 Ill. App. 3d 908, 913, 561 N.E.2d 212 (1990). However, "the court will exercise all reasonable presumptions in favor of the verdict or verdicts, which will not be found legally inconsistent unless absolutely irreconcilable." See Redmond v. Socha, 216 Ill. 2d 622, 643-44, 837 N.E.2d 883 (2005) (citing Tedeschi v. Burlington Northern R.R. Co., 282 Ill. App. 3d 445, 448–49, 668 N.E.2d 138

(1996)). A verdict will not be considered irreconcilably inconsistent if it is supported by "any reasonable hypothesis." Redmond, 216 Ill. 2d at 644.

¶ 34 Here, the plaintiff presented evidence that Mrs. Malak's death was caused by a deprivation of oxygen to the brain and that this injury would not have occurred if Dr. Bird had not violated the standard of care by placing the endotracheal tube in her esophagus, rather than in her trachea. This evidence indicated that Dr. Bird was negligent in inserting the tube, without regard to the circumstance that caused the cessation of Mrs. Malak's breathing. In finding Dr. Bird negligent, the jury was only required to find that Mrs. Malak had stopped breathing and that the improper intubation proximately caused her death. The jury was not required to determine what had caused Mrs. Malak to stop breathing in the first place. The jury's imposition of liability against Dr. Bird but not against Dr. Tata could have been premised on a finding that Mrs. Malak's cardiopulmonary arrest resulted from a cardiac arrhythmia or simply that the evidence presented at trial was insufficient to prove that Dr. Tata acted negligently. Therefore, the verdict against Dr. Bird was not dependent upon a finding that Dr. Tata had inadvertently injected lidocaine into Mrs. Malak's cervical spine. As such, the jury's verdict in favor of Dr. Tata was not irreconcilably inconsistent with the verdict against Dr. Bird. Thus, the trial court did not abuse its discretion in denying the motion for a new trial on this ground, particularly in light of the fact that the plaintiff failed to submit a special interrogatory that would have identified any possible inconsistency between the two verdicts. See Simmons v. Garces, 198 Ill. 2d 541, 555, 763 N.E.2d 720 (2002) (holding that special interrogatories are designed safeguard the integrity of a general verdict by testing the verdict against the jury's findings on specific issues of ultimate fact). Having carefully considered the record presented, we

conclude that the trial court did not abuse its discretion in denying the plaintiff's motion for a new trial.

¶ 35 The plaintiff also asserts that the trial court committed reversible error in refusing to postpone opening statements. The plaintiff claims that he was prejudiced by this ruling because it denied his attorney an opportunity to revise his prepared remarks in accordance with the grant of Dr. Tata's pretrial motion to exclude the speculative portion of Dr. Pyles' testimony. We cannot agree.

¶ 36 Supreme Court Rule 235 (eff. Jan. 1, 1967) specifically provides that opening statements are to be delivered "[a]s soon as the jury is empaneled," and that "[a]n opening statement may not be made at any other time, except in the discretion of the trial court." Therefore, decisions regarding the timing of opening statements are reviewed for an abuse of discretion. As previously noted, an abuse of discretion occurs only if "no reasonable person would take the view adopted by the trial court." Dawdy, 207 Ill. 2d at 177.

¶ 37 Here, the plaintiff's attorney was aware of the trial court's decision on the motion in limine two days before opening statements were scheduled to be delivered. As the trial court noted in denying the second request for reconsideration of its ruling, counsel for the plaintiff had ample opportunity to craft an opening statement that would conform to the pretrial ruling. Where, as here, there has been no unfair surprise or prejudice, we cannot say that the trial court abused its discretion in refusing the plaintiff's request to delay the commencement of opening statements.

¶ 38 We similarly reject the plaintiff's claim that the court erred in limiting him to 50 minutes, rather than the 60 minutes that he requested for his closing argument. It is well established that the length of closing argument is a matter that falls within the discretion of the circuit court, and its

determination in this regard will not be disturbed absent a manifest abuse of discretion. Tsoukas v. Lapid, 315 Ill. App. 3d 372, 383, 733 N.E.2d 823 (2000).

¶ 39 In this case, the plaintiff has not identified any particular topic, issue, or aspect of his case against Dr. Tata that he was prevented from addressing in a clear and coherent manner, as a result of the 50-minute time limitation. In the absence of some showing that the plaintiff was prejudiced by the trial court's denial of an additional 10 minutes, we find no reason to conclude that the trial court abused its discretion or acted unreasonably in limiting the plaintiff's closing argument to 50 minutes. See Tsoukas, 315 Ill. App. 3d at 385. Nor do we find any merit to the plaintiff's claim that his closing argument was inappropriately curtailed merely because the trial court sustained objections to certain portions of his argument. Thus, the trial court's decisions with regard to opening statements and closing arguments do not entitle the plaintiff to a new trial.

¶ 40 We next address the plaintiff's contention that the trial court erred in permitting Dr. Tata to rely on the medical journal article authored by Dr. Lubenow as substantive evidence. This argument is without merit.

¶ 41 Initially, we observe that Dr. Tata's testimony, that certain statements contained in the Lubenow article had no relevance to the instant litigation because the article related to injections administered in the lumbar spine, was elicited by the plaintiff's attorney on adverse examination. Counsel for the plaintiff moved to strike these explanatory comments on the basis that they had been "volunteered," but he did not object that this portion of Dr. Tata's testimony was hearsay or that it constituted the substantive use of medical literature. Consequently, the plaintiff has forfeited this issue on appeal. See Jones v. Rallos, 384 Ill. App. 3d 73, 83, 890 N.E.2d 1190 (2008) (holding that

when an objection is made, specific grounds must be stated, and other grounds not specified are waived on review). Also, because Dr. Tata's explanation as to why the Lubenow article had no bearing on the case had already been elicited by the plaintiff on adverse examination, the admission of similar testimony on examination by Dr. Tata's own attorney was cumulative of evidence that had already been admitted, which counsel for the plaintiff acknowledged during a sidebar. Accordingly, we find no reversible error in the trial court's decision to overrule the substantive-evidence objection. See Nassar v. County of Cook, 333 Ill. App. 3d 289, 303-04, 775 N.E.2d 154 (2002) (finding no prejudice where allegedly inadmissible testimony was elicited during adverse examination of the defendant doctor and was cumulative of previously introduced testimony).

¶ 42 Moreover, even if the issue had been preserved for review, we would conclude that the admission of Dr. Tata's explanatory remarks was proper. Because this assertion of error is directed at the trial court's evidentiary ruling, it is reviewed for an abuse of discretion. In re Leona W., 228 Ill. 2d 439, 460, 888 N.E.2d 72 (2008); In re Commitment of Simons, 213 Ill. 2d 523, 530-31, 821 N.E.2d 1184 (2004). An abuse of discretion occurs only if "no reasonable person would take the view adopted by the trial court." Dawdy, 207 Ill. 2d at 177.

¶ 43 Evidence is properly admitted if it is relevant; that is, if it has a tendency to prove a fact in controversy or render a matter in issue more or less probable. In re A.W., 231 Ill. 2d 241, 256, 897 N.E.2d 733 (2008). In formulating an opinion, an expert may rely on reports that are not admitted into evidence, as long as other experts in the field reasonably rely on such materials. See People v. Anderson, 113 Ill. 2d 1, 7, 495 N.E.2d 485 (1986); Wilson v. Clark, 84 Ill. 2d 186, 193-94, 417 N.E.2d 1322 (1981) (adopting Rules 703 and 705 of the Federal Rules of Evidence (Fed. R. Evid.

703, 705) to govern all cases involving expert testimony). Although reports made by others are not substantively admissible, an expert witness is allowed to reveal the contents of the materials upon which the expert has reasonably relied to explain the basis of his or her opinion. Anderson, 113 Ill. 2d at 9. In such a circumstance, the information underlying the expert's opinion does not constitute hearsay because it is not admitted for its truth, but only for the limited purpose of explaining the basis for the expert witness's opinion. Anderson, 113 Ill. 2d at 12.

¶ 44 Here, the record affirmatively demonstrates that the article authored by Dr. Lubenow was not admitted into evidence, and Dr. Tata did not read from the article, nor did he testify as to the empirical data utilized, the specific methodology employed, or the ultimate conclusions drawn by Dr. Lubenow. Rather, Dr. Tata only referred to the article in explaining the basis of his expert opinion that, if lidocaine had been injected into Mrs. Malak's cervical spine, the cessation of her breathing would have been immediate and not delayed by several minutes, as would occur if an anesthetic were injected into the lumbar spine. Also, Dr. Tata testified regarding the nature of the anatomy involved and stated, without objection, that there would be a delayed reaction following an injection into the lumbar spine because it would take time for the medication to travel to the location where it would affect the respiratory function. In addition, Dr. Tata further clarified that he did not disagree with the statements contained in the article, as they related to injections in the lumbar spine, but he disagreed with them and their applicability in situations involving injections in the cervical spine. Because Dr. Tata testified as a treating expert, it was permissible for him to explain the basis for his expert opinion that he had not deviated from the standard of care. See Anderson, 113 Ill. 2d at 9; see also Lawson v. G. D. Searle & Co., 64 Ill. 2d 543, 557-58, 356 N.E.2f 779 (1976).

Accordingly, we find no reversible error in the admission of Dr. Tata's explanatory comments.

¶ 45 Finally, the plaintiff contends that the cumulative effect of the trial court's rulings denied him a fair trial. Specifically, the plaintiff asserts that the evidence was closely balanced and that the improper use of medical literature and the limitation of his closing argument could have tipped the scales in favor of Dr. Tata. A new trial is necessary when the cumulative effect of trial errors so deprives a party of a fair trial that the verdict might have been affected. Cetera v. DiFilippo, 404 Ill. App. 3d 20, 47, 934 N.E.2d 506 (2010). The trial court's evidentiary ruling on the use of the medical journal article and the decision to restrict the plaintiff's closing argument to 50 minutes do not amount to reversible error, and we conclude that the cumulative effect of these asserted errors would not have affected the jury's verdict. For all of the foregoing reasons, the judgment of the circuit court is affirmed.

¶ 46 Affirmed.