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

Alejandro Cervantes, independent administrator of the estate of Idalia Corcoles, deceased,

Plaintiff,

v.

Ayoub Sayeg, M.D., 63rd Medical & Surgical Center d/b/a 63rd Laser & Skin Clinic, a corporation, Midway Cosmetic Institute, LLC d/b/a 63rd Laser & Skin Clinic, a corporation, Dr. Ayoub Sayeg, LLC, a corporation, Anti-Aging & Cosmetic Institute of Chicago, Ltd. d/b/a Anti-Aging Surgical Center, a corporation, Your New Looks at Chicago LLC, a corporation, Randa Sawan, M.D., Randa M. Sawan Anesthesia, Ltd., a corporation, Med Salon Ltd., a corporation,

Defendants.

No. 2021 L 002945

MEMORANDUM OPINION AND ORDER

Post-trial motions seeking a judgment notwithstanding the verdict or a new trial hinge on the trial court's careful review of the evidentiary record presented to the jury. In this case, the testimonial and documentary evidence fully supports the jury's verdict in favor of the plaintiff and against the defendants. The jury's award, although quite large, is not so excessive as to justify the request for remittitur relief. For those reasons, the defendants' post-trial motion must be denied.

Facts

Early on November 23, 2019, Idalia Corcoles underwent elective cosmetic surgery, including liposuction and a tummy tuck, at 63rd Laser & Skin Clinic. Dr. Ayoub Sayeg owned the clinic and conducted the surgery. Another corporate entity that he owned—Anti-Aging Surgical Center—hired Dr. Randa Sawan, the anesthesiologist who provided anesthesia during the procedure.

During and following the surgery, Corcoles showed signs of tachycardia, hypotension, and little to no urine output. Approximately four hours after the surgery concluded, an ambulance transferred Corcoles to Advocate Christ Medical Center where her condition continued to deteriorate. On November 24, 2019, Corcoles died from complications from severe blood loss.

Alejandro Cervantes, Corcoles's husband, filed suit against the defendants, raising claims under the Survival Act and the Wrongful Death Act. On December 10-13, 16-20, 2024, this case proceeded to trial before this court and a jury. The jury returned a verdict in the plaintiff's favor and awarded damages in the amount of $56,000,001.00. The defendants filed a post-trial motion for a judgment notwithstanding the verdict (*n.o.v.*), or in the alternative for a new trial in whole or on damages only, or in the alternative for a remittitur of the damages award. The estate filed a response and the defendants a reply.

Sayeg's Testimony

Sayeg admitted that he did not independently investigate Sawan's history and did not know that she had failed to pass her board examinations the maximum number of times. Sayeg further admitted that, had he known of that fact, it might have made a difference.

Sayeg testified that although Corcoles was at least pre-diabetic and on Metformin, no one checked her blood glucose levels before the surgery. Sayeg acknowledged that during the surgery, Corcoles showed signs of tachycardia, hypotension, and low urine output—three indications of blood loss. He also acknowledged that during the surgery he had the Foley catheter checked because Corcoles's urine output was so low.

Sayeg wrote in his post-surgery clinical note that Corcoles had lost 1,000ccs of blood during the procedure.[1] By the time Corcoles reached the recovery room at 09:30, her heart rate was above 200 beats per minute (BPM). Sayeg admitted that Sawan expressed her suspicion that Corcoles was bleeding; nonetheless, he did not examine Corcoles in the recovery room because he had already scrubbed and was prepping for the surgery of the next patient. At the time Sayeg began the second surgery, he knew that Corcoles's heart rate was above 250 BPM. Sayeg instructed that Corcoles's Foley catheter be changed because her urine output was low even after she had received Lasix.

Corcoles continued to be in distress in the recovery room. During that period, four blood glucose test results ranged between 393 to 464mg/dL, each of which Sayeg admitted were high. Four hours after the surgery had concluded, Sayeg had Corcoles transferred by ambulance to Advocate Christ Hospital's emergency department. He testified that he deferred to Sawan for transferring a patient. At no point while Corcoles was in the recovery room did Sayeg remove her surgical binder to examine the surgical site.

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[1] After Cervantes filed his complaint, Sayeg changed or "corrected" his entry to reflect a blood loss of 100ccs.

Sayeg testified that a liposuction cannula, such as the one used in his procedure, can injure a patient if it is not located in the right place. If the canula goes into the abdominal cavity, the spleen could be injured and bleeding could occur in the abdominal cavity. He agreed that it would be a violation of the standard of care if the cannula were in the peritoneal or retroperitoneal cavity. Sayeg agreed that bleeding is a recognized complication of this surgery and that Corcoles had three signs of bleeding. He also agreed that his placement of Jackson-Pratt drains outside the abdominal cavity would have been useless had Corcoles been bleeding inside the abdominal cavity.

Sayeg admitted that his clinic did not have the instruments necessary to transfuse blood or to check hematocrit, hemoglobin, or platelet levels. He also did not have the equipment to conduct a FAST examination, which checks for bleeding in the abdomen. He agreed that hypotension, tachycardia, and low urine output can result from bleeding. He agreed that if he suspected a patient were bleeding, the standard of care required transferring the patient as soon as possible to a hospital to stop the bleeding. He also agreed that a physical examination of the abdomen is needed to determine if a patient has blood in the abdomen.

Sayeg testified that he had been working with Sawan through a medical staffing agency. He acknowledged that he could have conducted a background check on her, but never did, and did not know when she last conducted a hospital case in Illinois. Sayeg knew Sawan was not board certified and agreed that it might have affected his decision to hire her had he known that she had failed the board examination so many times that for at least one period of time she was not eligible to take it, again.

Sayeg relied on his own testimony as to matters of fact as well as opinion. Not surprisingly, Sayeg testified that he complied with all standards of care as to Corcoles's pre-, intra-, and post-operative care and treatment.

Sawan's Testimony

Sawan told the jury that she went to medical school in the Commonwealth of Dominica, but then waited six years before beginning her residency. She admitted that she did not finish her residency in Ohio because of problems with the cardiology rotation. She also admitted to failing the board certification examination multiple times and that she was no longer attempting to take it. She told the jury that she had a lot of short-term hospital jobs and took many assignments as a *locum tenens* physician.

Sawan testified as to her surgical records. It was clear to Sawan that Corcoles began bleeding during the surgery. She reached this conclusion because Corcoles was hypotensive as early as 06:00 despite receiving fluids. Sawan noted

the continued decline in blood pressure, and administered Ephedrine around 07:00. Corcoles's heart rate then rose to 260, which Sawan acknowledged was very concerning. Around 08:00, Corcoles's heart rate was tachycardic despite remaining under anesthesia—a sign of bleeding.

Sawan testified that Corcoles's vital signs were already critical as soon as she arrived at the post-anesthesia care unit (PACU). The first set of vital signs showed a heart rate of 259 BPM and a blood pressure of 98/50. Sawan testified that a heart rate of 259 BPM could kill a patient, and Sawan said that she was very concerned. She testified that she told Sayeg at least three times as early as 09:30 or 09:40 that Corcoles could be bleeding. Ten minutes later, Corcoles's heart rate rose to 260 BPM and her blood pressure fell to 83/46. Sawan indicated that Sayeg knew of these readings based on the conversations he had with her and the nurse. Sawan also stated that during her stay in the PACU, Corcoles's respiration rate was in the 30s, indicating tachypnea. Sawan indicated that Corcoles was conscious, in pain, and having difficulty breathing.

At 10:05, Sawan administered esmolol, a beta blocker. The esmolol succeeded in decreasing Corcoles's heart rate below 100 BPM, but by 10:47 it had risen to 200 BPM. At 12:18, Corcoles was hypotensive at 65/37. At that time, Sawan was administering anesthesia in a subsequent surgery, so she could not devote her time exclusively to Corcoles. Sawan did not receive a vitals report at 13:00 and, therefore, did not consider transferring Corcoles because Sawan was still in surgery. Corcoles became apneic; consequently, a laryngeal mask airway was inserted into her mouth to help her breath. She eventually lost consciousness.

Sawan told the jury that she administered 4.6 liters of fluids during the operation and that by the time of Corcoles's transfer to Advocate Christ Hospital, she had received seven liters of fluids. Yet during the entire eight hours Corcoles was at the clinic, she had produced only 250ccs of urine. The administration of a large volume of fluid but the production of only a small volume of urine can be a sign of bleeding. Sawan stated that Sayeg was concerned enough about the low urine output wthat he had a new Foley catheter inserted.

Records indicate that at 14:05, paramedics began transporting Corcoles from the clinic to Advocate Christ Hospital. Sawan testified that she wished she could have transferred Corcoles sooner.

Advocate Christ Records

At Advocate Christ Hospital, tests revealed that Corcoles had approximately two liters of fresh and clotted blood—about half her total blood—in her abdomen. Clotted blood indicated that the blood had been in her abdomen for some time.

Corcoles later suffered a coronary arrest, leading to irreversible brain and vital organ damage. Corcoles died on November 24, 2019.

Dunn's Testimony

Dr. Tony Dunn testified for Cervantes as a Rule 213(f)(3) controlled expert witness. Dunn is double board certified in general surgery and surgical critical care. Dunn told the jury that there was no doubt Corcoles was bleeding internally based on her hypotension, tachycardia, and low urine output during the surgery. According to Dunn, Sayeg should have considered Corcoles to be bleeding until proven otherwise, but that he failed to recognize her bleeding. Dunn testified that Corcoles's very low hemoglobin score measured at Advocate Christ Hospital indicated that she had been bleeding for several hours. Dunn further explained that the Jackson-Pratt drains placed by Sayeg could not be relied on to establish Corcoles's intraabdominal bleeding.

Dunn opined that Corcoles's bleeding came from the rectus musculature. He explained that if a surgeon conducted a needle plication by suturing part of the fascia to the rectus muscle, the plication could cause bleeding. Dunn expressed his opinion that Corcoles's bleeding began intraoperatively and resulted from the plication of the rectus muscle that created a hole in the peritoneum. The hole served as the entry point for the blood into the peritoneal cavity. Dunn explained that the presence of both free and clotted blood in Corcoles's abdomen indicated that she had been bleeding for some time.

Dunn also opined that Corcoles had received excessive fluids and that such administration had harmed her. Dunn testified that Sawan's administration of multiple doses of esmolol and labetalol were below the standard of care and were very dangerous. According to Dunn, Corcoles did not need drug administration but needed transfer to a medical facility that had the ability to stop her bleeding. Dunn also told the jury that Corcoles's failure to respond to multiple doses of ephedrine should have indicated to Sawan that Corcoles was hypovolemic and hypotensive, additional signs of bleeding.

Dunn testified that by the time Corcoles arrived at Advocate Christ Hospital at 14:30, the lactic acid in her blood was 16mg/dL, meaning she was in profound shock from acute blood loss. A computerized tomography scan showed a large volume of free blood in the abdomen. Dunn testified that after Corcoles acceded to cardiac arrest, the emergency room team was able to sustain a pulse for only a short time because it was too late to save her life.

Dun testified that, had Corcoles been transferred to a hospital between 09:40 and 10:57, she would have survived. Dun explained that his opinions were not based on hindsight, but on the signs present during the surgery and in the PACU.

Those signs should have alerted the defendants to the fact that Corcoles needed to be transferred to a facility with a higher level of care.

Dunn also addressed the defendants' theory that Corcoles had succumbed to disseminated intravascular coagulopathy (DIC). Dunn testified that patients can survive DIC if it is properly treated in a timely fashion. At Sayeg's clinic, however, there were no blood products available for transfusion; in such an instance, the result can be deadly. Dunn opined that DIC did not cause Corcoles's death and that it ultimately made no difference whether she had DIC. Regardless of the type of bleeding, her treatment should have been the same—a transfer to a facility for a blood transfusion.

Minore's Testimony

Cervantes also called Dr. William Minore, an anesthesiologist, as a Rule 213(f)(3) controlled expert witness. Minore has served on a credentialing committee for 30 years. Minore opined generally that Sawan should not have been practicing anesthesia independently and should not have been doing so specifically as to Corcoles without supervision. Minore based his opinion, in part, on Sawan waiting years before beginning her residency and having failed her board examinations the maximum number of times.

Minore opined that Sawan was professionally negligent preoperatively by failing to insist on obtaining a medical clearance for Corcoles knowing that she was at least pre-diabetic and was taking Metformin. Sawan was also professionally negligent preoperatively for failing to take a blood glucose test, again because Sawan knew that Corcoles was at least pre-diabetic. Sawan should have known that high blood glucose interferes with coagulation, fluid status, and hemodynamics, and can cause blood glucose levels to spike. According to Minore, if Corcoles's preoperative A1C was greater than 225, her surgery should have been cancelled because of the risk of osmotic uresis. She was also professionally negligent during the procedure by failing to recognize signs of blood loss.

Minore opined that Corcoles's blood pressure of 98/50 with a pulse of 254 BPM should have signaled to Sawan that Corcoles was extremely hypovolemic. These were signs of bleeding that Sawan should have recognized and prompted a transfer to a hospital. Minore opined that had the standard of care been followed, Corcoles would have survived. Specifically, had she been transferred before 13:00, she would have survived. Minore estimated Corcoles's blood loss to have been 3.8 liters; any loss above two liters is considered catastrophic.

Minore further testified that Corcoles's blood loss was reflected in her increasing inability to breath. A plastic surgery could cause an increased breath rate of four to six breaths per minute, but Corcoles's increased by 20 breaths per

minute. Her fragile condition was evident before she became unconscious immediately before her transfer to Advocate Christ Hospital. Her cardiac arrest was the result of hemorrhagic shock that led to multisystem organ failure.

Minore was critical of Sawan's care for other reasons. For example, Sawan deviated from the standard of care by administering Toradol as that medication can increase bleeding. Further, Sawan started a second surgery despite Corcoles remaining in extremely unstable condition in the recovery room. Sawan also failed to recognize and investigate signs of tachypnea and mental status change. Sawan also failed to have an EKG taken of Corcoles in the recovery room. Finally, Sawan left Corcoles's care to a nurse who had no history of working in a recovery room. Each of these deviations from the standard of care proximately caused Corcoles's death.

Solomon's Testimony

Cervantes also disclosed Dr. Mark Solomon, a plastic and general surgeon, to testify as to institutional negligence and other matters. Solomon opined that Anti-Aging breached the standard of care by hiring Sawan to perform anesthesia services in this case. Specifically, he opined that Sawan should not have been permitted to practice anesthesia independently and that Anti-Aging committed institutional negligence by hiring her only because she had privileges at a Chicago-area hospital, a requirement set by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Acording to Solomon, that deviation from the standard of care proximately caused Corcoles's death.

Solomon opined that Sayeg was negligent in each phase of his operative care. First, Sayeg was negligent in Corcoles's preoperative care. He breached the standard of care by not reviewing the preoperative records and by failing to check Corcoles's blood glucose levels. Further, Sayeg's failure to obtain a medical clearance should have caused him to postpone the surgery. Solomon also criticized Sayeg's interoperative care. Sayeg failed to recognize or investigate Corcoles's bleeding complications, particularly based on her low blood pressure, low urine output, and high heart rate. Solomon believed Corcoles's bleeding started around 07:00 and that the bleeding was from the rectus muscles as they are very vascular. Sayeg also breached the standard of care in his postoperative care by failing to recognize Corcoles's change in vital signs, have an EKG run, conduct an abdominal examination and, instead, rely on the blood returned in the drains. Solomon opined that Sayeg breached the standard of care by starting surgery on another patient while Corcoles was still unstable.

According to Solomon, Corcoles should have been transferred to a hospital by 09:40 and Sayeg deviated from the standard of care by failing to do so. His ultimate decision to have Corcoles transferred came too late and led to her death. Solomon

opined that Sayeg's breach of the standard of care proximately caused Corcoles's death and that it could have been avoided. Solomon rejected the theory that disseminated intravascular coagulopathy (DIC) caused Corcoles's death. He testified that DIC, if it occurred, was irrelevant to Corcoles's cause of death because it had nothing to do with her cardiac arrest.

In contrast, the defendants argue that Solomon failed to offer an opinion critical of Anti-Aging's credentialing of Sawan. Rather, they point out that Sawan had staff privileges at two Chicago-area hospitals, meaning that she met the AAAASF criteria. The defendants suggest that Solomon never opined as to the standard of care for a reasonably careful medical clinic under similar circumstances, and they argue that Solomon never opined that anything Anti-Aging did proximately caused Corcoles's death.

The defendants further argue that Solomon did not opine that Anti-Aging's failure to obtain a preoperative medical clearance, history, and blood glucose level proximately caused Corcoles's death. They point out that Solomon admitted to the jury that Corcoles's blood glucose levels had been stable for at least one year and a half before her surgery. Further, Corcoles had been taking Metformin before her surgery and initial consultation with Sayeg. At the same time, Solomon conceded that an A1C of less than eight is appropriate for elective surgery and that Corcoles last draw before surgery was less than 5.6 or 5.7 as that is the threshold for diabetes. Corcoles's primary care provider never diagnosed her with diabetes, only pre-diabetes.

During cross examination, the defendants' attorney asked Solomon questions about the type of needle Sayeg had used during Corcoles's procedure. Solomon testified that Sayeg had used a cutting needle during the procedure. Solomon refined his answers further on re-direct examination.

Jury Issues

In addition to these evidentiary issues, issues arose concerning two jurors. The first issue concerns juror Cecelia Mejia. On December 19, 2024, Mejia notified the court that she worked as a certified nursing assistant at Misericordia Hospital, where Xavier Castillo, Corcoles's son, also worked. Mejia indicated that she did not recognize Castillo's name when this court read it from the witness list, but recognized him by face when he testified. Mejia made it clear that she did not know Castillo, had never worked with him, and indicated that he worked in another section of the hospital. This court instructed Mejia not to speak with anyone about the issue. Mejia indicated that she had not and would not, but that another juror realized that Mejia worked at the same facility and turned to Mejia to see if she was going to say or do something.

The other juror issue concerned alternate juror Magdalena Miskowicz. Before closing arguments, Corcoles's attorney notified defense counsel that Miskowicz worked at St. Viator High School with Maggie Haskins, the wife of Clifford Law Offices partner, Charles Haskins. Miskowicz had contacted Maggie Haskins to tell her that she was running late for court. Miskowicz had likely made the connection herself because attorney Haskins's name had been mentioned the day before during expert testimony.

Closing Argument

The defendants also raise an issue with the plaintiff's closing argument, which the defendants suggest deprived them of a fair trial because Corcoles's attorney said that the surgery center was unlicensed. It had previously been made plain that the state of Illinois does not require ambulatory surgery centers to be licensed in order for their facilities to operate. When Corcoles's attorney made the improper remark, the defendants' attorneys objected, and this court sustained the objection.

The jury returned a verdict in the estate's favor and awarded $56,000,001.00 in damages.

Analysis

The defendants present two arguments for post-trial review. First, they argue that a judgment *n.o.v.* is warranted as to Anti-Aging because the plaintiffs failed to establish a case of institutional negligence. Second, they argue that they are each entitled to a new trial because the jury's verdict was against the manifest weight of the evidence. Either request must overcome high evidentiary hurdles.

A judgment *n.o.v.* may be granted only if "'all of the evidence, when viewed in its aspect most favorable to the opponent, so overwhelmingly favors [a] movant that no contrary verdict based on that evidence could ever stand.'" *Steed v. Rezin Orthopedics & Sports Med., S.C.,* 2021 IL 125150, ¶ 34 (quoting *York v. Rush-Presbyterian-St. Luke's Med. Cntr.*, 222 Ill. 2d 147, 178 (2006) (quoting, in turn, *Pedrick v. Peoria & Eastern R.R. Co.*, 37 Ill. 2d 494, 510 (1967)). The entry of a judgment *n.o.v.* is inappropriate if reasonable minds could differ as to the inferences and conclusions to be drawn from the facts. *York,* 222 Ill. 2d at 178. A reviewing court, including a trial court on a post-trial motion, "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.* (quoting *Maple v. Gustafson*, 151 Ill. 2d 445, 452-53 (1992)). A reviewing court is not to reweigh the evidence, determine credibility of witnesses, or substitute its judgment simply because the jury could have drawn

other inferences or conclusions. *Schiller v. HomeServices of Ill., LLC*, 2024 IL App (3d) 220405, ¶ 35.

The standard for a new trial is different. A trial judge is to set aside a jury verdict and order a new trial only if: "(1) the jury verdict is contrary to the manifest weight of the evidence or (2) serious and prejudicial errors were made at trial in the exclusion or admission of evidence." *McHale v. W.D. Trucking, Inc.*, 2015 IL App (1st) 132625, ¶ 56. "A verdict is considered to be against the manifest weight of the evidence only when the opposite result is clearly evident or where the jury's findings are unreasonable, arbitrary, and not based upon any of the evidence." *Bland v. Q-West, Inc.*, 2023 IL App (2d) 210683, ¶ 10. "[F]or a new trial based on the evidentiary rulings, the law requires finding the error caused substantial prejudice and affected the outcome." *Browning v. Advocate Health & Hosp. Corp.*, 2023 IL App (1st) 221430, ¶ 49.

Institutional Negligence

The defendants argue they are deserving of a judgment *n.o.v.* or a new trial because Cervantes failed to prove that Anti-Aging Surgical Center was institutionally negligent by credentialing Sawan. To establish a negligent credentialing claim, Cervantes had to present expert testimony that: (1) Anti-Aging failed to meet the standard of reasonable care in granting privileges to Sawan, whose conduct is at issue; (2) Sawan breached the standard of care; and (3) the negligent granting of privileges to Sawan proximately caused Corcoles's death. *See Frigo v. Silver Cross Hosp. & Med. Cntr.*, 377 Ill. App. 3d 43, 72 (1st Dist. 2007).

The defendants argue that Cervantes failed to meet the *Frigo* requirements because Solomon acknowledged that Sawan had privileges at a Chicago area hospital—an alternative requirement set by the AAAASF. That argument incorrectly presumes that the AAAASF standards constitute the standard of care for credentialing in an institutional setting. Rather, the jury was free to consider all the evidence of Sawan's background and qualifications and Anti-Aging's decision to grant her privileges. Thus, the jury could consider Sawan's admission that she waited six years after graduating from medical school before beginning a residency. The jury could also consider that she failed to complete her residency in Ohio because she had problems with the cardiology rotation. The jury could also consider Sawan's admission that she had failed her board examinations the maximum number of times and that, although the board no longer imposed a maximum number of times to take its examination, Sawan had not sought to re-take the examination. The jury was also open to hear Sawan's testimony that she had worked at a large number of medical facilities on a *locum tenens* basis.

Sawan's testimony provided the basis for Solomon's opinion that Sawan should never have been credentialed even if she met the AAAASF requirement of

having a hospital privilege. Solomon explicitly testified that it was against the standard of care to retain Sawn to perform the anesthesia in this case. He further testified that this deviation from the standard of care proximately caused Corcoles's death. If Anti-Aging believed that Solomon had failed to explain the bases for his opinions on direct examination, that was a shortcoming Anti-Aging should have explored on cross examination. In sum, the jury was not required to accept Anti-Aging's testimony that Sawan was qualified simply because she fulfilled an AAAASF standard. There is no error to the jury's finding that Anti-Aging was liable based on institutional negligence; a judgment *n.o.v.* or a new trial is not warranted.

Pre-Operative Clearance and Pre-Diabetes

The defendants argue that they are entitled to a judgment *n.o.v.* because Cervantes did not establish that the failure to obtain pre-operative medical clearance proximately caused Corcoles's death and, therefore, the issue of pre-diabetes should not have been on the issues instruction. This argument overlooks much of the testimony the jury received. For example, Minore opined that Sawan was professionally negligent preoperatively by failing to obtain a medical clearance or check Corcoles's blood glucose level. These pre-checks were critical according to Minore because they would affect blood coagulation, fluid status, and hemodynamics. Sawan's breach of this standard of care is directly attributable to her employer, Anti-Aging. Alternatively, the defendants' argument is irrelevant and does not constitute the type of error that would require the jury's verdict to be set aside. The reason is that there was so much other testimony as to the defendants' professional failures during the intraoperative and post-operative settings that any pre-operative failures were beside the point. Further, any testimony as to the pre-operative failures would not have inflamed the passions of the jury any more than did the evidence of the defendants' professional failures in the intraoperative and post-operative settings.

New Trial on All Issues

The defendants also argue that the manifest weight of the evidence augers in favor of a new trial on all issues. The first set of evidence supporting such a request relates to the questioning of two venire panelists that the defendants now say they would have struck for cause. As to that subject, the defendants correctly point out that direct relationships between jurors and parties can create a presumption of bias. *City of Naperville v. Wehrle*, 340 Ill. 579, 582 (1930) (quoting *Crawford v. United States*, 212 U.S. 183, 195-96 (1909)). There is, however, no such presumption in this case.

The first issue of juror bias concerns juror Mejia. On December 19, 2024, Mejia notified the court that she worked as a certified nursing assistant at

Misericordia Hospital, where Xavier Castillo, Corcoles's son, also worked. In response to questions, Mejia answered that she did not recognize Castillo's name when this court read it from the witness list, but recognized him by face when he testified the previous day. Mejia made it clear that she had not worked with Castillo and that he worked in another section of the hospital. This court instructed Mejia not to speak with anyone about the issue. Mejia indicated that she had not and would not, but that another juror realized that Mejia worked at the same facility and turned to Mejia to see if she was going to say or do something. At bottom, the issue relating to Mejia is irrelevant because all parties were on notice from Castillo's deposition that he had applied for employment at Misericordia. Armed with that knowledge, the defendants' attorneys, had they desired, could have followed up with Mejia in *voir dire* and asked her whether she knew or knew of Castillo. It is groundless to complain now about information that was long ago within the parties' domain.

The other juror issue concerned juror Magdalena Miskowicz. Before closing arguments, Corcoles's attorney notified defense counsel that Miskowicz worked at St. Viator High School with Maggie Haskins, the wife of Clifford Law Offices partner, Charles Haskins, and that Miskowicz had contacted Haskins to discuss that she was running late for court. Miskowicz had likely made the connection because attorney Haskins's name had been mentioned the day before during expert testimony. The issue concerning Miskowicz is, however, wholly attenuated because she was an alternate juror who was excused before the jury began its deliberations; this issue does not serve as the basis for a judgment *n.o.v.* or a new trial.

Undisclosed Opinions

Illinois law is plain that attorneys may elicit new and previously undisclosed opinions during the cross examination of an opposing party's Rule 213(f)(3) expert witness. *Stapleton v. Moore*, 403 Ill. App. 3d 147, 160 (1st Dist. 2010) (citing Ill. S. Ct. R. 213). During his direct examination, Solomon did not identify the type of needle Sayeg used in his surgery on Corcoles. On cross examination, however, the defendants' attorney made such an inquiry. Solomon answered that Sayeg had used an FS-2 needle, which is one with cutting edges. He further explained that a round needle is used for plication, but that a cutting needle for suturing skin would be used because it has a lot of resistance. There was no objection to the questions or the answers.

Solomon's testimony also served as the proper basis for Cervantes to amend his complaint after both he and the defendants rested their case.

Plaintiff's Closing Argument

The defendants argue that the plaintiff's closing argument deprived them of a fair trial because the facility was not licensed to practice surgery. At that point, the defendants' attorney objected, and the court sustained the objection. As if that were not enough, Corcoles's attorney explained what he meant—that the facility did not have the ability to transfuse blood, and did not have diagnostic testing equipment, such as ultrasound or CT scanner—all of which were true.

Verdict

The defendants argue that they deserve a new trial as to damages or alternatively a remittitur. A verdict is not considered excessive if it lies within the flexible range of conclusions that can be supported by the facts. *Riley v. Koneru*, 228 Ill. App. 3d 883, 888 (1st Dist. 1992). Here, the record is devoid of any error on which such post-trial relief on damages could be based.

The jury did not award all that had been requested for past grief and suffering and future grief and suffering. Further, the jury came up with its own number for loss of society, cutting against any argument that they had been improperly instructed to "send a message." It is also significant that the jury's Wrongful Death Act award went to compensate five surviving family members, not just Cervantes. Further, Sawan's testimony unquestionably suggested that Corcoles, herself, knew she that was dying, an inference that certainly may have influenced the jury in its award of Survival Act damages.

Partial Tender

The defendants have made the unusual request to make a partial tender of the judgment. This court is unfamiliar with such a request and was unable to find a case citation supporting such a post-judgment request. As such, this court does not believe it is authorized to order the relief the defendants are seeking absent an agreement from Cervantes.

Conclusion

For the reasons presented above, it is ordered that:
the defendant's post-trial motion is denied.

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John H. Ehrlich, Circuit Court Judge