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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0090-15T2

ALEXANDRA GRANOVSKY,

Plaintiff-Appellant/
Cross-Respondent,

v.

STEPHEN A. CHAGARES, M.D.,

Defendant-Respondent/
Cross-Appellant,

and

LOUIS MAZZELLA, M.D. and
MONMOUTH MEDICAL CENTER,

Defendants.

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Argued September 28, 2016 – Decided August 15, 2017

Before Judges Alvarez, Accurso and Manahan.

On appeal from Superior Court of New Jersey, Law Division, Monmouth County, Docket No. L-3717-10.

Hugh M. Turk argued the cause for appellant/cross-respondent (Sullivan, Papain, Block, McGrath & Cannavo PC, attorneys; Mr. Turk, of counsel and on the brief).

Richard A. Amdur argued the cause for respondent/cross-appellant (Amdur, Maggs & Shor, PC, attorneys; Mr. Amdur, on the brief).

PER CURIAM

Plaintiff Alexandra Granovsky appeals from the jury's no cause verdict on her medical malpractice claim against defendant Stephen A. Chagares, M.D. Defendant cross-appeals from a pre-trial ruling preventing the surgeon who repaired the injury inflicted by defendant from offering opinions on the standard of care. Because we conclude evidentiary error deprived plaintiff of a fair trial, we reverse. We find no merit to the cross-appeal.

Defendant operated on plaintiff, a thirty-four-year-old pharmacist, to remove her gallbladder by performing a laparoscopic cholecystectomy. There is no dispute that in the course of that procedure, defendant, a general surgeon, cut the wrong duct, resulting in plaintiff's injury. The issue at trial was whether that was a recognized complication of the surgery, as defendant argued, or a deviation from the standard of care.

The gallbladder is a storage facility for bile, which is produced in the liver to aid in the digestion of fatty foods. The liver is located in the upper right abdomen. The gallbladder is underneath it. The liver and the gallbladder

each have ducts, which connect the two organs, and carry the bile into the small intestine. The liver has two ducts, one from the left lobe and the other from the right lobe, which merge to form the common hepatic duct. The duct descending from the gallbladder is called the cystic duct. The cystic duct from the gallbladder merges with the common hepatic duct from the liver to form the common bile duct, which empties bile into the duodenum, the start of the small intestine.

To remove the gallbladder, the surgeon frees it from the liver by clipping and cutting the cystic duct and the cystic artery, the main blood supply to the gallbladder. It is undisputed that clipping and cutting the common bile duct is not part of the procedure and will, if not repaired, result in serious harm to the patient.

Defendant testified he put five clips on what he believed to be the cystic duct, two clips close to the gallbladder and three lower down and cut between them. After he cut what he believed to be the cystic duct, he put six clips on what he believed to be a bifurcated cystic artery, one on each branch close to the gallbladder and two lower on each branch and cut both branches between the clips. Although defendant wrote in his post-operative report that the surgery was performed without

complications, he conceded at trial that he inadvertently clipped and cut plaintiff's common bile duct causing her injury.

A few days after the surgery, plaintiff went to an emergency room in New York complaining of nausea, vomiting and jaundice. She was transferred to Westchester Medical Center, where Dr. Manuel Rodriguez-Davalos performed an open surgical procedure and discovered that plaintiff's common bile duct had been severed. Dr. Rodriguez-Davalos repaired the problem by performing a Roux-en-Y hepaticojejunostomy, a procedure to re-route plaintiff's biliary system by attaching the common hepatic duct directly to the jejunum, the middle section of the small intestine.

At Dr. Rodriguez-Davalos's de bene esse deposition, the parties stipulated the doctor was testifying as plaintiff's treating physician and not as an expert on liability. Following the deposition, plaintiff filed a pre-trial motion to strike certain non-responsive comments in which the doctor expressed the opinion that defendant did not deviate from the standard of care.

Judge Quinn granted the motion, reasoning that the witness was not "produced as an expert on liability." The judge accordingly struck those portions of the testimony in which the doctor expressed the view that defendant had removed plaintiff's

gallbladder "in an appropriate fashion," that "some abnormalities . . . sometimes are difficult [for surgeons] to identify," "that the hepatic duct and the common bile duct are very close to the cystic duct. . . . So it is not uncommon that . . . these structures, can be confused or again because of the small size and the fact that they can run parallel, can be misidentified," and that cutting the wrong duct was not an "uncommon" problem and "could happen to any surgeon in the country." Judge Quinn subsequently denied defendant's motion for reconsideration.

Shortly before a scheduled trial date, defendant subpoenaed Dr. Rodriguez-Davalos for a second deposition. Over plaintiff's objection, Judge Quinn entered an order which permitted the deposition to proceed, but prohibited "questions on standard of care." Defendant was permitted to question the doctor "only on [the] surgery he did."

Defendant's counsel did not schedule Dr. Rodriguez-Davalos's second deposition until just prior to a rescheduled peremptory trial date. At a pre-trial conference, counsel advised the judge assigned to try the case of the scheduled deposition and Judge Quinn's prior rulings regarding its scope. The trial judge advised counsel he would not disturb Judge

Quinn's prior rulings regarding the deposition or its limited scope.

The other pre-trial ruling with significance for the issues on appeal involved informed consent. Plaintiff did not bring an informed consent claim. Anticipating defendant would attempt to introduce his consent form and that he advised plaintiff of the risk of common bile duct injury, plaintiff made a motion in limine to exclude all evidence of informed consent at trial. She contended the absence of an informed consent claim made evidence of consent both irrelevant and unfairly prejudicial because of its risk of confusing the jury. Defendant countered that showing the jury that he informed plaintiff before the surgery that injury to the common bile duct can occur, constituted proof that such an injury was a known risk and its occurrence was not a deviation from the standard of care.

The trial judge denied plaintiff's motion, finding no New Jersey case law on point and the cases from other jurisdictions "not precedent for the conclusion the plaintiff asks me to draw here." Instead, the judge pronounced himself convinced that excluding reference to the preoperative discussions "would certainly result, could certainly result in the same type of prejudicial inferences that the plaintiff is concerned with[,] being visited upon the defendant."

The judge explained:

> [Plaintiff has] the burden of proof. But the defendant has a right to defend himself, and that would substantially impede his ability to do so. . . . You're talking about inferences that would lead a jury to infer that Dr. Chagares took no steps to explain the procedure, or could lead to the conclusion that a juror or all the jurors could infer that there was a lack of explanation of the significance of the surgery. And I don't see any way of separating the two.

The judge concluded his ruling on the issue by saying that he was "not going to preclude the defendant from effectively advancing a defense to the complaint that's been made against him."

At trial, plaintiff presented the video of Dr. Rodriguez-Davalos's first deposition, redacted in accordance with Judge Quinn's order, to explain the surgeon's discovery of plaintiff's transected common bile duct and its repair. Plaintiff's liability expert, Dr. Michael Drew, testified defendant deviated from the standard of care by failing to obtain a critical view of both the cystic duct and the cystic artery entering the gallbladder before clipping and cutting either structure. He further claimed defendant should have realized his error before concluding the procedure.

Based on defendant's post-operative report, Dr. Drew concluded defendant never obtained that critical view of both structures entering the gallbladder, but instead clipped and cut what he thought was the cystic duct before the cystic artery was visible. Dr. Drew explained that defendant's technique was "the old way of doing it, what's called the infundibular approach." He claimed that approach resulted in "more common bile duct injuries than surgeons had seen in the previous 30 or 40 years in the first couple of years" of laparoscopic procedures. Dr. Drew claimed the number of common bile duct injuries occurring as a result of the infundibular approach resulted in its abandonment in the mid-1990s when it was replaced by the critical view method. Defendant operated on plaintiff in 2009.

Defendant's counsel cross-examined Dr. Drew about his preoperative discussions with patients and defendant's informed consent form. Counsel got the doctor to concede there is "a difference between a complication and medical malpractice" and that he tells his patients that "a possible complication is damage to the common bile duct."

Defendant's experts, Dr. Richard Koehler and Dr. Josef Fischer, both testified that cutting the common bile duct was a recognized complication of laparoscopic cholecystectomy and not a deviation from the standard of care. Defendant's counsel

elicited testimony from each of them that they tell their patients that injury to the common bile duct is a risk of complication of the procedure and that it is in every consent form.

Over plaintiff's objection, the judge admitted Dr. Koehler's consent form, which includes "possible injury to common bile duct requiring endoscopic or surgical repair" as one of the risks of the procedure. Dr. Koehler testified that although transecting the common bile duct was "very uncommon," he includes injury to the common bile duct in his standard consent form because "[i]t is a part of the human anatomy that has wide variations" and "I want to make sure the patient understands that." Dr. Koehler agreed with plaintiff's counsel that "when he tell[s] a patient one of the risks, for example is injury to a bowel or a blood vessel or to the bladder, [he] certainly [isn't] telling them that [he's] going to commit malpractice."

Dr. Koehler testified that in his opinion, a surgeon seeing and cutting what he thinks is the cystic duct, but instead is the common bile duct is not negligence, because "misidentification is not malpractice." The trial judge prohibited plaintiff's counsel from impeaching Dr. Koehler on cross-examination with the Society of American Gastrointestinal

and Endoscopic Surgeons Manual, notwithstanding the doctor had acknowledged it as authoritative during his deposition, based on the judge's understanding that plaintiff's counsel "had an obligation to provide [his adversary with what he planned to reference] in the form interrogatories."

Dr. Fischer, a distinguished professor at Harvard Medical School and author of textbooks on surgery, testified that injury to the common bile duct during laparoscopic gallbladder surgery is "a complication that can happen in the best of hands." He contended that only thirty-five percent of gallbladders are in the configuration contained in textbooks and that anomalies such as a short cystic duct, limitations on a surgeon's field of view in a laparoscopic procedure, and the presence of fat, which "obscures your view" all contribute to a surgeon not correctly identifying the structures to be clipped and cut.

Dr. Fischer testified that although common bile duct injuries are reported to occur in .4 to .7 percent of laparoscopic gallbladder cases, new research suggests it is as high as 1.9 to 4 percent. He testified, "[n]ow if there are injuries to the common duct or whatever they are of 4 percent, then it becomes something which is a matter of course of that operation and not practice below the standard."

On cross-examination, Dr. Fischer testified that in his view, defendant erred by not

> looking for the cystic duct and the cystic artery when he should have. I think that was the error in this, he went first and clipped what turned out to be the common duct. I think that was the error. And then, if you read the [operative] note carefully and it's a difficult [operative] note to read, then he went and he looked at the cystic artery and what he thought was the cystic duct. And then concluded that the cystic artery bifurcated and that is a known anomaly.

When plaintiff's counsel asked why that was not malpractice, Dr. Fischer responded:

> Well, you know, if we have incidents of injury to common ducts and other aspects and we've been doing laparoscopic cholecystectomies for 20 years. And we still have a significant incidence of injury to the common duct. And these are people who are experienced people.
>
> I think what you have to say [is] that there's something wrong with the operation, which is my view. And why I have suggested to [the] American College of Surgeons is that we stop doing laparoscopic cholecystectomies until we can come to some conclusion with the legal profession as to what is appropriate for compensation and get it out of the court system. We have done that with other things.

Plaintiff's counsel followed up by asking the witness if he had "ever spoken before [any] committees, State Legislatures, [or] Congress on the topic of tort reform?" Defendant

immediately objected. The court sustained the objection and also sustained defendant's objection to plaintiff's next question, which was "You think there's a better way to handle the medical malpractice cases[?]" The court ruled that plaintiff would be permitted to cross-examine the doctor "as to his opinion and his direct testimony but this is an explanation of his political views."

Although the trial judge had already denied defense counsel's motion to play the unredacted tape of Dr. Rodriguez-Davalos's first de bene esse deposition when plaintiff put it in evidence, ruling that Judge Quinn's pre-trial order remained law of the case, the trial judge permitted defendant to read the doctor's second deposition to the jury in the defense case, notwithstanding that it contained comments nearly identical to the ones excised by Judge Quinn. Specifically, plaintiff's counsel objected to inclusion of the following testimony.

> Q: How often do you find or does the literature reflect finding any variations in the anatomy? Is that very rare that there are variations in the biliary anatomy, or it is well known that there are such variations?
>
> A: As I mentioned, it's well known. It's not rare. And again, any board certified surgeon in the country knows that these variations exist. And we know that, all of us that do biliary surgery or everybody that does cholecystectomies know that these are

variations that are hard to define preoperatively and, therefore, all of us are at risk of having a complication. That's what makes this surgery so serious.

Q: Serious in what – can you elaborate a little bit more by what you mean by "that's what makes this surgery so serious"?

A: Right. Because if you have a surgery that is performed, you know, so commonly and you have an injury of zero point four to zero point six percent, then you know that there's a large number of patients that will have bile duct injury on series that have been described nationwide and internationally. We know that this is one of the common things we face as surgeons, not only hepatobiliary surgeons, like myself, but any general surgeon that does gallbladder surgery knows.

And we discuss this with our patient before going to the operating room that, you know, there is a zero point four to zero point six percent chance of having an injury, and the injury can be across the spectrum. It can be a small injury that may just require a drainage, like [plaintiff] had at the beginning. It could be injury that actually transects or divides the whole ductile system. There are cases where, not only the common bile duct and the common hepatic duct are injured, but also the hepatic artery, the portal vein. There are patients that need a transplant because of this type of surgery.

So, therefore, it is a serious complication, although it's a complication that can happen to any surgeon that performs laparoscopic cholecystectomy or open cholecystectomy.

The trial judge permitted the testimony, although noting "[i]f it was standard of care rather than diagnosis maybe my ruling would be different." The judge ruled the testimony was "placing in context . . . the treatment [plaintiff] received before. And putting into context her complaints to him so he's in a position to assess those. I think that's all part of the diagnosis and prognosis that Stigliano[1] talks about." The judge also permitted defense counsel to read to the jury what Dr. Rodriguez-Davalos testified he advises his own patients regarding the risks attendant to a laparoscopic cholecystectomy and that bile duct injuries "can really happen to any surgeon[,] [e]ven surgeons with very high expertise."

Plaintiff appeals, contending the trial judge erred in permitting Dr. Rodriguez-Davalos to offer liability opinions contrary to Stigliano and two prior orders in the case, in admitting evidence of informed consent in a case in which there was no informed consent claim, and in improperly limiting her cross-examination of the defense experts. She also contends the defense experts offered net opinions without factual support. Because we agree with plaintiff's first two points, we reverse the verdict and deny defendant's cross-appeal that the pre-trial

[1] Stigliano v. Connaught Labs., Inc., 140 N.J. 305 (1995).

orders relating to Dr. Rodriguez-Davalos' testimony were issued in error. We address plaintiff's remaining arguments only for guidance on re-trial.

The law regarding the limits of a treating physician's testimony at trial is well settled. As our Supreme Court recently observed, "[o]ur courts have long permitted treating physicians to offer medical testimony regarding the diagnosis and treatment of their patients, pursuant to N.J.R.E. 701." Delvecchio v. Twp. of Bridgewater, 224 N.J. 559, 576 (2016); Stigliano, supra, 140 N.J. at 314. The Court established that precedent in Stigliano, which continues to guide questions regarding the trial testimony of treating doctors. Delvecchio, supra, 224 N.J. at 577-79.

In Stigliano, the plaintiffs' child experienced a seizure after her pediatrician administered a DPT shot. 140 N.J. at 307. The plaintiffs subsequently took the child to three pediatric neurologists for diagnosis and treatment. Id. at 308. All three concluded the child suffered from a chronic or primary seizure disorder, not caused by the DPT shot. Ibid. In the plaintiffs' suit against the pediatrician and the maker of the DPT vaccine, the plaintiffs secured a pre-trial ruling barring the treating neurologists from testifying as to their opinions as to the cause of the child's seizures. Id. at 309-10. The

Supreme Court disagreed, holding the neurologists, although no doubt experts in their field, were fact witnesses in the case who "may testify about their diagnosis and treatment of [the child's] disorder, including their determination of that disorder's cause." Id. at 314. The Court reasoned that "[b]ecause the determination of the cause of a patient's illness is an essential part of diagnosis and treatment, a treating physician may testify about the cause of a patient's disease or injury." Ibid.

In holding a treating doctor may be called by a defendant to testify about the cause of the plaintiff's illness, the Court distinguished Piller v. Kovarsky, 194 N.J. Super. 392 (Law Div. 1984) and Serrano v. Levitsky, 215 N.J. Super. 454 (Law Div. 1986), two cases in which trial courts had prohibited treating physicians from offering opinions regarding the negligence of the defendant doctors. The Court observed that "Piller and Serrano differ significantly on the facts. In those cases, the defendant-doctors sought to ask the treating physicians not about their treatment of the plaintiffs, but about the defendant's alleged malpractice." Stigliano, supra, 140 N.J. at 315.

Defendant did the same thing here. Plaintiff consulted Dr. Rodriguez-Davalos for diagnosis and treatment of her symptoms of

nausea, vomiting and jaundice several days post a laparoscopic cholecystectomy. Upon conducting an open surgical procedure, he discovered her common bile duct had been transected. Upon making that diagnosis, Dr. Rodriguez-Davalos treated plaintiff by effecting a surgical repair. The doctor could certainly testify that the cause of plaintiff's problem was a severed bile duct. How it happened and why it happened, or that it could have happened to the best of surgeons, however, are beyond the scope of what this fact witness could offer the jury and should not have been permitted. See N.J.R.E. 701; Stigliano, supra, 140 N.J. at 314.

Judge Quinn was correct to excise all statements by Dr. Rodriguez-Davalos regarding the difficulties faced by surgeons performing laparoscopic cholecystectomies and the standard of care, including that cutting the wrong duct was not an "uncommon" problem and "could happen to any surgeon in the country." The trial judge erred in not staying that course when he permitted defendant to read into the record nearly identical comments from Dr. Rodriguez-Davalos's second deposition. The comments went well beyond the doctor's own diagnosis or treatment of plaintiff, and defendant could not fairly use this fact witness to "plac[e] in context . . . the treatment [plaintiff] received before."

Simply stated, medical malpractice defendants may not use the plaintiff's treating doctors to provide expert testimony relating to deviation from the standard of care. See Carchidi v. Iavicoli, 412 N.J. Super. 374, 382 (App. Div. 2010). "[T]hat Dr. Rodriguez-Davalos's substantial experience leads him to describe the common bile duct as being so close to and running parallel to the cystic duct that it is not uncommon for them to be confused and misidentified," as defendant argues, is no basis for the admission of that testimony from a treating doctor. Those opinions were plainly not "inextricably intertwined" with Dr. Rodriguez-Davalos's "examination, diagnosis, treatment plan and cause determination," Carchidi, supra, 412 N.J. Super. at 382-83, but concerned only defendant doctor's alleged malpractice, and were thus inadmissible.

Having reviewed the record, we cannot dismiss the error as harmless. See R. 2:10-2; Hisenaj v. Kuehner, 194 N.J. 6, 12 (2008). In crafting the rule established in Stigliano, the Court recognized that "[a] jury could find the treating doctors' testimony to be more impartial and credible than that of the retained experts" as they could very likely be "the only medical witnesses who have not been retained in anticipation of trial." Stigliano, supra, 140 N.J. at 317.

In making his closing argument to the jury, defense counsel told the jury over and over that Dr. Rodriguez-Davalos, who "is not involved in this suit in any way other than he does the repair," who "certainly doesn't have any interest in getting involved in this and criticizing anybody," who is just here to "tell the truth," who "doesn't have any reason to favor anyone in this case," and that "[t]his is his patient," said, "[t]his could happen to anyone, I read it to you yesterday. This could happen to anyone. All of us are at risk of having a complication. It's a complication that can happen to any . . . surgeon that performs this operation."

Counsel went on to quote Dr. Rodriguez-Davalos on the number of gallbladder surgical injuries annually, the vagaries of the biliary system and his view of an intraoperative cholangiogram, a technique employed in the course of a laparoscopic cholecystectomy to delineate the anatomy of the biliary ducts that Dr. Drew opined defendant could have used here. Given how extensively the doctor was permitted to testify beyond the scope of his own diagnosis and treatment and defense counsel's reliance on that testimony in summing up to the jury, we conclude the error was "clearly capable of producing an unjust result" and entitles plaintiff to a new trial. See R. 2:10-2.

We also conclude the court erred in admitting evidence of informed consent in a case in which there was no informed consent claim. Over plaintiff's objection, the trial judge admitted defendant's testimony regarding his discussion with plaintiff of the risk of injury to the common bile duct prior to surgery; Dr. Koehler's consent form and what he tells his patients of the risk of bile duct injury; Dr. Fischer's testimony that a common bile duct injury is part of every gallbladder surgeon's consent form; testimony by Dr. Rodriguez-Davalos as to his consent form and his advice to patients of the risk of injury to the bile duct prior to surgery; and the cross-examination of plaintiff's expert, Dr. Drew, regarding what he tells his own patients about the risk of complications to the common bile duct in the course of laparoscopic cholecystectomy.

The trial judge admitted the testimony based on his belief that excluding it "would lead a jury to infer that [defendant] took no steps to explain the procedure, or could lead to the conclusion that a juror or all the jurors could infer that there was a lack of explanation of the significance of the surgery." The judge ruled he would not "preclude . . . defendant from effectively advancing a defense to the complaint that's been made against him." Although we certainly agree that defendant is entitled to defend himself against the complaint "made

against him," the question is whether he may mount such a defense when plaintiff has made no such complaint.

A patient's right to be informed about medically reasonable treatment alternatives and their attendant risks is separate and distinct from a cause of action predicated on a physician's breach of a standard of care, notwithstanding both are a form of medical negligence. Matthies v. Mastromonaco, 160 N.J. 26, 39 (1999). Although when the claims are brought together the facts underlying them can be "intertwined," there is no question but that they are different claims having different elements of proof. See Newmark-Shortino v. Buna, 427 N.J. Super. 285, 303-04, 308 (App. Div. 2012), certif. denied, 213 N.J. 45 (2013). "[T]he informed-consent basis of malpractice, as opposed to deviation from the applicable standard of care, rests not upon the physician having erred in diagnosis or administration of treatment but rather in the failure to have provided the patient with adequate information regarding the risks of a given treatment or with adequate information regarding the availability of alternative treatments and the comparative risks and benefits of each." Eagel v. Newman, 325 N.J. Super. 467, 474-75 (App. Div. 1999).

Relying on out-of-state authority, plaintiff contends that her having been advised of the risk of bile duct injury and

having consented to the laparoscopic cholecystectomy is irrelevant to the issue of whether defendant deviated from the standard of care in performing the procedure. She claims the extensive testimony and evidence presented on informed consent unduly prejudiced her in two ways. It diverted the jury's attention from the claim she actually brought, that is whether defendant deviated from the standard of care in performing the surgery, and it allowed defendant to implicitly make the improper argument that having been advised of the possibility of bile duct injury and having consented to the surgery, she assumed the risk.

Defendant counters that "[w]hile plaintiff frames the references" made at trial "to the various surgical consent forms and the explanations" provided plaintiff of the risks of surgery, including bile duct injury, "as attempts to convert the case to one of informed consent, the clearly expressed basis for that evidence was to show the jury that bile duct injury was a known and recognized risk of a laparoscopic cholecystectomy." Defendant cites Dr. Koehler's testimony that injury to the common bile duct, though uncommon, is a recognized complication of the procedure and thus must be discussed with the patient as an example of how such testimony was relevant even in the absence of an informed consent claim.

In a recent decision considering whether the admission of informed consent evidence in the absence of an informed consent claim is reversible error, we followed the unanimous view of the state courts that have considered the question that such evidence is irrelevant to whether the doctor provided negligent treatment and that its admission risks undue prejudice to patients. See Ehrlich v. Sorokin, ___ N.J. Super. ___ (App. Div. 2017) (slip op. at 11-15).

The plaintiff in Ehrlich claimed the defendant doctor negligently performed a colonoscopy and polypectomy procedure, burning her colon and causing a perforation. Id. at 4. She did not bring an informed consent claim. Ibid. The doctor denied any negligence, claiming any colonoscopy carries a risk for perforation, and "burning a colon is a 'known complication of the use of [the APC] [Argon Plasma Coagulation] for the performance of colonoscopy.'" Id. at 7.

The trial court denied plaintiff's in limine motion to exclude evidence of informed consent and, over her objection, permitted the jury to review the informed consent forms she signed in its deliberations. Id. at 4-5, 7-8. Correcting his earlier statement that the documents went "to the standard of care," the judge ruled that "in a fundamental sense, there could be no way to have a fair trial that would allow the plaintiff to

explore this treatment . . . , including almost every single statement written by Dr. Sorokin, and exclude the informed consent." Id. at 8. We disagreed.

Relying on a recent case from the Pennsylvania Supreme Court finding that a patient's agreement "'to a procedure in light of the known risks does not make it more or less probable that the physician was negligent in either considering the patient an appropriate candidate for the operation or in performing it in the post-consent timeframe,'" as well as several other out-of-state cases holding generally that evidence of informed consent is irrelevant and potentially prejudicial where the issue is negligent treatment, we reversed.[2] Id. at 12-13 (quoting Brady v. Urbas, 111 A.3d 1155, 1162 (Pa. 2015)). We reasoned in line with that general authority that Ehrlich's acknowledgment of the risk for perforation "had no bearing" on the only issue at trial, whether Dr. Sorokin "use of the APC without a saline lift deviated from the standard of care." Id. at 14. We also concluded the evidence had the capacity to

[2] We also relied on our own analogous precedent in Gonzalez v. Silver, 407 N.J. Super. 576, 593-95 (App. Div. 2009), in which we barred on re-trial plaintiff's statement to defendant doctor that plaintiff injured his elbow "car surfing" because of the statement's irrelevance to the diagnosis and treatment of plaintiff's elbow injury and its "enormous potential for prejudice," outweighing the worth of the evidence for impeachment purposes. Ehrlich, supra, slip op. at 13-14.

mislead the jury into reasoning that Ehrlich's consent to the procedure implied a consent to the resulting injury, making it lose sight of the central question of whether the defendant doctor's actions conformed to the standard of care. Id. at 15.

We agree with the reasoning of Ehrlich and follow it here. Plaintiff's knowledge of the risk of bile duct injury in the course of a laparoscopic cholecystectomy is entirely irrelevant to whether defendant performed the procedure in accordance with the applicable standard of care. As the Supreme Court of Virginia has succinctly explained:

> Knowledge by the trier of fact of informed consent to risk, where lack of [in]formed consent is not an issue, does not help the plaintiff prove negligence. Nor does it help the defendant show he was not negligent. In such a case, the admission of evidence concerning a plaintiff's consent could only serve to confuse the jury because the jury could conclude, contrary to the law and the evidence, that consent to the surgery was tantamount to consent to the injury which resulted from that surgery. In effect, the jury could conclude that consent amounted to a waiver, which is plainly wrong.
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> [Wright v. Kaye, 593 S.E.2d 307, 317 (Va. 2004).]

We reject defendant's argument that the informed consent evidence could assist in either establishing the standard of care for the procedure or bolstering his claim that plaintiff's transected bile duct resulted from a recognized complication of

the procedure and not negligence. A patient's knowledge of the risks of a surgical procedure obviously cannot establish the standard of care for the physician performing it. See Velazquez v. Portadin, 163 N.J. 677, 686 (2000) (defining a physician's standard of care as "that degree of care, knowledge, and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field"). Likewise, that a recognized complication of a surgical procedure occurred says nothing about whether it could have been avoided by the surgeon's exercise of reasonable care.

Certainly, the known risks of a surgical procedure are relevant to the standard of care applicable to a surgeon performing the procedure. See Hayes v. Camel, 927 A.2d 880, 890 (Conn. 2007) (noting that "evidence of the risks of a surgical procedure is relevant in the determination of whether the standard of care was breached"). And defendant is, of course, free to argue to the jury that common bile duct injuries can occur in the course of a laparoscopic cholecystectomy in the absence of negligence. We, however, agree with those courts that have determined that presenting such evidence through the vehicle of informed consent poses enormous risks of jury confusion. See Ehrlich, supra, slip op. at 15-16. Such evidence can readily be presented clearly and without confusion

through the testimony of a defense expert regarding the risks of the procedure, without reference to what advice the expert provides patients or what plaintiff was told of the risks of the surgery. See, e.g., Hayes, supra, 927 A.2d at 890; Waller v. Aggarwal, 688 N.E.2d 274, 276 (Ohio Ct. App. 1996).

We agree with plaintiff that the informed consent evidence at trial was unduly prejudicial to her. In addition to the informed consent testimony elicited from defendant and all of the experts in the case, defendant's counsel highlighted the testimony and defendant's advice to plaintiff regarding the risks repeatedly in his closing argument, asking the jury:

> Do you think he's telling her, hey I may commit malpractice on you? Or is he telling her the possible risks, known risks and complication[s] which he has a duty to do which he did do.

Although defendant undoubtedly has the right to defend himself against the complaint made against him, he does not have the right to set up a straw man argument against the complaint he would rather defend, diverting the jury's attention from the negligent treatment claim plaintiff brought, and improperly suggesting to the jury that having been advised of the possibility of bile duct injury and having consented to the surgery, plaintiff assumed the risk.

Given our disposition of the appeal, we need not resolve plaintiff's remaining points of error. We comment briefly only on those issues that might occur on re-trial.

Regarding the use of learned treatises, the Supreme Court in Jacober v. St. Peter's Medical Center, 128 N.J. 475, 490-91 (1992) established that experts may "refer on direct examination to statements from learned treatises if they relied on those treatises in forming their opinions." See N.J.R.E. 803 (c)(18). With regard to Dr. Drew's reliance on sections of the Mastery of Surgery text edited by Dr. Fischer, one of defendant's experts, we are not aware of any requirement that such reliance must be demonstrated exclusively in the expert's report, as opposed to his deposition testimony. As for plaintiff's employment of the Society of American Gastrointestinal and Endoscopic Surgeons Manual on cross-examination of Dr. Koehler, because plaintiff employed it to impeach the witness, notice was not required. See Form A(1) Uniform Interrogatories #10, Pressler & Verniero, Current N.J. Court Rules, Appendix II to R. 4:17-1 at www.gannlaw.com (2017).

Regarding the trial judge's refusal to allow plaintiff's counsel to cross-examine Dr. Fischer on his views of tort reform after he testified that he had "suggested to [the] American College of Surgeons . . . that [surgeons] stop doing

laparoscopic cholecystectomies until we can come to some conclusion with the legal profession as to what is appropriate for compensation and get it out of the court system," we need not decide whether we would reverse such a ruling in light of the trial court's broad discretion to control cross-examination. See Delgaudio v. Rodriguera, 280 N.J. Super. 135, 141 (App. Div. 1995).

We note, however, that the scope of cross-examination concerning bias is also broad, and that N.J.R.E. 607 expressly permits a party to introduce extrinsic evidence for the purpose of impairing the credibility of a witness. If what the trial judge characterized as Dr. Fischer's "political views" informed his opinion on the standard of care, then those views would appear a proper subject of cross-examination, the standard being its effect "upon substantial justice." Glenpointe Assocs. v. Twp. of Teaneck, 241 N.J. Super. 37, 55 (App. Div.), certif. denied, 122 N.J. 391 (1990).

Finally, we address plaintiff's contention that Dr. Fischer's was a net opinion because it was without factual support in the record. Because defendant did not move to strike Dr. Fischer's testimony at trial, the issue is not properly before us. Nieder v. Royal Indem. Ins. Co., 62 N.J. 229, 234 (1973). If such a motion is made on re-trial, the court must

consider whether there is any factual support in the record for Dr. Fischer's opinion that plaintiff had a short cystic duct in light of defendant's testimony that "it looked like a perfectly appropriate cystic duct. There was no indication [that it was shorter than normal]." See Townsend v. Pierre, 221 N.J. 36, 55 (2015) (holding an expert opinion that is unsupported by the factual record or based on an expert's speculation that contradicts that record constitutes net opinion).

Reversed and remanded. We do not retain jurisdiction.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION