NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2781-15T3

NORMA S. EHRLICH,

Plaintiff-Appellant,

v.

JEFFREY J. SOROKIN, M.D.,

Defendant-Respondent.

APPROVED FOR PUBLICATION

July 25, 2017

APPELLATE DIVISION

Submitted May 25, 2017 – Decided July 25, 2017

Before Judges Hoffman, O'Connor and Mawla.

On appeal from Superior Court of New Jersey, Law Division, Camden County, Docket No. L-2859-13.

M. Mark Mendel, LTD., attorneys for appellant (John J. Del Casale, on the brief).

Stahl & DeLaurentis, P.C., attorneys for respondent (Sharon K. Galpern, on the brief).

The opinion of the court was delivered by

HOFFMAN, J.A.D.

Plaintiff Norma S. Ehrlich appeals from a January 28, 2016 Law Division order dismissing her complaint against defendant Jeffrey J. Sorokin, M.D., based on a no-cause jury verdict in her medical negligence action. This suit arose after plaintiff

suffered complications from a colonoscopy and polypectomy procedure defendant performed in 2011. On appeal, plaintiff raises three claims of trial error, asserting the judge (1) admitted irrelevant evidence regarding informed consent, (2) delivered inadequate jury instructions on the standard of care, and (3) admitted net opinion testimony. Following our review of the record and applicable law, we agree the admission of informed consent evidence constituted harmful error. R. 2:10-2. We therefore vacate the order of dismissal and remand for a new trial consistent with this opinion.

I.

We begin by summarizing the most pertinent evidence from the record. In May 2003, plaintiff first came under the care of defendant, a gastroenterologist, after her family physician referred her based upon complaints of back pain and rectal bleeding. Defendant recommended plaintiff undergo a colonoscopy, which he performed on May 27, 2003.

Plaintiff's colonoscopy revealed the presence of a polyp at the tip of her cecum opposite the ileocecal valve. According to defendant, because the polyp's size and histologic type made it a significant risk for malignancy, he recommended plaintiff undergo surgery to remove a portion of her colon. Plaintiff declined surgery, so defendant referred her to another

gastroenterologist, Dr. Jerome Waye, one of the few doctors who – at that time – removed polyps with a colonoscope.

On November 14, 2003, Dr. Waye performed this procedure; however, plaintiff subsequently suffered a hemorrhage. In May 2004, plaintiff returned to the care of defendant, who informed her she needed a surveillance colonoscopy. Because plaintiff suffered from recurrent polyps, defendant performed five colonoscopy and polypectomy procedures between 2004 and 2011. Defendant used several techniques to remove plaintiff's recurrent polyps. One of these procedures, the "saline lift" technique, involves injecting fluid into the colon to lift the polyp from the colon wall. Once lifted, the polyp is usually removed with a hot or cold snare.

An alternative procedure, Argon Plasma Coagulation (APC), utilizes a thin catheter passed through a channel. Conductive argon gas then passes through the channel to the location of the polyp, followed by an electrical charge that vaporizes the cells of the polyp. Unlike the snare technique, the APC catheter does not make direct contact with the polyp.

Defendant applied the following techniques to remove polyps from plaintiff's colon on the following dates:

> November 16, 2004 - saline lift to remove a polyp with a hot snare.

December 28, 2005 - saline lift to remove a polyp with hot and cold snares.

March 20, 2007 - hot snare to remove a polyp; at trial, defendant explained he did not use saline because his "clinical judgment was that it did not need the saline."

September 21, 2009 – hot snare to remove a polyp, followed by the APC to "ablate whatever remaining polyp tissue was there."

August 29, 2011 – APC to remove a polyp.

Following the August 29 procedure, defendant discharged plaintiff to her home; however, at approximately 3:00 a.m. on August 30, plaintiff awoke in pain and told her husband, "[C]all 9-1-1[,] I'm in trouble." Emergency personnel transported plaintiff to Virtua Hospital, where she underwent emergency surgery. Virtua doctors determined plaintiff suffered from a perforation of her colon and peritonitis. The doctors performed a right hemicolectomy, ileostomy, and mucous fistula on plaintiff. She later underwent surgery to reverse the ileostomy.

Plaintiff filed her complaint against defendant on July 12, 2013, alleging he negligently performed the August 2011 procedure by "[f]ailing to inject the polyp and surrounding colon with Saline to create a cushion underneath the polyp." She did not assert a claim for lack of informed consent.

The case proceeded to a jury trial in January 2016. Prior to testimony, plaintiff moved in limine to exclude evidence regarding her consent to the colonoscopy procedures from 2003 to 2011. The trial judge denied the motion, finding "the forms and any information provided to the patient was part of the standard of care, and therefore relevant." Plaintiff again raised the issue after opening statements, but the judge reaffirmed his decision.

Plaintiff then testified, describing her history of treatment with defendant. Because the trial court denied plaintiff's in limine motion to exclude informed consent evidence, plaintiff's counsel also questioned plaintiff regarding the various consent forms she signed before each procedure completed by defendant.[1]

On cross-examination, defense counsel asked plaintiff about the language from one of her consent forms, which stated the procedure could result in injury and hospitalization. Plaintiff said the form indicated "passage of the instrument may result in an injury, but it never said that there would be a possibility

[1] During the charge conference following the conclusion of testimony, plaintiff's counsel explained that he addressed informed consent matters during his case in chief only after the trial court rejected his request to exclude informed consent evidence as irrelevant.

that my colon might be burnt." Defendant also asked plaintiff about the 2011 consent form, which she signed in defendant's office in June 2011, two months before the August 2011 procedure. Plaintiff reiterated defendant never discussed the potential for burning.

Plaintiff presented expert testimony from gastroenterologist Stuart Finkel, M.D., who asserted defendant deviated from the standard of care in both the 2009 and 2011 procedures. Regarding the 2011 procedure, Dr. Finkel stated the APC burned plaintiff's colon, resulting in the perforation, because defendant "failed to perform saline injection lift technique prior to that application of the APC, which increased her risk for this particular complication." He noted "that the finding of a flat, broad, [two] centimeter sessile polyp in . . . the thinnest area of the colon and most at risk for perforations" required defendant to "create [a] cushion of saline" before using the APC; defendant's failure to do so deviated from the standard of care.

Defendant presented expert testimony from Timothy Hoops, M.D. Prior to Dr. Hoops' testimony, the judge held an N.J.R.E. 104 hearing to determine the admissibility of his opinion on proximate cause. According to Dr. Hoops, plaintiff's multiple polypectomies likely would have scarred her tissue or resulted

in fibrosis, which would make the saline lift procedure ineffective by holding down the surface of the tissue. He gave his opinion to a reasonable degree of medical probability, based on "years of both my experience, as well as experience of people that I've seen . . . and on the medical literature." However, Dr. Hoops conceded none of defendant's records for plaintiff mentioned scarring or fibrosis. Plaintiff thus moved to preclude this testimony as net opinion, which the trial judge denied. Dr. Hoops then testified to this information before the jury.

Dr. Hoops also testified that defendant's use of the APC "was within the accepted standards of care." He noted, "At the time [the 2011] procedure was performed," there were no guidelines regarding the use of saline with the APC, and "[t]here was nothing for it or against it;" in addition, he had never seen a doctor use them together. He further noted, "[A]t the time of the procedure . . . there was no evidence that doing the saline lift would have reduced the risk for perforation." On cross-examination, Dr. Hoops acknowledged that saline lifts are "very safe" overall, but added, "[T]here might be some risks for infection."

Defendant testified he did not use the saline lift technique during the August 2011 procedure because "there was no

literature to support the use of the saline lift technique with an [APC]." He said there is a risk for perforation any time he performs a colposcopy, and burning a colon is a "known complication of the use of [the APC] for the performance of colonoscopy."

At the end of the testimony, the trial judge allowed the jury to review plaintiff's informed consent documents as part of its deliberation. Responding to plaintiff's objection, the judge stated:

> If you can go and talk about all that Dr. Sorokin had done in 2003, 2004, 2005 and so on, and exclude this small piece of it, that cannot be consistent with notions of justice or the search of truth. And maybe if I mis-characterized it as going to the standard of care that was my fault and a mistake. But in a fundamental sense, there could be no way to have a fair trial that would allow the plaintiff to explore this treatment for all these years, include the detail of it, including almost every single statement written by Dr. Sorokin, and exclude the informed consent. That can't be consistent with a notion of a fair trial.

Plaintiff then submitted a proposed jury instruction on the standard of care. The trial judge denied this request and proceeded to charge the jury under the model jury charge. The next day, the jury asked the court to reiterate "the definition of standard of care[.]" Plaintiff again requested a custom jury charge, but the judge re-read the previous instruction.

Following additional deliberation, the jury reached a 6-1 verdict that defendant did not breach the standard of care.

Plaintiff filed a motion for a new trial, which the judge denied. This appeal followed.

II.

We first address plaintiff's contention the trial judge erred by allowing defendant to present irrelevant and misleading evidence of her informed consent to the colonoscopy procedures. Plaintiff argues, because she did not assert a claim for lack of informed consent, the sole issue was whether defendant was negligent for failing to perform a saline lift with the APC. She asserts a new trial is necessary because defendant misled the jury to believe consent was connected to the standard of care. We are constrained to agree.

Our review of the trial court's evidential rulings "is limited to examining the decision for abuse of discretion." Parker v. Poole, 440 N.J. Super. 7, 16 (App. Div.) (quoting Hisenaj v. Kuehner, 194 N.J. 6, 12 (2008)), certif. denied, 223 N.J. 163 (2015). We will only reverse if the error "is of such a nature as to have been clearly capable of producing an unjust result." Ibid. (quoting R. 2:10-2).

Pursuant to our rules, evidence is relevant if it has "a tendency in reason to prove or disprove any fact of consequence

to the determination of the action." N.J.R.E. 401. Relevant evidence is generally admissible, N.J.R.E. 402, but "may be excluded if its probative value is substantially outweighed by the risk of . . . undue prejudice, confusion of issues, or misleading the jury." N.J.R.E. 403.

To prevail in a medical malpractice action based upon a deviation from the standard of care, the plaintiff "must generally present expert testimony establishing '(1) the applicable standard of care; (2) a deviation from that standard of care; and (3) that the deviation proximately caused the injury.'" Newmark-Shortino v. Buna, 427 N.J. Super. 285, 304 (App. Div. 2012) (quoting Teilhaber v. Greene, 320 N.J. Super. 453, 465 (App. Div. 1999)), certif. denied, 213 N.J. 45 (2013). "A physician must act with 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." Aiello v. Muhlenberg Reg'l Med. Ctr., 159 N.J. 618, 626 (1999).

Informed consent is generally unrelated to the standard of care for performing medical treatment. Eagel v. Newman, 325 N.J. Super. 467, 474-75 (App. Div. 1999).

> [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.
>
> [Ibid.]

"Although each cause of action is based on different theoretical underpinnings, 'it is now clear that deviation from the standard of care and failure to obtain informed consent are simply sub-groups of a broad claim of medical negligence.'" Newmark-Shortino, supra, 427 N.J. Super. at 303 (quoting Howard v. Univ. of Med. & Dentistry of N.J., 172 N.J. 537, 545 (2002)). However, these theories are distinguishable because they represent two independent duties: "(1) the duty to diagnose and treat a patient in accordance with the standard of care; and (2) the duty to disclose all medically reasonable treatment alternatives . . . so that a patient may make an informed decision." Ibid. (citing Matthies v. Mastromonaco, 160 N.J. 26, 39-40 (1999)).

Plaintiffs must meet a different, four-part test to establish the prima facie case for lack of informed consent. See Teilhaber, supra, 320 N.J. Super. at 465. "[T]o sustain a claim based on lack of informed consent, the patient must prove that the doctor withheld pertinent medical information

concerning the risks of the procedure or treatment, the alternatives, or the potential results if the procedure or treatment were not undertaken." Howard, supra, 172 N.J. at 548.

As plaintiff recognizes, there are no New Jersey cases specifically addressing the admissibility of informed consent evidence where the plaintiff has only asserted a claim of negligent treatment. She therefore relies on cases from other state courts addressing this issue, in particular a recent Pennsylvania Supreme Court decision, Brady v. Urbas, 111 A.3d 1155 (Pa. 2015).

In Brady, the plaintiff asserted a claim for negligent treatment and moved in limine to exclude any consent-related evidence; the trial court denied her motion. After reviewing the evidence during deliberations, the jury returned a verdict in favor of the plaintiff's doctor. Id. at 1158. On appeal, the doctor argued the evidence was relevant to establish the applicable standard of care. Id. at 1159. The Pennsylvania Supreme Court disagreed, finding "the fact that a patient may have agreed 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." Id. at 1162. The Court also concluded that such

evidence could confuse the jury by distracting it from whether the doctor breached the standard of care. Id. at 1163-64.

The other state courts plaintiff cites reached similar conclusions. See Baird v. Owczarek, 93 A.3d 1222, 1232 (Del. 2014) (agreeing that "evidence of informed consent, such as consent forms, is both irrelevant and unduly prejudicial in medical malpractice cases without claims of lack of informed consent" (quoting Hayes v. Camel, 927 A.2d 880, 889 (Conn. 2007))); Waller v. Aggarwal, 688 N.E.2d 274, 275 (Ohio Ct. App. 1996) ("[T]he issue of informed consent was not relevant to appellant's claim of negligence."); Wright v. Kaye, 593 S.E.2d 307, 317 (Va. 2004) (holding where the plaintiff did not plead lack of informed consent, "evidence of information conveyed to [plaintiff] concerning the risks of surgery in obtaining her consent is neither relevant nor material to the issue of the standard of care"); cf. Hayes, supra, 927 A.2d at 889-91 (holding the trial court abused its discretion by admitting such evidence, but finding the error harmless).

Additional state courts have found evidence of informed consent irrelevant and potentially prejudicial where the issue was negligent treatment. See Schwartz v. Johnson, 49 A.3d 359 (Md. Ct. Spec. App. 2012); Wilson v. Patel, 517 S.W.3d 520 (Mo. 2017); Warren v. Imperia, 287 P.3d 1128 (Or. Ct. App. 2012); cf.

Liscio v. Pinson, 83 P.3d 1149, 1156 (Colo. App. 2003) (finding informed consent evidence may be irrelevant but not reversible error where the plaintiff "opened the door").

Furthermore, although not directly on point, our decision in Gonzalez v. Silver, 407 N.J. Super. 576 (App. Div. 2009), is instructive on this issue. Gonzalez was a medical malpractice action wherein the defendant doctor attempted to introduce hearsay testimony regarding statements plaintiff made about the cause of his injury. Id. at 593. We held that such testimony was irrelevant to the issue of whether or not the defendant doctor provided proper medical care, and though it was perhaps relevant for impeachment, it carried "an enormous potential for prejudice." Id. at 594-95. We concluded the balance "should have weighed in favor of excluding such evidence." Id. at 595.

Considering Gonzalez and the non-binding but persuasive out-of-state cases, we are convinced the admission of the informed consent evidence in this matter, where plaintiff asserted only a claim of negligent treatment, constituted reversible error. The only issue at trial was whether defendant's use of the APC without a saline lift deviated from the standard of care. Plaintiff's acknowledgment of the risk for perforation had no bearing on this determination. Indeed, although negligent treatment and informed consent fall under the

umbrella of medical negligence, our law clearly distinguishes the two claims, and they require different elements of proof. See Newmark-Shortino, supra, 427 N.J. Super. at 304. We therefore conclude the informed consent evidence was irrelevant to the issue presented at trial, N.J.R.E. 401, and should have been excluded on plaintiff's motion in limine.

We reject defendant's assertion the evidence was relevant to "counter plaintiff's testimony on direct examination that [defendant] gave plaintiff absolutely no information about her condition and treatment." We also disagree with the judge's end-of-trial conclusion that plaintiff opened the door by exploring her entire history with defendant. Rather, the record shows that after twice attempting to exclude this evidence, plaintiff tried to minimize its damage by addressing it on direct examination. As the judge incorrectly ruled the informed consent evidence admissible prior to any testimony, we flatly reject defendant's attempt to assign relevance to this evidence after the fact. Moreover, we find defendant went beyond the purported purpose of rebutting plaintiff's claims by raising the consent issue during Dr. Hoops' testimony and during summation.

We further conclude this evidence had the capacity to mislead the jury, N.J.R.E. 403, thereby making it capable of producing an unjust result. R. 2:10-2. As the Pennsylvania

Supreme Court noted, "the jury might reason that the patient's consent to the procedure implies consent to the resultant injury, see Wright, [supra,] 593 S.E.2d at 317, and thereby lose sight of the central question pertaining to whether the defendant's actions conformed to the governing standard of care." Brady, supra, 111 A.3d at 1163. This was especially true here, where the jury received the consent forms as part of their deliberations, immediately after hearing defense counsel's summation referencing this issue.

Accordingly, we conclude that the admission of the informed consent evidence constituted reversible error. We therefore vacate the dismissal order and remand for a new trial.

III.

In order to provide guidance to the court on remand, we briefly address plaintiff's remaining arguments and find they lack merit. Plaintiff first argues the trial judge erred by rejecting her proposed jury charge on the standard of care. The proposed charge added the following language to the model jury charge:

> The law recognizes that the practice of medicine is not an exact science. Therefore, the practice of medicine according to accepted medical standards may not prevent a poor or unanticipated result. However, when a risk is obvious, and a precautionary measure available, an industry or professional standard that does not call

> for such precaution is not conclusive if, regardless of the standard or custom, the exercise of reasonable care would call for a higher standard. Therefore, whether Dr. Sorokin was negligent depends not on the outcome but on whether he adhered to or departed from the applicable standard of care.
>
> [(emphasis added).]

Plaintiff based this language on our decision in Estate of Elkerson v. North Jersey Blood Center, 342 N.J. Super. 219 (App. Div.), certif. denied, 170 N.J. 390 (2001). In Elkerson, the plaintiff produced expert testimony establishing that the entire blood bank industry was following inadequate safety standards in screening donated blood, when a better test was known and available. Id. at 233-35. In that context, we held the trial court erred in limiting the jury to considering whether the defendant blood bank followed the prevailing industry practice at the time of the plaintiff's blood transfusion. "[T]he trial court's negligence charge constitutes reversible error because it did not allow the jury to reject the industry standard applied uniformly by blood banks in 1983 in favor of its own expert-informed judgment in determining whether that custom was or was not reasonable." Id. at 235.

Elkerson is inapplicable here because plaintiff did not produce an expert report to opine the existing standard of care for APC use was unreasonable. Rather, this was a case where

plaintiff presented expert testimony that the standard of care required defendant to use the saline lift with the APC, and defendant presented expert testimony that the standard of care did not require this technique. Unlike in Elkerson, here no guidelines stated doctors should not use a saline lift with the APC. We therefore find the trial judge did not err by rejecting plaintiff's requested charge.

Plaintiff also argues the trial judge erred by permitting Dr. Hoops to deliver net opinion testimony regarding proximate cause. "The net opinion rule is a 'corollary of [N.J.R.E. 703] . . . which forbids the admission into evidence of an expert's conclusions that are not supported by factual evidence or other data.'" Townsend v. Pierre, 221 N.J. 36, 53-54 (2015) (alterations in original) (quoting Polzo v. County of Essex, 196 N.J. 569, 583 (2008)). A net opinion is "a bare conclusion unsupported by factual evidence." Creanga v. Jardal, 185 N.J. 345, 360 (2005). To avoid a net opinion, the expert must "'give the why and wherefore' that supports the opinion." Townsend, supra, 221 N.J. at 54 (quoting Borough of Saddle River v. 66 E. Allendale, LLC, 216 N.J. 115, 144 (2013)).

Experts are required to "be able to identify the factual bases for their conclusions, explain their methodology, and demonstrate that both the factual bases and the methodology are

reliable." Id. at 55 (quoting Landrigan v. Celotex Corp., 127 N.J. 404, 417 (1992)). The net opinion rule is a "prohibition against speculative testimony." Harte v. Hand, 433 N.J. Super. 457, 465 (App. Div. 2013) (quoting Grzanka v. Pfeifer, 301 N.J. Super. 563, 580 (App. Div. 1997), certif. denied, 154 N.J. 607 (1998)).

Dr. Hoops testified that plaintiff's multiple polypectomies would have caused scarring in her colon, likely making the saline lift procedure ineffective. Plaintiff asserts, because defendant's notes contained no reference to scar tissue, Dr. Hoops' testimony on this issue "constituted nothing more than mere speculation." Although the record did not show definitive evidence of scarring, Dr. Hoops set forth the factual basis for his opinion, noting in the "majority of cases," a polypectomy procedure would result in scarring, and it was "[a]bsolutely more likely than not that . . . [the] area would have been scarred down and would not have lifted. The . . . saline lift would have been unsuccessful; you would have had a non-lift sign." He based this opinion on his medical experience. Therefore, giving deference to the trial judge's decision on expert testimony, Townsend, supra, 221 N.J. at 52, we discern no error in his admission of this evidence.

Vacated 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