RECORD IMPOUNDED

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-5215-14T4

C.A.,[1] a Minor, by her Mother and Guardian ad Litem, ESTHER APPLEGRAD, ESTHER APPLEGRAD, individually, and GEDALIA APPLEGRAD, individually,

Plaintiffs-Appellants/
Cross-Respondents,

v.

ERIC BENTOLILA, M.D., an individual, GITA PATEL, R.N., an individual, and MARY BROWN, an individual,

Defendants,

and

VALLEY HOSPITAL, an entity, KOURTNEY KACZMARSKI, R.N., an individual, and YIE-HSIEN CHU, M.D., an individual,

Defendants-Respondents/
Cross-Appellants.

Argued December 4, 2017 – Decided April 18, 2018

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[1] We use initials to protect the minor's privacy consistent with previous opinions in this litigation. See C.A. v. Bentolila, 428 N.J. Super. 115 (App. Div. 2012), rev'd, 219 N.J. 449 (2014).

Before Judges Sabatino, Ostrer and Whipple.

On appeal from Superior Court of New Jersey, Law Division, Passaic County, Docket No. L-0908-08.

Cynthia A. Walters argued the cause for appellants/cross-respondents (Budd Larner, PC, attorneys; Cynthia A. Walters, of counsel and on the briefs; Terrence John Hull, on the briefs).

Ross A. Lewin argued the cause for respondents/cross-appellants Valley Hospital and Kourtney Kaczmarski, R.N. (Vasios, Kelly & Strollo, PA and Drinker Biddle & Reath, LLP, attorneys; Ross A. Lewin and Rowena M. Duran, of counsel and on the briefs; J.C. Jones, on the briefs).

Ellen L. Casagrand argued the cause for respondent/cross-appellant Yie-Hsien Chu, M.D. (Buckely Theroux Kline & Petraske, LLC, attorneys; William G. Theroux, of counsel; Ellen L. Casagrand, on the briefs).

PER CURIAM

A prior appeal in this medical malpractice case addressed pretrial issues of discovery and confidentiality under the Patient Safety Act ("PSA"), N.J.S.A. 26:2H-12.23 to -12.26. The case now returns to our court following a lengthy trial. The jury issued a verdict in favor of defendants. Plaintiffs appeal, raising a host of alleged trial errors. In addition, defendants provisionally cross-appeal some of the trial court's rulings.

For the reasons amplified in this opinion, we affirm in part, reverse in part, and remand for a new jury trial. Our primary

ground for reversal concerns material flaws in the jury instructions and the verdict sheet that were likely to have misguided the jurors, thereby producing an inconsistent and unsound verdict. We also reverse the trial court's handling of issues concerning a settling co-defendant's privilege against self-incrimination and the prejudicial manner in which that privilege was invoked. We affirm the balance of the other rulings challenged on the appeal and cross-appeal, reserving some discrete issues for re-examination at or before the new trial.

I.

A.

As we previously noted in our 2012 opinion, C.A., 428 N.J. Super. at 121, this medical malpractice case arises out of the delivery of an infant, C.A., who was deprived of oxygen at birth, resulting in her sustaining permanent brain damage. Plaintiff Esther Applegrad is the mother and guardian ad litem of C.A. Co-plaintiff Gedalia Applegrad is C.A.'s father.[2]

C.A. was born at defendant Valley Hospital on May 26, 2007. Her mother's obstetrician/gynecologist, defendant Eric Bentolila, M.D., was the attending physician who managed the pregnancy. Dr. Bentolila vaginally delivered C.A. from a breech position.

[2] For simplicity, we shall refer to the mother as "Mrs. Applegrad" and the father as "Mr. Applegrad."

Defendant Kourtney Kaczmarski, R.N., was on shift at the Hospital when Mrs. Applegrad was admitted. Nurse Kaczmarski provided care to Mrs. Applegrad during her labor. The nurse communicated with Dr. Bentolila several times during that time frame, although she ended her shift almost two hours before C.A. was born. Defendant Yie-Hsien Chu, M.D., is the pediatrician who attended to C.A. after her delivery. Defendants Gita Patel, a labor and delivery nurse, and Mary Brown, a respiratory therapist, also participated in the patients' care.[3]

Although some facts regarding C.A.'s birth were described in the prior opinions of this court and the Supreme Court, we revisit the pertinent chronology of events in light of the proofs that emerged at trial.

Dr. Bentolila saw Mrs. Applegrad from the time she was twenty-four weeks pregnant until C.A.'s delivery. The fetus was in a breech position at twenty-six weeks, but Dr. Bentolila did not view that as a concern at that time because he felt most babies will "turn" during pregnancy. In fact, as of May 10, 2007, the baby's position was vertex, or head down.

Dr. Bentolila saw Mrs. Applegrad on May 25. He noted she was forty weeks and three days into her pregnancy at that point. He

[3] As we note infra, both Patel and Brown have been dismissed from the case.

determined that the baby's position had become vertex and that Mrs. Applegrad was dilated one centimeter. He also determined that the amniotic fluid was within normal limits. Because Mrs. Applegrad was "post-date," several days beyond forty weeks, Dr. Bentolila considered when to induce her.

Mrs. Applegrad agrees that she saw Dr. Bentolila on May 25, and that he gave her an ultrasound. Around midnight, her water broke. After calling Dr. Bentolila, Mrs. Applegrad arrived at the Hospital on May 26 shortly after 5:00 a.m. The amniotic fluid in the womb was clear.

Events on May 26 Before the Delivery

Dr. Bentolila arrived at the Hospital around 8:00 a.m. and saw Mrs. Applegrad that morning. At that time, he filled out a physician's order sheet. The medical order stated that if Mrs. Applegrad did not go into labor by noon, the drug Pitocin should be administered to induce contractions. The order noted that no internal examination be conducted prior to the administration of the drug Pitocin. It further notated that the fetal position was vertex.

Dr. Bentolila stated in his deposition that he did not examine Mrs. Applegrad internally on May 26 because her water had broken and he was concerned about causing an infection. He further stated that he "relied on [his] exam from the day before." After he

wrote the order, Dr. Bentolila left the Hospital to go to religious services. According to Mrs. Applegrad, Dr. Bentolila told her before he left that if she did not go into labor by noon, he would induce her.

The Hospital's policy and procedure regarding the administration of Pitocin stated the physician must "examine the patient to confirm a vertex presentation within one hour prior to the start" of administration of the drug. The Pitocin may be administered by a registered nurse. If there is a "non-reassuring fetal heart rate pattern," the Pitocin drip should be discontinued and the responsible physician notified.

Nurse Kaczmarski was working the 11:00 a.m. to 7:00 p.m. shift on May 26. Mrs. Applegrad was her only patient that day. The nurse recalled that Dr. Bentolila told her that Mrs. Applegrad's water had broken around midnight. Kaczmarski understood the order to mean that she was not to examine Mrs. Applegrad vaginally prior to the start of the Pitocin. She was aware of the Hospital's policy not to induce if the baby was breech. Labor not yet having started, Nurse Kaczmarski administered the Pitocin at noon.

Nurse Kaczmarski called Dr. Bentolila at about 2:30 p.m. to tell him that Mrs. Applegrad was complaining of a headache. Dr. Bentolila prescribed Tylenol. At about that time, Kaczmarski

noticed meconium, a fetal discharge, coming from the patient. Kaczmarski, in her experience, did not believe the meconium to be unusual because Mrs. Applegrad was past her due date. The nurse did not recall whether she told Dr. Bentolila about the meconium when she spoke to him at that time.

Because Mrs. Applegrad began feeling contractions, Nurse Kaczmarski performed a sterile vaginal examination of her at 3:45 p.m. Kaczmarski testified that there was a "standard order" in the Hospital giving a nurse the discretion to conduct such an examination when she believed it to be necessary. She determined from the examination Mrs. Applegrad was four centimeters dilated.

Nurse Kaczmarski could not determine the position of the baby at that time, but she believed the baby was "still very high" up. However, the nurse stated that when she did the vaginal examination she was not trying to determine the position of the baby. Sometimes Kaczmarski could feel a head when doing such an examination, but she testified that it was not part of her job to determine fetal presentment.

Nurse Kaczmarski did another sterile vaginal examination at 4:45 p.m., at which time Mrs. Applegrad was six centimeters dilated. According to Mrs. Applegrad, Kaczmarski told her at both the 3:45 p.m. and 4:45 p.m. examinations that she had felt the baby's head.

About 5:00 p.m., Nurse Kaczmarski noticed that the fetal heart rate had risen from 155 to 170. She also noted the presence, once again, of meconium. The nurse called Dr. Bentolila at 5:00 p.m. and informed him of the increased heart rate, but not the meconium.

Dr. Bentolila ordered an antibiotic be administered because of the possibility that Mrs. Applegrad might be developing an infection as a result of her water having been broken by that point for seventeen hours. He noted the increase in the fetal heart rate, known as tachycardia, could have been a sign of an infection. Mrs. Applegrad was given an epidural at 5:30 p.m.

Nurse Kaczmarski did another sterile examination at 5:40 p.m. and found Mrs. Applegrad was by that point eight centimeters dilated. Kaczmarski also noticed large, thick meconium. She called Dr. Bentolila and told him about the thicker meconium and that the fetal heart rate had risen to 175. Dr. Bentolila advised the nurse that he was on his way to the Hospital. Mrs. Applegrad continued to receive Pitocin.

Dr. Bentolila arrived back at the Hospital at 6:15 p.m., at which time he determined that the baby was in a breech position. He also examined the heart rate strip. He performed a vaginal examination, which revealed that Mrs. Applegrad was nine centimeters dilated.

Dr. Bentolila claimed in his deposition that he fully discussed with Mr. and Mrs. Applegrad the respective pros and cons of vaginal delivery and a Cesarean section ("C-section"), and that they decided on a vaginal delivery. According to Dr. Bentolila, he had performed at least three breech vaginal deliveries in the previous four to five months.

Mrs. Applegrad testified that after Dr. Bentolila told her that the baby was breech, she asked him if a C-section was necessary, and he assured her that she could deliver vaginally. She stated that she preferred to deliver vaginally because the recovery was easier. According to Mrs. Applegrad, Dr. Bentolila did not advise her that she was unsuitable for vaginal delivery due to the baby's position.

Nurse Kaczmarski testified that Dr. Bentolila was informed that an operating room was available, should he decide to perform a C-section. Dr. Bentolila and the Applegrads then had a discussion, apparently in Hebrew, following which Dr. Bentolila told Nurse Kaczmarski that the plan was to have a vaginal delivery.

Nurse Patel was the charge nurse in the labor and delivery ward on May 26 from 3:00 p.m. to 11:00 p.m. She stated that, after Dr. Bentolila determined the baby was breech, he told her that he nonetheless believed the baby could be safely delivered vaginally.

The Delivery

Nurse Kaczmarski's shift ended at 7:00 p.m., at which time Mrs. Applegrad was fully dilated. Mrs. Applegrad began pushing. Kaczmarski left the hospital fifteen minutes later.

Nurse Susan DaSilva[4] came on duty at 7:00 p.m. The baby's heart rate was 175 to 180 at that time. DaSilva put an oxygen mask on Mrs. Applegrad. DaSilva observed a large amount of meconium five minutes later.

During the next ninety minutes or so, Dr. Bentolila had Mrs. Applegrad push on and off, and increased the level of Pitocin. The fetal heart rate rose to as high as 190, and as low as 60, during this time.

C.A. was born at 8:44 p.m. There was thickened meconium at delivery. C.A. was born "hypotonic," meaning with no tone. Nurse DaSilva described C.A. as pale and limp upon delivery, noting that a code was called a minute after the child's birth.

Events After the Delivery

After the baby was delivered, Nurse DaSilva saw Dr. Bentolila tear up the original order he had written that morning and place it in a shredder box. She told Nurse Patel what she had seen. Patel proceeded to unlock the shredder box and retrieve the order.

[4] Nurse DaSilva died before trial.

Nurse Patel similarly stated that, after the delivery, Nurse DaSilva told her something that caused her to check the shredder box. Patel found in the box an order sheet that had been "ripped in half." Patel notified the labor and delivery unit. Patel then handed the order to the manager of the hospital's risk management department. She identified the handwriting on the order as being Dr. Bentolila's. The order was eventually taped back together.

Nurse Patel saw another order for Pitocin in the chart. This new order apparently omitted the statement on the original order that the baby was vertex, as well as Dr. Bentolila's instruction to defer a vaginal examination prior to administering the Pitocin. Nurse Kaczmarski, meanwhile, denied having anything to do with the attempted destruction of the original order.

Dr. Chu, the pediatrician, arrived at the delivery room prior to delivery. She set up a resuscitation table and made sure that all her equipment was in working order. Dr. Chu was told of the presence of the meconium-stained amniotic fluid, which indicated to her some form of stress to the baby during delivery.

After the umbilical cord was cut, C.A. was handed to Dr. Chu, who proceeded to examine the baby's throat. C.A. was not moving or breathing. The baby also had poor color and poor muscle tone.

Dr. Chu suctioned the baby's upper airway, using a suction catheter, because C.A. had many secretions in her mouth and Dr.

Chu could not see C.A.'s vocal cords. Dr. Chu then used an endotracheal tube ("ET tube") connected to a meconium aspirator, in order to suction C.A.'s throat. Although there were "a lot" of secretions, Dr. Chu did not find any meconium present.

Dr. Chu then intubated C.A. by placing the ET tube through the baby's vocal chords. Her first attempted intubation was unsuccessful because of the amount of secretions in the vocal chords. Dr. Chu was successful, however, on her second attempt to insert the ET tube. Brown, the respiratory therapist, then heard breathing sounds in both of the baby's lungs.

Dr. Chu denied that she had placed the tube in the baby's esophagus rather than the throat. According to Dr. Chu, had she done so, she would not have heard any air being pumped into the baby's lungs, but rather the air would have gone into the stomach.

C.A. failed to respond to being placed on a warming table, and Dr. Chu applied a towel. At thirty seconds to one minute after birth, Dr. Chu began positive pressure ventilation ("PPV"). She did this through an "Ambu bag," because of C.A.'s breathing difficulties. As explained by Dr. Chu, PPV involves the use of air pressure to expand the lungs.

C.A.'s heart rate improved a small amount for two or three minutes, increasing to 50-70 beats per minute. However, at that point, C.A. stopped breathing. Dr. Chu began chest compressions

and called a Neonatal Intensive Care Unit ("NICU") code. At the five-minute mark, C.A.'s Apgar score was zero, and remained so until the ten-minute mark.

Prosperita Du, a nurse with the Hospital's neonatal unit, had been in the delivery room taking notes while C.A. was born. At 8:55 p.m., Nurse Du wrote that the NICU unit was called. The record does not reveal precisely how long it took for the code cart to arrive, but it apparently took between one to three minutes.

At 8:55 p.m., Dr. Chu called for an anesthesiologist to help with the baby's resuscitation. Dr. Chu did so because, despite repeated attempts at suctioning and opening the baby's airway, she still observed inadequate chest movement.

At 8:58 p.m., Dr. Chu administered epinephrine through the ET tube. Dr. Chu testified that she did not consider removing the ET tube from C.A. because air was still getting into the lungs, and she "felt confident" that the tube was in the correct position. Dr. Chu further stated that the risk of giving epinephrine too early was that it could damage the heart by making it work harder to supply oxygen.

Dr. Stephen Gal, the anesthesiologist, arrived at or about 9:00 p.m. He observed the intubation tube was apparently dislodged. He was able to re-intubate C.A. In order to do so,

Dr. Gal had to occlude the pop-off valve, a device that prevented the delivery of too much air to the lungs which could cause them to collapse.

C.A. was transferred to the neonatal unit at 9:25 p.m. Brown, the respiratory therapist, placed C.A. on a ventilator about forty-five minutes after birth.

It is undisputed that C.A. has profound and permanent disabilities associated with her brain damage.

B.

In March 2008, plaintiffs filed an initial complaint in the Law Division asserting medical negligence against Dr. Bentolila and the Hospital. Thereafter, in May 2009, plaintiffs filed an amended complaint to add Nurses Kaczmarski and Patel as defendants. A stipulation dismissing the complaint against Nurse Patel with prejudice was entered in October 2009.

Eventually, Dr. Bentolila and plaintiffs reached a settlement for an undisclosed sum. A stipulation of dismissal as to Dr. Bentolila was entered on November 25, 2009.

In March 2010, plaintiffs filed a second amended complaint, this time adding Dr. Chu and Therapist Brown as defendants. They both denied liability.

During discovery, plaintiffs moved to compel the disclosure of the Hospital's investigative and peer review records relating

to C.A.'s birth. The Hospital withheld several of those documents. After the trial court ruled that certain of those documents were protected from discovery, this court granted plaintiffs' motion for leave to appeal and remanded the matter for further development of the record. C.A. v. Bentolila, No. A-3747-09 (App. Div. Jan. 5, 2011).

After the record on the privilege issue was more fully developed, plaintiffs again appealed from the trial court's order denying discovery. On August 9, 2012, we held that some of the contested documents were privileged from discovery under the PSA, but others were not. C.A. v. Bentolila, 428 N.J. Super. 115 (App. Div. 2012), rev'd, 219 N.J. 449 (2014). The privilege issue then was considered by the Supreme Court, which reversed the portion of this court's holding that some of the documents sought by plaintiffs were not privileged under the PSA. C.A. v. Bentolila, 219 N.J. 449 (2014).

Back on remand in the trial court, therapist Brown's motion for summary judgment was granted in January 2015.[5] However, Nurse Kaczmarski's own motion for summary judgment was denied.

The jury trial took place over forty-five intermittent days in February, March, April, and May 2015. During the course of the

[5] This disposition has not been appealed.

protracted trial, the court entered an order which, relevant to this appeal, stated that (1) evidence regarding Dr. Bentolila's attempted "spoliation" of and revision to his medical order was admissible; (2) a jury charge on preexisting cause under Scafidi v. Seiler, 119 N.J. 93 (1990), would be given; and (3) defendants were permitted to introduce evidence regarding Mrs. Applegrad's preexisting condition of chorioamionitis.

C.

The trial proofs included testimony from numerous fact witnesses and several competing experts. We describe in detail key facets of that testimony because of its importance to the legal issues before us.

Dr. Crawford (Neonatal & Perinatal Medicine – Plaintiffs)

Caroline Crawford, a physician, testified for plaintiffs as an expert in neonatal and perinatal medicine, and resuscitation. Dr. Crawford testified that C.A. was in a "very difficult situation" at birth. Her heart rate was only fifty and she was limp, "floppy like a rag doll," with poor color, no response to stimulation and not breathing. Dr. Crawford testified that the uniform resuscitation procedures recommended by the American Academy of Pediatrics required four steps within two minutes of life if a baby is in distress. These were: (1) clear the airway; (2) if the baby still was not breathing, insert the ET tube with

Ambu bag into the trachea; (3) assure adequate blood circulation; and (4) if necessary, the use of epinephrine to jolt the heart into pumping.

Dr. Crawford opined that Dr. Chu deviated from accepted standards of care by not immediately intubating C.A. to clear the airway of thick meconium, and by not calling an emergency code sooner. According to Dr. Crawford, the code should have been called after no more than two minutes. In addition, Dr. Crawford determined that Dr. Chu had not placed the ET tube in the proper area, and had improperly left it in place even though there was inadequate chest movement. She concluded that the intubation was made into the esophagus rather than the trachea. According to Dr. Crawford, Dr. Chu's failure to correct this error allowed the baby's cardiac arrest to continue longer than necessary.

In addition, Dr. Crawford asserted that C.A. should have been intubated at thirty seconds, not at three minutes. As a result of this claimed deviation, an obstruction of mucous or meconium was created in the baby's trachea. Dr. Crawford further noted that the very brief increase in the baby's heart rate after Dr. Chu utilized the PPV was insufficient. The failure to call the code and administer the epinephrine until the eleven-minute mark also contributed, in her view, to the adverse outcome.

Dr. Crawford concluded that, as a result of the "faulty

resuscitation," C.A. suffered "profound irreversible brain damage from a prolonged cardiac arrest and prolonged deprivation of oxygen and blood flow to her brain." Dr. Crawford added that had the resuscitation been properly and timely carried out, C.A. would have been "fine."

In addition, Dr. Crawford testified that chorioamnionitis, i.e. an inflammation of the amniotic fluid caused by the meconium, did not have an effect on C.A. That is because there was no fetid vaginal discharge and no uterine tenderness. Nor was there a drop in C.A.'s blood platelets, as Dr. Crawford explained would be seen with chorioamnionitis.

Dr. Adler (Pediatric Neurology – Plaintiffs)

Daniel Adler, M.D., testified for plaintiffs as an expert in pediatric neurology. Dr. Adler stated that C.A. suffered from permanent brain damage in the form of cerebral palsy. Her condition resulted from hypoxic-ischemic encephalopathy, reduced blood flow and oxygen levels to the brain because of events surrounding the time of her birth. Based on his review of C.A.'s brain scans, Dr. Adler concluded that the damage to her occurred after she was delivered. Dr. Adler noted the blood platelet level, a measure of the oxygen going to the brain, was in normal range prior to C.A.'s birth. Therefore, "any hypoxia before the birth wasn't significant" and did not contribute to the injury.

Dr. Adler noted that C.A.'s heart rate was not normal for twenty-two minutes after birth. He maintained this is when the child's brain injury took place. Dr. Adler acknowledged that, considering the extent of the injury, "there must have been some hypoxia occurring right before the delivery . . . . It must have preexisted the delivery by some minutes." Nonetheless, he concluded that, had C.A. been adequately resuscitated by ten minutes of age, she would only have suffered limited neurological injury, if any. Those injuries would have included walking at a late developmental time, delayed language skills, and some behavioral difficulties.

Further, Dr. Adler testified that chorioamnionitis did not play a role in C.A.'s brain injury. He asserted that condition would not explain a baby who was born with a heart rate of fifty, but rather would cause chronic problems that were not present in C.A.'s blood tests. Nor was there any evidence that C.A. had an infection.

In Dr. Adler's opinion, C.A. was comatose and in a persistent vegetative state after she was born, but became minimally conscious in 2010. She remained dependent on a feeding tube. He added that there was no possibility that C.A.'s condition would improve. He predicted that she would live to no more than fifteen to twenty years of age.

Nurse Bolletino (Obstetrical Nursing – Plaintiffs)

Tina Bolletino, a labor and delivery nurse, testified for plaintiffs as an expert in obstetrical nursing. She opined that Nurse Kaczmarski failed to follow the Hospital's nursing policy with regard to the administration of Pitocin by failing to question Dr. Bentolila's order; in not telling him about the abnormal fetal heart rate sooner; and in not acting as the patient's advocate to make sure that Dr. Bentolila examined Mrs. Applegrad to assess whether the baby was in a vertex position before ordering that she be induced. Nurse Bolletino criticized Kaczmarski's failure to inform Dr. Bentolila of the meconium until almost three hours after she had first documented it. Nurse Bolletino also opined that Kaczmarski deviated from the appropriate standard of nursing care by not putting Mrs. Applegrad on an oxygen mask, which would have increased the amount of oxygen to the baby.

Kucsma (Forensic Economist – Plaintiffs)

Kristin Kucsma, a forensic economist, testified for plaintiffs as an expert in economic losses. She performed an appraisal of C.A.'s economic loss based on lifetime care through 2021 and 2026 under a ten-to-fifteen-year life expectancy. Kucsma determined that if C.A. lives till 2019, the cost of her home care

would be nearly $12 million.[6] She also concluded that the present value of C.A.'s total economic loss, had she received a high school diploma, was $12,957,854. Assuming that, if healthy, C.A. would have obtained a college degree, Kucsma calculated the present value of the total economic loss at $13,543,369.

Dr. Beckmann (Labor & Delivery Nursing – Defense)

Claudia Beckmann, who holds a doctorate in infant nursing, testified for Nurse Kaczmarski as a defense expert in labor and delivery nursing. Dr. Beckmann concluded that Kaczmarski complied with the applicable standard of care for a labor and delivery nurse in her treatment of Mrs. Applegrad. Dr. Beckmann further opined that Kaczmarski acted appropriately in following Dr. Bentolila's instructions to defer a vaginal examination, because of the risk of infection due to Mrs. Applegrad's water having broken. According to Dr. Beckmann, Kaczmarski met the applicable standard of care when she performed a vaginal examination at 3:45 p.m. to determine how far Mrs. Applegrad was dilated, and in calling Dr. Bentolila at around 5:00 p.m. after the baby's heart rate had increased.

Dr. Small (Obstetrics/Labor & Delivery – Defense)

Daniel Small, M.D., testified for Nurse Kaczmarski as an

[6] The proofs reflected, as stipulated on the verdict sheet, $2,375,596 in past medical costs.

expert in obstetrics and labor and delivery. According to Dr. Small, a doctor can defer a vaginal examination within one hour of inducement if there is a medical reason indicating it is not in the patient's best interest to do so. In this instance, because Mrs. Applegrad's water had broken, Dr. Small felt there was a much higher risk of infection for her and for the baby had a vaginal examination been done before inducement. Dr. Small believed that Dr. Bentolila's 8:30 a.m. order on May 26 was "entirely appropriate . . . ." In addition, he testified that a labor and delivery nurse has to rely on a doctor's representation as to the baby's presentation.

However, Dr. Small did conclude that Dr. Bentolila had deviated from the applicable standard of care, when he failed to call for a C-section after he arrived at the hospital at 6:15 p.m. According to Dr. Small, the harm from Dr. Bentolila's failure to do so became compounded as time went on. Had C.A. been born by 7:00 p.m., Dr. Small believed that she would have been fine. He noted that very few doctors deliver babies vaginally who are in breech position, because there is an increased risk of head entrapment. Delivering a baby who was breech after the mother had been on Pitocin was even more unusual. In addition, C.A.'s heartbeat was growing faster by the hour, indicating an infection. Dr. Small also faulted Dr. Bentolila for not having a sufficiently-

detailed informed consent discussion with the parents about the risks of a vaginal delivery in these circumstances.

Dr. Small rejected the suggestion that it was too late to do a C-section at 6:15 p.m. on May 26 because Mrs. Applegrad was then nine centimeters dilated. According to Dr. Small, a C-section can be performed any time prior to delivery. He believed that by 6:30 p.m. Dr. Bentolila should have performed the C-section. In addition, he noted that there were large decelerations in the heart rate, starting at around 7:00 p.m. Dr. Small opined that Dr. Bentolila, having seen this, violated the applicable standard of care by not calling for a C-section at this point.

Starting after 7:30 p.m., Mrs. Applegrad began experiencing "deep decelerations." This is when Dr. Small believed that the brain damage occurred. The baby's heart rate remained low until delivery.

Dr. Mandelbaum (Pediatric Neurology – Defense)

David Mandelbaum, M.D., testified for Nurse Kaczmarski as a defense expert in pediatric neurology. He concluded that C.A.'s neurological disability was due to hypoxic ischemic encephalopathy, meaning an inadequate supply of blood oxygen to the brain. According to Dr. Mandelbaum, this condition was due to a combination of injuries prior to birth, including: too much amniotic fluid that was swallowed by the fetus; Mrs. Applegrad's

hypothyroidism; the baby being breech; the chorioamnionitis; and the "dramatic" fluctuation in heart rate after Mrs. Applegrad began pushing. As Dr. Mandelbaum described it, "there was . . . a profound . . . impairment of blood flow to the fetus . . . that was manifest in this dramatically abnormal heart rate."

Based on the placental tissue obtained from C.A. after birth, Dr. Mandelbaum stated that there was chorioamnionitis, i.e., an inflammation of the amniotic sack, as well as funisitis, an inflammation of the umbilical cord. As to the timing of the baby's injury, Dr. Mandelbaum testified that he believed it had occurred before birth, when Mrs. Applegrad started pushing. He added: "This was a devastated baby at birth and if it wasn't . . . devastated . . . the resuscitation would have been more effective. The reason the resuscitation failed was because of the preexisting injury." Dr. Mandelbaum estimated that only twenty percent of the injury would have been evident, had the baby been delivered prior to the "period of acute profound hypoxia ischemia."

Dr. Bedrick (Neonatologist and Pediatrics – Defense)

Alan Bedrick, M.D., a neonatologist, testified for Nurse Kaczmarski and Dr. Chu as a defense expert in pediatrics and neurology. In Dr. Bedrick's opinion, the bulk of C.A.'s injury occurred prior to birth, and, more specifically, within the sixty to ninety minutes beforehand. Upon examining the fetal heart

monitor strips, Dr. Bedrick noted a progressive deterioration over that period of time, to a point where there were "very profound, distinct abnormalities . . . ." He reviewed the placenta pathology report, and noted that there was acute chorioamnionitis and acute funisitis. As a result, C.A. was receiving less oxygen and nutrients. According to Dr. Bedrick, both of those conditions were related to the subsequent development of cerebral palsy. Thus, he believed these conditions "very well could have" played a role in the damage suffered by C.A., but he could not quantify to what degree.

Dr. Bedrick described the effort to resuscitate C.A. as "challenging." In his opinion, "the medical and nursing team handled that situation expertly and appropriately." With respect to Dr. Chu, he testified that she met the standard of care in her treatment of C.A. He felt Dr. Chu had appropriately addressed C.A.'s airway and supported her heart with cardiac massage. Nor was it a deviation for Dr. Chu to have departed from neonatal resuscitation guidelines because C.A. was born with profound brain damage.

Dr. Bedrick opined that Dr. Chu further acted appropriately by clearing the airway of fluid, and by initiating PPV thirty seconds to one minute after birth, because there was no meconium recovered from the suctioning. Dr. Bedrick did not believe that

C.A.'s gasping for air (known as "apneic") required Dr. Chu to call a code, because that call is reserved for cardiac difficulties. Dr. Bedrick did not believe that there was a total occlusion of C.A.'s ET tube, because breathing sounds were heard. Nor did he believe that the ET tube was misplaced in the esophagus, but that it was in the trachea the entire time.

Further, Dr. Bedrick opined that Dr. Chu's failure to administer epinephrine by two minutes after birth did not violate the standard of care, and was within her medical judgment, because C.A.'s airway and breathing had not been "taken care of." Thus, stimulating the heart in those circumstances could have caused the baby harm. As a result, not administering the epinephrine until seventeen minutes after birth was also appropriate. Nor did Dr. Chu violate the applicable standard of care by not pulling the tracheal tube sooner because there were breathing sounds. According to Dr. Bedrick, C.A. responded after the pop-off valve was occluded, because there likely was mucus partially occluding the ET tube, which was "inadvertently popped . . . ."

On the whole, Dr. Bedrick concluded that Dr. Chu's overall care and treatment was within accepted standards of medical practice, because she effectively provided ventilation and confirmed that there was no meconium in C.A.'s airway. He asserted that C.A.'s "ongoing airway difficulty" was not due to Dr. Chu's

treatment, but rather to the secretions in the airway. Even had the resuscitation gone perfectly, Dr. Bedrick believed that C.A. would have had a brain injury because she was brain-damaged at the time of birth. He cited in this regard the changes in the baby's heart rate sixty to ninety minutes before delivery, and the low heart rate and difficulty breathing at birth. He also cited the chorioamnionitis, which he opined can cause brain injury.

Dr. Posencheg (Neonatal Resuscitation – Defense)

Michael Posencheg, M.D., a neonatologist, testified for Dr. Chu as a defense expert in neonatal resuscitation. Dr. Posencheg stated that either a suction catheter or an ET tube with a meconium aspirator could appropriately be used to remove meconium prior to the administration of PPV. According to Dr. Posencheg, when C.A.'s heart rate fell at two to three minutes of life, Dr. Chu complied with the applicable standard of care by initiating chest compressions. The expert added that Dr. Chu was "doing her best to establish ventilation, and that is the most important thing . . . ." Nor did he believe that it was a violation of the standard of care for Dr. Chu to have been unsuccessful on her initial attempt to intubate.

Further, Dr. Posencheg opined that Dr. Chu had acted with proper judgment in the timing of the administration of the epinephrine, because to administer the drug when the baby's

breathing is poor can damage the baby's heart. Therefore, he felt Dr. Chu did not violate the standard of care by not giving the epinephrine at one and a half to two minutes of life because there was insufficient ventilation at that time.

The Parents' Testimony

Mrs. Applegrad, who has four other children, testified that when she was told of C.A.'s impaired condition, she was "devastated." According to Mrs. Applegrad, C.A.'s condition impacted the "whole family dynamics" including her relationship with her husband. She noted he began to worry about everyone in the family, but they were able to "work it out" through counseling.

Mr. Applegrad testified that his wife "changed" after C.A.'s birth, remarking that she "is just not happy anymore." Mr. Applegrad was present during the entire labor and delivery, including when the medical personnel were working to resuscitate C.A. He recalled that at one point, Dr. Bentolila told both parents that "it doesn't look good."

D.

After considering these extensive proofs, the jury returned a verdict, finding that (1) Nurse Kaczmarski had deviated from accepted standards of nursing practice; (2) her deviation was the proximate cause of some of C.A.'s injuries; and (3) the deviation was a substantial factor in the cause of the ultimate injury.

However, the jury also found that the defense had proven that Dr. Bentolila's acts or omissions had "destroyed" the connection between the nurse's deviation and C.A.'s ultimate injury. The jury separately found that plaintiffs had failed to prove that Dr. Chu deviated from accepted standards of medical practice.

Judgment in favor of Nurse Kaczmarski and the Hospital, and dismissing plaintiffs' complaint, was entered on June 8, 2015. The court also entered a judgment of no cause of action as to Dr. Chu on the same date.

Plaintiffs appealed. Nurse Kaczmarski cross-appealed from the January 12, 2015 order denying summary judgment. Dr. Chu cross-appealed from the trial court's May 11, 2015 in limine ruling to deny her motion to dismiss plaintiffs' negligent infliction of emotional distress claim.

II.

Among the many arguments plaintiffs advance in support of reversal and a new trial, none are more significant or compelling than their contention that the jury instructions and corresponding verdict sheet were severely flawed in several respects.

In particular, plaintiffs contend the jury charge contained an improper and confusing mixture of passages on liability, proximate causation, and superseding intervening cause, while at the same time prejudicially confining a Scafidi "increased risk"

instruction only to defendant Dr. Chu's conduct. The instructions also included what plaintiffs characterize as a vague and insufficiently tailored "medical judgment" charge as to Dr. Chu. These flawed instructions on the law were accompanied by an "equally problematic" verdict form. Plaintiffs maintain these errors produced a confounding and legally-inconsistent series of juror responses on the verdict form, and an unsustainable verdict. We agree, albeit based upon a slightly different analysis.

The verdict form the court created and used in this case,[7] consisted of the following queries and yielded the following juror votes with respect to the liability issues:

JURY INTERROGATORIES

> 1. Have the Plaintiffs proven by the preponderance of the evidence that Kourtney Kaczmarski, RN deviated from accepted standards of nursing practice?
>
> Yes ✓ If your answer is "Yes", proceed to Question 2.
>
> No _____ If your answer is "No", proceed to Question 5.
>
> Vote 8-0
>
> 2. Have the Plaintiffs proven that Ms. Kaczmarski's deviation from accepted standards of nursing practice was a proximate cause of some of the plaintiff's injury?

[7] We were advised at oral argument by plaintiffs' counsel that she did not see the form of the verdict sheet until the day it was issued.

Yes _✓___ If your answer is "Yes", proceed to Question 3.

No _____ If your answer is "No", proceed to Question 5.

Vote 8-0

3. Have the Plaintiffs proven that Ms. Kaczmarski's deviation from accepted standards of nursing practice was a substantial factor in causing the Plaintiff's ultimate injury?

Yes _✓___ No _____ Vote 7-1

If your answer is "Yes", proceed to Question 4.
If your answer is "No", proceed to Question 5.

4. Has Kourtney Kaczmarski proven that Dr. Bentolila's acts and/or omissions destroyed the connection between Ms. Kaczmarski's deviation from accepted standards of nursing care and the plaintiff's ultimate injury?

Yes _✓___ No _____ Vote 8-0

Proceed to Question 5.

5. Have the Plaintiffs proven by the preponderance of the evidence that Yie-Hsien Chu, MD deviated from accepted standards of medical practice?

Yes _____ If your answer is "Yes", proceed to Question 6.

No _✓___ If your answer is "No", and your answer to 1, 2 **or** 3 was "No", or your answer to 4 was "Yes", stop and return your verdict.

If your answer to 1, 2 and 3 was "Yes" and your answer to 4 was "No", proceed to Question 10.

Vote 7-1

6. Have the Plaintiffs proven that Dr. Chu's deviation from accepted standards of medical practice increased the risk of harm posed by the Plaintiff's pre-existing condition at birth?

Yes _____ If your answer is "Yes", proceed to Question 7.

No _____ If your answer is "No", and your answer to 1, 2 or 3 was "No", or your answer to 4 was "Yes", stop and return your verdict. If your answer to 1, 2 **and** 3 was "Yes" and your answer to 4 was "No", proceed to Question 10.

Vote _____

7. Was the increased risk of harm a substantial factor in causing the Plaintiff's ultimate injury?

Yes _____ If your answer is "Yes", proceed to Question 8.

No _____ If your answer is "No", and your answer to 1, 2 **or** 3 was "No", or your answer to 4 was "Yes", stop and return your verdict. If your answer to 1, 2 and 3 was "Yes" and your answer to 4 was "No", proceed to Question 10.

Vote _____

8. Has Dr. Chu met her burden of proving that some portion of the ultimate injury was a result of the pre-existing condition?

Yes _____ If your answer is "Yes", proceed to Question 9.

No _____ If your answer is "No", proceed to Question 10.

Vote _____

9. State in percentages, what portion of the ultimate injury is a result from:

A. The pre-existing condition _____% (Only answer if answer to Question 8 was "Yes")

B. Yie-Hsien Chu, MD's deviation from the accepted standard of medical practice _____%

Total _____100___%

The total must equal 100%.

Vote _____

Proceed to Question 10.

10. Has a defendant(s) proven by the preponderance of the evidence that Eric Bentolila, MD deviated from accepted standards of medical practice?

Yes _____ If your answer is "Yes", proceed to Question 11.

No _____ If your answer is "No", and your answer to 3 was "Yes", and your answer to 4 was "No", and, your answer to 7 was "Yes", proceed to Question 12. If the answer is "No", **and** your answer to 3 was "Yes", 4 was "No" **or** your answer to 7 was "Yes", proceed to Question 13.

Vote _____

11. Has a Defendant(s) proven that Dr. Bentolila's deviation from accepted standards of medical practice was a proximate cause of the plaintiff's injury?

Yes _____ If your answer is "Yes", proceed to Question 12.

No _____ If your answer is "No", and your answer to 3 was "Yes", and your answer to 4 was "No", and, your answer to 7 was "Yes", proceed to Question 12. If the answer is "No", and your answer to 3 was "Yes", 4 was "No" **or** your answer to 7 was "Yes", proceed to Question 13.

Vote _____

12. State in percentages, what portion of the ultimate injury is a result of:

A. Kourtney Kaczmarski, RN's deviation from the accepted standard of nursing practice _____%

B. Yie-Hsien Chu, MD's deviation from the accepted standard of medical practice _____%

C. Eric Bentolila, MD's deviation from the accepted standard of medical practice _____%

Total _____100___%

The total must equal 100%. Only assign a percentage to Nurse Kaczmarski if you answered "Yes" to Question 3 and "No" to Question 4; only assign a percentage to Dr. Chu if you answered "Yes" to Question 7; only assign a percentage to Dr. Bentolila if you answered "Yes" to Question 11.

[Remainder of verdict form relating to damages issues omitted].

As we will now demonstrate, this series of queries on the verdict form was confusing, incomplete, and improperly sequenced. In fact, the jurors found it necessary to request clarification of the critical concepts of proximate cause and substantial factors during their deliberations.

It is well-established that appropriate instructions to a jury concerning the applicable law are "essential" for a fair trial. Wade v. Kessler Inst., 172 N.J. 327, 341 (2002); see also Henebema v. S. Jersey Transp. Auth., 430 N.J. Super. 485, 501 (App. Div. 2013), aff'd 219 N.J. 481 (2014). The instruction should correctly state the law in understandable language. Jurman v. Samuel Braen, Inc., 47 N.J. 586, 591-92 (1966). A jury charge and a verdict sheet should not confuse or mislead the jury. Maleki v. Atl. Gastroenterology Assocs., PA, 407 N.J. Super. 123, 128 (App. Div. 2009).

Although there are some variations, traditional negligence elements, or their analogs, largely apply in a medical malpractice case. Verdicchio v. Ricca, 179 N.J. 1, 23 (2004). A plaintiff in such cases must prove: (1) the applicable standard of care, (2) breach of that standard, and (3) that the breach proximately caused the injury. Ibid.

In a more routine malpractice case in which the plaintiff's injury can be traced to a single cause, the traditional "but for" test, i.e., assessing whether the injury would not have occurred but for the wrongful act, applies to the question of causation. Ibid. However, the "but for" test can be unsuitable where one or more actions "operate to bring about a certain result, and any one of them operating alone would be sufficient." Id. at 24 (citation omitted). For such contexts, our courts have adopted an alternate "substantial factor" test. Ibid. Under this different legal test of causation in a medical malpractice case, the fact-finder must decide whether the "defendant's deviation . . . increased a patient's risk of harm, or diminished the chance of survival, and whether such an increased risk was a substantial factor in producing the ultimate harm." Ibid. (citation omitted).

The substantial-factor test, as applied in the context of medical malpractice actions, was refined in Evers v. Dollinger, 95 N.J. 399 (1984). In Evers, the Supreme Court held that when there is evidence that a defendant's negligent act or omission increased the risk of harm to the plaintiff, and that the harm was sustained, it becomes a question for the jury as to whether or not that increased risk was a substantial factor in producing the ultimate result. Id. at 414-15.

Thereafter, in Scafidi, 119 N.J. at 108, the Court applied

this test to circumstances where a patient was treated for a preexisting condition, (i.e., premature labor), and a physician's negligence allegedly worsened that condition. The Court recognized that, in such a situation, it may be difficult to identify and prove the precise injury caused solely by the physician. Ibid. As the Court explained:

> Because the modified standard of proximate causation is limited to that class of cases in which a defendant's negligence combines with a preexistent condition to cause harm . . . the jury is first asked to verify, as a reasonable medical probability, that the deviation . . . increased the risk of harm from the preexistent condition. Assuming that the jury determines that deviation increased the risk of harm from the preexistent condition, we [then] use the "substantial factor" test of causation . . . .
>
> [Id. at 108-09 (citations omitted) (emphasis added).]

Thus, a typical Scafidi situation involves a plaintiff who sought treatment for a preexisting condition, and a defendant physician, through negligence, allegedly either failed to diagnose or improperly treated the condition, causing it to worsen. Komlodi v. Picciano, 217 N.J. 387, 415 (2014). Such a "preexistent condition or disease is one that has become sufficiently associated with a plaintiff prior to the defendant's negligent conduct . . . ." Anderson v. Piciotti, 144 N.J. 195, 211 (1996) (citation omitted).

Once a jury determines that a plaintiff has satisfied these inquiries about increased risks and substantial factors, it must next apportion damages. Reynolds v. Gonzalez, 172 N.J. 266, 283 (2002). Although the Scafidi model jury charge was devised generally for the benefit of plaintiffs (because it is the defendant who allegedly effectively deprived the plaintiff of a greater chance to survive or avoid deterioration), in some cases a defendant may seek the Scafidi charge in order to ensure a proper apportionment of damages. Anderson, 144 N.J. at 211.

Generally speaking, without evidence of a preexisting condition, a Scafidi charge is inappropriate. In many Scafidi-type cases, the existence or identity of a preexisting condition is readily apparent and undisputed. Even so, where the condition is not so apparent prior to the defendant's alleged deviation, that does not automatically preclude "a Scafidi charge on the one hand, nor mandate[] a straight proximate cause instruction on the other." Gonzalez v. Silver, 407 N.J. Super. 576, 590 (App. Div. 2009). In addition, the charge tends to be applied in cases with complicated fact patterns. See Anderson, 144 N.J. at 207 (citing the "complicated claims" in Evers and Scafidi).

At least two potential preexisting conditions were involved in the chronology of events. First, at some point between Dr. Bentolila's examinations of Mrs. Applegrad on May 25 and May 26,

the baby, who apparently had been in a vertex position, moved into a breech position. According to plaintiff's experts and their theories of the case, this fetal position made a vaginal delivery more complicated, and should have alerted defendants to exercise greater precautions in the hours leading up to the birth. Second, the ongoing hypoxia likewise was a preexisting condition that arguably required different measures to assure a successful delivery. There is evidence both of these preexisting conditions were manifest before Dr. Bentolila delivered the child.

As we have already noted, according to plaintiffs' experts, Nurse Kaczmarski deviated from the standards of care and increased the risks of harm to the baby in several ways. These alleged deviations included the nurse's failure to report sufficient information about the baby's status sooner to Dr. Bentolila. As plaintiffs argue, if the nurse had done so, Dr. Bentolila might have returned to the Hospital earlier to deliver the child, might not have ordered Pitocin to be administered to promote contractions, and might not have tried a risky vaginal delivery and instead proceeded with a C-section. We agree this is an appropriate context for a Scafidi charge to be issued on enhanced risk. The charge should have been given with respect to Nurse Kaczmarski's liability and not confined to Dr. Chu.

We further agree with plaintiffs that the court erred in

having the jury consider principles of superseding cause in the manner presented on the verdict form. A superseding or intervening act is one that breaks the chain of causation linking a defendant's wrongful act and the harm suffered by a plaintiff. Komlodi, 217 N.J. at 418 (citation omitted). Such an act is essentially the immediate or sole cause of the injury or harm. Ibid. "Therefore, if in looking back from the harm and tracing the sequence of events by which it was produced, it is found that a superseding cause has operated, there is no need of determining whether the actor's antecedent conduct was or was not a substantial factor in bringing about the harm." Restatement (Second) of Torts § 440 cmt. b (Am. Law Inst. 1965) (emphasis added).

Case law on issues of superseding cause generally focuses upon whether the intervening cause was "so closely connected with the defendant's negligent conduct" that the defendant's responsibility should not be terminated. Lynch v. Scheininger, 162 N.J. 209, 227 (2000). That inquiry looks to whether the intervening cause was sufficiently foreseeable. Ibid. The factors to be considered in that inquiry typically include:

> (a) the fact that its intervention brings about harm different in kind from that which would otherwise have resulted from the actor's negligence;
>
> (b) the fact that its operation or the consequences thereof appear after the event

> to be extraordinary rather than normal in view of the circumstances existing at the time of the operation;
>
> (c) the fact that the intervening force is operating independently of any situation created by the actor's negligence, or, on the other hand, is or is not a normal result of such a situation;
>
> (d) the fact that the operation of the intervening force is due to a third person's act or to his failure to act;
>
> (e) the fact that the intervening force is due to an act of a third person which is wrongful toward the other and as such subjects the third person to liability to him;
>
> (f) the degree of culpability of a wrongful act of a third person which sets the intervening force in motion.
>
> [Restatement (Second) of Torts § 442 (Am. Law Inst. 1965).]

The failure of a third party to act to prevent harm threatened to another by an actor's negligent conduct is not a superseding cause unless, because of the lapse of time or otherwise, the actor's negligent conduct is found to have shifted from the actor to a third party. Restatement (Second) of Torts § 452 (Am. Law Inst. 1965). Thus, ordinarily, if the third person "is under a duty to the other to take such action, his failure to do so will subject him to liability for his own negligence . . . but his failure to perform his duty does not relieve the original actor of liability for the results of his own negligence." Id. at cmt.

b. However, in "exceptional cases," a court may find that the entire duty and responsibility for the prevention of harm has passed to a third person as a superseding cause:

> Various factors will enter into it. Among them are the degree of danger and the magnitude of the risk of harm, the character and position of the third person who is to take responsibility, his knowledge of the danger and the likelihood that he will or will not exercise proper care, . . . the lapse of time, and perhaps other considerations. The most that can be stated here is that when by reason of the interplay of such factors, the court finds that full responsibility for control of the situation and prevention of the threatened harm has passed to the third person, his failure to act is then a superseding cause, which will relieve the original actor of liability.
>
> [Id. at cmt. f (emphasis added).]

These principles of superseding cause were illuminated and applied by the Supreme Court in Komlodi, 217 N.J. at 413. In that case, a physician was accused of malpractice for prescribing a narcotic patch, to a patient whom she knew abused alcohol and drugs. Id. at 393. The patient had orally ingested the patch, causing permanent brain damage. Id. at 394. The Court held that the trial judge erred by giving a Scafidi charge in conjunction with a superseding cause charge, because the two charges, as presented, "became blurred. . . ." Id. at 413-15. The Court also held that the Scafidi charge and the verdict form failed to give

the jury sufficient guidance. Id. at 416. Therefore, the Court reversed the verdict in favor of the defendant and remanded for a new trial and proper instructions on both the concepts of enhanced risk of harm and superseding cause. Id. at 417-20.

The present case likewise is one in which the verdict sheet critically "blurred" the concept of a superseding cause with other key concepts relating to causation. The result was a jury verdict that is hopelessly inconsistent.

Specifically, on Question 2 of the verdict sheet, the jury found that Nurse Kaczmarski's negligent conduct was a "proximate cause" in producing at least some of C.A.'s post-birth injuries. Then, in Question 3, the jury found that the nurse's deviation from standards of care was a "substantial factor" in causing those injuries to C.A. But then, inexplicably, in Question 4 the jurors further concluded that Dr. Bentolila's actions "destroyed the connection" between Nurse Kaczmarski's deviations and the baby's ultimate injuries.

If, as the jurors found in Question 4, Nurse Kaczmarski's casual connection was "destroyed" by an intervening force, i.e., Dr. Bentolila, then the nurse logically could not have been a "substantial" factor in producing the harm to the child. The jury's two divergent findings in Questions 3 and 4 cancel out one another. The superseding cause, by its very nature, renders all

other causes insubstantial. See Restatement (Second) of Torts § 440 cmt. b (Am. Law Inst. 1965).

In fact, the model civil jury charge for superseding cause, which the court read in this case, states that if such a superseding cause is proven, then the defendant's conduct "was not a contributing factor to the accident/incident/event or injury/loss/harm." Model Jury Charges (Civil), 6.14, "Proximate Cause – Where There is Claim of Intervening or Superseding Cause for Jury's Consideration" (approved Aug. 1999) (emphasis added). The Model Charge also states that "[t]o be an intervening cause the independent act must be the immediate and sole cause of the accident/incident/event or injury/loss/harm." Ibid. (emphasis added). The jury in this case easily could have been confused by this, as shown by their simultaneous and inconsistent findings that Nurse Kaczmarski was a "substantial factor" in producing the harm to C.A. and that Dr. Bentolila's conduct was a superseding (i.e., the "sole") cause.

The court failed to explain the inter-relationship of these critical concepts of causation adequately to the jury. The failure was compounded by the improvident manner in which the verdict sheet was sequenced and structured, with the jurors being improperly allowed to consider whether Dr. Bentolila was a superseding cause after they had already concluded that Nurse

Kaczmarski's negligence was a substantial factor in producing the harm. They should not have been allowed to decide the "substantial factor" question if they had determined in their deliberations that Dr. Bentolila's conduct was totally to blame as a superseding cause. As the comment to Section 440 of the Second Restatement we have previously quoted states, there was "no need" for the jurors to address that question in this setting.

The more appropriate way to structure the verdict sheet would be to ask the jurors about whether Dr. Bentolila was a superseding cause before reaching the question of whether Nurse Kaczmarski's own deviations were a substantial factor in causing the harm. If the answer to the superseding cause query is "Yes," then the jury should not go on to consider whether the earlier negligent conduct of Nurse Kaczmarski was a substantial causal factor. Conversely, if the answer to the superseding cause inquiry is "No," then the jury should go on to consider whether Nurse Kaczmarski's deviations comprised a substantial factor in causing harm.[8] The directions on the verdict sheet used here — including which queries to skip depending on the jury's prior answers — were severely flawed.

These troublesome circumstances likely resulted in the inconsistent verdict the jury rendered. We are mindful that

[8] We realize counsel strategically might not prefer this sequence, but it is superior to the illogical sequence used here.

inconsistent verdicts are not per se intolerable in our legal system, if supportable by the evidence. State v. Banko, 182 N.J. 44, 46 (2004). Even so, a cogent evidential basis for the inconsistent verdict in this case is not manifest from the record. We cannot fathom from the evidence how Nurse Kaczmarski's proven deviation from the standard of care was a "substantial factor" in producing the harm to C.A., while, at the same time, Dr. Bentolila's deviations entirely "destroyed" that causal connection. If the causal link to Nurse Kaczmarski was completely eliminated, then that link cannot be substantial. The jury charge should have explained this interplay and the verdict form directions should have avoided this inconsistent outcome. They did not. See Neno v. Clinton, 167 N.J. 573, 589 (1999) (noting how a proper jury charge on causation at a retrial would be likely to prevent repetition of the inconsistent verdict reached at the first trial).

The court further erred in issuing a "medical judgment" charge with respect to Dr. Chu's actions without a detailed instruction "tailored" to the facts and co-theories of liability. To be sure, Dr. Chu's decisions about when to call a code, when to administer the PPV, when to administer epinephrine, and whether to use a suction catheter versus a meconium aspirator were all proper subjects of such a judgment charge. Das v. Thani, 171 N.J. 518,

527 (2002). Critically, however, the relevant segment of the charge contained only a vague, generic reference to Dr. Chu's medical judgment, alluding merely to "the delivery and or resuscitation" of C.A. Case law makes clear that a more specific charge tailored to the case was essential. See, e.g., Velazquez v. Portadin, 163 N.J. 677, 689 (2000); Das, 171 N.J. at 528-29.

The charge and verdict sheet defects in this case were not harmless. Such fundamental defects in how the jury was guided to apply the law are "poor candidates" to be rehabilitated under a harmless error theory. Ewing v. Burke, 316 N.J. Super. 287, 293 (App. Div. 1998).

For these reasons, we must vacate the verdict and order a new trial, at which appropriate instructions and verdict sheet should be provided, consistent with our opinion.

III.

Another compelling basis for setting aside the verdict stems from the circumstances surrounding Dr. Bentolila's invocation of his privilege against self-incrimination and his refusal to testify at trial about certain key subjects and events. Plaintiffs argue the trial court erred in advising Dr. Bentolila, sua sponte, of his right against self-incrimination, and in requiring that Dr. Bentolila exercise that right over their objection in front of the jury. Plaintiffs further contend the adverse inference charge

given by the court was insufficient to eliminate the prejudice they suffered as a result of Dr. Bentolila's exercise of privilege because the court stressed to the jury that it was illegal in New Jersey to destroy a medical record.

Here is the pertinent sequence of events. As we have already noted, Dr. Bentolila settled with plaintiffs long before trial. During the discovery period he was deposed.

Plaintiffs did not call Dr. Bentolila in their case in chief, but called him on rebuttal to challenge Dr. Small's expert testimony for the defense. At that point, the court was advised by defense counsel that Dr. Bentolila's destruction of his original May 26 medical order might constitute a fourth-degree criminal offense. In response, the court determined that it had an obligation to advise Dr. Bentolila of his potential criminal exposure and also to report his conduct to the County Prosecutor's Office.

The following day, Dr. Bentolila appeared with a civil attorney. Rather than allow Dr. Bentolila to testify without a warning, the court determined to inform him that he could be exposing himself to prosecution if he testified. In addition, the court told Dr. Bentolila that it was bound to report his conduct to the Prosecutor's Office. The court declined to address the statute of limitations, which plaintiffs claimed had expired with

respect to Dr. Bentolila's alleged criminal offense.

Having been warned by the court, Dr. Bentolila sought guidance from a criminal attorney, who advised him to assert his Fifth Amendment rights. The criminal attorney advised the court that Dr. Bentolila would assert those rights unless there was a judicial determination that any criminal action against him was barred by the statute of limitations. The court reiterated that it would not make a determination as to the statute of limitations question unless and until the Prosecutor's Office weighed in. The court also tentatively determined that it would require Dr. Bentolila to invoke the privilege in open court in front of the jury.

The court regarded Dr. Bentolila's culpability as a critical issue for the jury. The court found that his admission that he had destroyed the original medical record "overwhelmingly demonstrate[d] a consciousness of wrongdoing on his part." Accordingly, the court ruled that Dr. Bentolila could be called to the stand to testify, but also that he could invoke the Fifth Amendment. The court added: "[H]e will be required if he is taking the Fifth, to do it in the presence of the [j]ury so that the [j]ury doesn't speculate as to why the [d]efense spent so much time on this issue [in their openings] and then never asked him."

During Dr. Bentolila's brief ensuing testimony, plaintiffs' counsel asked him, "Now, if I were to ask you some questions about

what happened on May 26th, 2007, would you be comfortable answering those questions?" Dr. Bentolila responded, "With the advice of my counselor, I would like to use the Fifth Amendment . . . and not answer any question about it." The court then inquired of Dr. Bentolila whether, should anyone ask him any questions "related to what you may have done or not done, thought about, any of your involvement with the birth of [C.A.] on May 26th, 2007, anything related to the events of May 26th, 2007, you would rely upon your Fifth Amendment right based on the advice of your lawyer and not answer any of those questions?" Dr. Bentolila responded affirmatively, and the direct examination abruptly ended.

At the conclusion of Dr. Bentolila's testimony, the court issued this limiting instruction to the jury:

> All witnesses in any case here in the United States have the right to assert the privilege against self-incrimination protected by the Fifth Amendment to the United States Constitution. All citizens are afforded constitutional rights, and they are permitted to rely upon those and exercise those rights.
>
> Here, Dr. Bentolila has chosen to rely upon his Fifth Amendment right against self-incrimination. He has every right to do so. Had he testified without resorting to his Fifth Amendment rights, I believe he would have been asked many, many questions. But because he is relying on his Fifth Amendment rights as to any questions related to his treatment of Mrs. Applegrad on May 26, 2007, up until and following the delivery and birth of [C.A.], I decided to only have him answer

> and invoke the Fifth Amendment related to a few questions, as opposed to all of the potential questions he could have been asked by the various attorneys.
>
> Because he is relying on a constitutional right, which everyone has, I instruct you that you are not to draw a negative or adverse inference from his exercise of that right. You may consider, however, all the testimony from other witnesses and all of the evidence in the case, as well as all inferences that flow from that evidence regarding what Dr. Bentolila did or did not do regarding this incident.

The court revised these instructions in its final charge to the jury, stating:

> You may consider all the testimony from other witnesses and all the evidence in this case, as well as all inferences that flow from that evidence regarding what Dr. Bentolila did or did not do regarding the incident, although you may not draw an adverse or negative inference as to Dr. Bentolila or his credibility based on the fact that he relied on the Fifth Amendment and would not respond to questions about whether or not he altered the medical records[. Y]ou may, if you choose to, draw a negative inference that his actions demonstrate his belief that the original record would create liability for him in this matter, and you may consider his actions with regard to the records in assessing his credibility.

Additionally, the court issued the jury the following instruction concerning the destruction of the medical record:

> Physicians have a duty to ensure that all treatment records accurately reflect the treatment of services rendered. Corrections

> or changes to entries may be made only where the change is clearly identified as such, dated and initialed by the person making the change. In fact, it is illegal in this state to alter medical records with the intent to deceive or mislead anyone.
>
> In this case you heard that Dr. Bentolila altered his records in the following manner. It is alleged that he wrote an original order, and that after [C.A.] was born he removed the original and rewrote it, placing the original in a shred box.
>
> The alteration of medical records is admissible as evidence of a defendant's own belief that the original record would create liability for him. If you find that Dr. Bentolila removed and rewrote a record, or altered the medical records with the intent to deceive or mislead anyone, you may infer that the alteration of the records in this case occurred because Dr. Bentolila believed the original record would have been unfavorable in the trial of this matter to him . . . . You can draw an adverse inference against him if you choose to do so.

As it had planned, the trial court wrote to the Bergen County Prosecutor that Dr. Bentolila had allegedly destroyed a portion of a patient's medical chart.[9]

In a criminal context, the Supreme Court has strongly discouraged New Jersey courts from warning witnesses of their privilege against self-incrimination to the detriment of a defendant's due process rights, because doing that can effectively

[9] There is no indication in this record of any action taken by the prosecutor, other than an acknowledgment of receiving the court's letter.

"drive" the witness off the stand. State v. Feaster, 184 N.J. 235, 255 n.6 (2005). We have similarly cautioned trial judges from doing so in the civil context. "A trial court has no obligation to warn even a potential witness who is not represented by counsel that his or her testimony may be self-incriminating." All Modes Transport, Inc. v. Hecksteden, 389 N.J. Super. 462, 470 (App. Div. 2006) (citation omitted). Rather, the proper course is to leave the matter of suspicion of criminality for attention at the conclusion of the case. Ibid. It is at that point the trial court "must undertake the responsibility of determining whether a witness's testimony should be referred to the appropriate prosecuting authority." Ibid.

In All Modes, we held the trial court had erred in interrupting the defendant's testimony to warn him that the court would be compelled to refer the matter to the prosecutor if his cross-examination revealed substantial evidence of tax fraud. Id. at 469-70. As Judge Skillman wrote:

> [T]he trial court's apparent view that it had an obligation to warn [the defendant] that continuation of his cross-examination could result in him incriminating himself was mistaken . . . .
>
> . . . .
>
> It is even clearer in this case than in a case involving a non-party witness who is not represented by counsel that the trial

> court had no obligation to interrupt [the] cross-examination.
>
> [Id. at 470-71.]

Here, Dr. Bentolila was originally a party. But after he settled, he took on the status of a non-party witness. Hence, our case law — establishing that a trial court has no obligation to warn a witness his or her testimony may be incriminating — controls. The trial court here was under the misimpression that it had such a duty. By taking the actions it took before the case concluded, the court "effectively drove" Dr. Bentolila "off the stand . . . ." Webb v. Texas, 409 U.S. 95, 98 (1972).

We appreciate the trial court's legitimate concerns about Dr. Bentolila, perhaps unwittingly, providing trial testimony that could have incriminated him. The court took pro-active steps to prevent that from occurring, and in doing so attempted to carry out what it regarded as its ethical and legal obligation. We respect its vigilance. However, the law imposes no such obligation to take the prophylactic measures the court took.

As the process unfolded, plaintiffs were clearly prejudiced by the court's preemptive warning, which curtailed their ability to elicit Dr. Bentolila's testimony about his May 26 conduct. Not only were they unable to respond to the evidence of the destroyed medical order, they also were unable to establish from the doctor

other evidence, such as whether he examined the fetal position when he first saw Mrs. Applegrad that morning; what he contends Nurse Kaczmarski said to him in their phone conversations; and how his actions from 6:15 p.m. until C.A.'s delivery were impacted by his communications with the nurse.

Plaintiffs also were prejudiced by defense counsel highlighting Dr. Bentolila's destruction of the medical order in their closings, as part of an effort to shift the blame to that settling defendant. For instance, in Dr. Chu's closing, her counsel stated with respect to Dr. Bentolila:

> You saw and heard, he attempted to destroy a medical record. Thankfully he got caught, because if he got away with it Ms. Kaczmarski had no defense to this case, none whatsoever . . . .
>
> I submit that what he did was unethical, immoral, and as Your Honor will tell you, it's also in the State of New Jersey illegal.

Similarly, Nurse Kaczmarski's attorney stated in his closing regarding Dr. Bentolila:

> He went and took the record out of the chart, tore it up, substituted a false record, and then the plaintiffs bring him in to testify and Dr. Bentolila . . . takes the Fifth Amendment, and refuses to tell us anything about that day. That evidence in terms of destroying of the medical record is evidence of Dr. Bentolila being aware of the issues concerning his guilt.

We recognize that similar consequences might have ensued if the trial court never intervened at all and Dr. Bentolila, with the advice of an attorney, had invoked the Fifth Amendment on his own. Even so, the trial court's well-intentioned actions materially altered the adversarial balance, to the detriment of plaintiffs. Moreover, by having Dr. Bentolila invoke his Fifth Amendment rights in front of the jurors, and then issuing a stern instruction in the jury charge about the illegality of destroying medical records, the dramatic impact was magnified.[10]

We realize these events occurred extemporaneously in the midst of a lengthy and complex trial with multiple issues, claims, and attorneys. The court attempted, as best it could, to respond to the situation in an ad hoc manner. However, the court's mistaken assumption that it had an obligation to advise Dr. Bentolila of his Fifth Amendment rights and to report him to authorities triggered a chain of events that manifestly prejudiced

[10] That said, we discern no harm to plaintiffs in the court's issuance of the adverse-inference instruction, given Dr. Bentolila's decision to invoke the privilege. An adverse inference instruction is optional in a civil case where a witness invokes the self-incrimination privilege. Baxter v. Palmigiano, 425 U.S. 308, 318 (1976); Mahne v. Mahne, 66 N.J. 53, 60 (1974). Moreover, the trial court limited the permissible adverse inference to Dr. Bentolila's destruction of the medical order and did not allow the inference to extend to his assertion of the privilege. We reject plaintiffs' claim of error on this discrete point.

plaintiffs. That unfortunately stifled their ability to explore critical factual matters through Dr. Bentolila's otherwise-anticipated testimony.

On remand at a new trial, the court and counsel should confer in advance to develop appropriate procedures to deal with Dr. Bentolila's potential testimony and any renewed invocation of privilege he might assert. Among other things, the court and counsel should attempt to prevent or minimize the prospect of Dr. Bentolila invoking a privilege in front of the jurors.[11] Counsel and the court are encouraged to agree in advance to a "script" delineating what the jurors are told about the subject. The propriety and content of a "records destruction" charge should also be reexamined, depending on whether the doctor reasserts a privilege.

In addition, the proper topical scope of the privilege warrants further consideration. It is not obvious, for example, whether Dr. Bentolila's privilege not to testify about the shredding incident at the time of C.A.'s delivery should extend broadly to the other events that preceded the incident — such as

[11] We decline to resolve the parties' arguments about whether the criminal statute-of-limitations has lapsed or, conversely, been tolled for a "continuing wrong," particularly in the absence of the State. That issue can be reconsidered, if necessary, on remand, ideally with the State's participation.

the communications he had with Nurse Kaczmarski earlier in the day, and the medical care provided before the baby was delivered. These scope questions are reserved for the trial court to consider anew on remand.

IV.

We have considered all of the remaining issues raised in the appeal and cross-appeal. None of them warrant relief or detailed discussion here. For sake of completeness, we briefly note our conclusions regarding those issues.

A.

We reject plaintiffs' claims that the trial court improperly admitted testimony that Mrs. Applegrad suffered from chorioamnionitis, and failed to conduct a timely preliminary hearing under N.J.R.E. 104 about the admissibility of such evidence. The evidence of this preexisting medical condition was relevant under N.J.R.E. 401 to causation issues, and not substantially outweighed by countervailing admissibility factors under N.J.R.E. 403. The court did not misapply its discretion by deferring a Rule 104 hearing until the time of defense expert Dr. Mandelbaum's testimony. Kemp v. State, 174 N.J. 412, 432 (2002).

B.

The trial court did not err in the instructions it supplied to the jury concerning which claims applied to Dr. Chu, as opposed

to matters that were the responsibility of the Hospital such as the equipment provided in the delivery room. The charge was not misleading or improper, even if it was not phrased in words that plaintiffs would have preferred to track their theories against Dr. Chu. Mayles v. Wentlejewski, 337 N.J. Super. 466, 471 (App. Div. 2001).

C.

We reject Nurse Kaczmarski's argument that she was entitled to summary judgment dismissing the claims against her before trial. Viewing the records, as we must, in light most favorable to plaintiffs, genuine issues of material fact concerning her role warranted those claims proceeding to trial. Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 540 (1995). Likewise, as we are unpersuaded Nurse Kaczmarski was entitled to a directed verdict at trial, she fails to surmount the strict standards for such relief under Rule 4:40-1. Reasonable minds could — and did — differ about her potential deviations from the standards of care and her causal role. Moreover, as we have already discussed, the question of Dr. Bentolila's alleged role as a superseding cause is a hotly-disputed fact question for the jury.

D.

We do not adopt plaintiffs' position that, in the event of a retrial, the jury's determinations that Nurse Kaczmarski deviated

from accepted standards of care, and that her deviation was a substantial factor in C.A.'s injury, should be binding on a new jury. Issues in negligence cases generally should be retried together, unless the issue unaffected by the error "is entirely distinct and separable from the other issues." Ahn v. Kim, 145 N.J. 423, 434 (1996). This principle comports with the proposition that negligence and causation are generally intertwined. Ibid. In addition, we must be mindful whether the jury on retrial will be confused by having to answer questions on one issue without considering the other. See, e.g., Henebema, 219 N.J. at 492. We are satisfied that a retrial on all issues, unaffected by what the first jury concluded on a flawed verdict sheet and flawed instructions, is the appropriate course of action here.

E.

We discern no need to address the remaining issues, including the proper scope of the Applegrads' claims for post-birth emotional distress damages, and the application of the collateral source rule to any damages awarded.[12] Those arguments should be renewed, if necessary, before the trial court on remand. Any other points we have not addressed do not warrant discussion. R. 2:11-

[12] In any event, it appears that defendants concede the damages must exclude sums subject to recoupment by Medicaid. See N.J.S.A. 2A:15-97. This concession and the appropriate calculations can be confirmed before the new trial.

3(e)(1)(E).

Affirmed in part, reversed in part, and remanded for a new trial.