

**MEDICAL MALPRACTICE LAW**  
**Fall Semester - 2009**

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**Course Description and Objectives:**

The goal of this course is threefold. First, each student should gain a comprehensive knowledge of medical malpractice law. Second, each student should gain a comprehensive understanding of the role that expert witnesses play in complex civil litigation. Finally, it is my intent to at least introduce each student with the practice and procedure for taking the depositions of both parties and experts in complex litigation.

The first goal is the easiest. Medical malpractice law is not a complex field of law, and the only difficult issue is proximate causation. However, medical malpractice law provides an excellent vehicle upon which to broaden one's understanding of both tort and trial law, along with practice and procedure.

The second goal is extremely important, and goes well beyond any particular body of law. Medical malpractice law, like most complex civil litigation, is all about expert witnesses. Gaining a comprehensive understanding of the law of expert witnesses is essential for anyone who wishes to become a trial lawyer. Medical malpractice law presents many opportunities to study the use of expert testimony, and we will explore the nuances of the issues that arise in such cases.

Finally, in addition to understanding how expert witnesses are used in these cases, I believe that it will be very helpful for each student to understand the practice and procedure for taking the depositions of both parties and experts in complex litigation. This is also a critical skill for every trial lawyer, and malpractice cases provide ample opportunity to develop this skill.

The curriculum is ambitious. I will make adjustments as is necessary and fair so as to avoid imposing an undue burden on the class. However, I believe that this course will provide a substantial amount of practical knowledge which will be of great value throughout your careers if you give this the appropriate effort.

**Class schedule and Attendance:**

All classes will meet on Tuesday nights at 6:05 p.m. in room 272. The nature of this course is such that attendance is essential to achieving a comprehensive understanding of subject matter. Therefore, attendance will be mandatory. Students who miss a class will be asked to make up the class at a mutually convenient time.

**Required Text and Materials:**

We will be using "*New Jersey Medical Malpractice Law*", (New Jersey Institute of Continuing Legal Education-4th Ed. 2009). **I WILL EMAIL A COPY OF THIS BOOK TO ALL STUDENTS, AND THERE IS NO NEED TO BUY A COPY OF THE BOOK.** **However, please do not share this book with anyone, as it will cause problems with my publisher.**

We will also use numerous articles and other materials, which I will also email to all students. Finally, we will use the records and depositions from several actual cases that I litigated to a conclusion. I will also provide electronic copies of these documents.

**Grading:**

The grading shall be as follows:

100% of the final grade will be based on the final exam.

I reserve the right to use discretion to raise a student's grade, as permitted by the rules governing grading at the law school.

**Office Hours:**

I will usually be available for consultation after class. I can be reached at my office Bendit Weinstock, 80 Main St., west Orange, N.J. 07052, 973-736-9800; fax 973-325-3115; email abrown@benditweinstock.com. Office hours are by appointment at any mutually convenient time.

I look forward to meeting all of you.

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**MEDICAL MALPRACTICE LAW**  
**Course Syllabus:**

**August 25, 2009: Week One: The Nature of Medical Malpractice**

**Topics:**

- A. Introduction to medical malpractice law
- B. Introduction to public policy issues
- C. The duty of care
- D. The standard of care
- E. Medical judgment

**Reading:**

***New Jersey Medical Malpractice Law***

[Sec. 1] The Generally Accepted Standard of Care

[Sec. 2] The Role of the Physician's Judgment

[Sec. 3] Personal Standards Distinguished

***Model Jury Charge*** 5.50A, Duty and negligence

***Model Jury Charge*** 5.50G, Medical Judgment

**September 1, 2009: Week Two: The Nature of Medical Malpractice**

**[continued]**

**Topics:**

A: Review of prior materials.

B. The duty of care of secondary medical providers

B: Miscellaneous duties

**Reading:**

***New Jersey Medical Malpractice Law,***

[Sec. 4] The Duty of the Examining or Consulting Physician

[Sec. 5] The Duty of a Specialist

[Sec. 6] The Standard of Care for a Hospital Resident Physician

[Sec. 9] The Duty of a Credentialer

[Sec. 10] The Duty of an Employer

[Sec. 15] Duty of the Emergency Department

[Sec. 18] The Duty of Confidentiality

[Sec. 20] The Duty to Keep Psychiatric Records Confidential

[Sec. 21] The Duty to Provide Genetic Counseling

[Sec. 22] The Duty Regarding Treatment of a Body

[Sec. 23] The Duty to the Elderly and Infirm Patient

[Sec. 24] The Duty to a Suicidal Patient

[Sec. 27] The Duty to Testify or Provide Litigation Support

[Sec. 28] The Duty to Maintain Insurance

## **September 8, 2009 Week Three: Informed Choice, Consent and Refusal**

### **Topics:**

A: Informed Choice, Consent and Refusal

**Reading:** *New Jersey Medical Malpractice Law,*

[Sec. 29] The Fully-Informed Patient

[Sec. 30] The Doctrine of Informed Consent and Refusal

[Sec. 31] The Reasonable Patient Standard

[Sec. 32] The Duty to Advise a Patient of Test Results

[Sec. 35] Proximate Causation in Informed Consent Cases

[Sec. 36] The Statute of Limitations in the Informed Consent Case

[Sec. 52] Expert Testimony in Informed Consent Cases

**Model Jury Charge** 5:50C, Informed Choice and Consent (Competent Adult and No Emergency)

## **September 15, 2009: Week Four: Miscellaneous Causes of Action**

### **Topics:**

A: Miscellaneous Causes of Action

B: Course review

### **Reading:**

*New Jersey Medical Malpractice Law,*

[Sec. 37] Strict Liability in Tort

[Sec. 38] Abandonment

[Sec. 42] The Mishandling of a Corpse

[Sec. 43] The Unauthorized Autopsy

[Sec. 45] Alteration or Destruction of Medical Records

[Sec. 46] Sexual Misconduct

**Model Jury Charge** 5:50H Medical Negligence. Alteration of Medical Records<sup>4</sup>

**Model Jury Charge** 5:50I Fraudulent Concealment of Medical Records

## **September 22, 2009: Week Five: The Requirement of Expert Testimony**

### **Topics:**

A. The Requirement of Expert Testimony

B. Res Ipsa

C. Common Knowledge

D. The *Anderson v. Somberg* Doctrine

### **Reading:**

*New Jersey Medical Malpractice Law,*

[Sec. 47] The Requirement of Expert Testimony

[Sec. 48] Expert Testimony in Malpractice Cases

[Sec. 49] Res Ipsa Loquitur

[Sec. 50] The Common Knowledge Doctrine

[Sec. 51] The *Anderson v. Somberg* Doctrine

**September 29, 2009: Week Six: The Requirement of Expert Testimony  
[Continued]**

**Topics:**

- A. The Qualification of The Expert Witness
- B. The Foundation for Expert Witness Testimony and Net Opinion
- C. The Requirements of The Expert Report
- D. The Affidavit of Merit

**Reading:**

*New Jersey Medical Malpractice Law,*

[Sec. 53] The Qualification of the Expert Witness

[Sec. 54] The Foundation for Expert Testimony

[Sec. 55] The Net Opinion Rule

[Sec. 56] The Requirements of the Expert Report

[Sec. 57] The New Jersey Medical Care Access and Responsibility and Patients First Act,  
*N.J.S.A. 2A:53A-38 et seq.*

[Sec. 58] The Affidavit of Merit

**Friday October 6, 2009: Week Seven: The Requirement of Expert  
Testimony [Continued]**

- A. Miscellaneous Issues Re: Expert Witnesses, Including *Jacober*, Use of PDR, Protocols, etc.
- B: Review of the law of expert witnesses

**Reading:**

*New Jersey Medical Malpractice Law,*

[Sec. 59] The *Jacober* Rule/Learned Treatises

[Sec. 60] The Physicians' Desk Reference/Package Inserts

[Sec. 61] Hospital Protocols and Procedure Manuals

[Sec. 62] Recommendations of Professional Medical Boards or Organizations

[Sec. 63] Recommendations of the American Medical Association

[Sec. 64] Statutes and Administrative Codes

[Sec. 65] Discovery of Treatises to be Utilized as Evidence of the Standard of Care

[Sec. 66] Compelling Expert Testimony/Use of the Adversary's Expert

[Sec. 67] Refusal or Inability of an Expert to Testify

## **October 13, 2009: Week Eight: Proximate Causation**

### **Topics:**

- A. Pre-existing Condition
- B. Loss of a Chance
- C. Aggravation of a Prior Injury or Tort
- D. Pain and Suffering
- E. Avoidable Consequences
- F. Proximate Cause in Informed Consent Cases

### **Reading:**

#### ***New Jersey Medical Malpractice Law,***

[Sec. 68] Proximate Causation

[Sec. 69] Reasonable Degree of Medical Probability

[Sec. 70] Pre-Existing Condition

[Sec. 71] Loss of a Chance

[Sec. 72] Aggravation of a Prior Independent Tort

[Sec. 73] Pain and Suffering

[Sec. 74] Avoidable Consequences/Comparative Negligence

[Sec. 75] Proximate Causation in the Informed Consent Case

***Model Jury Charge*** 5.50E Medical Negligence, Pre-existing Condition - Increased Risk/loss of Chance -Proximate Cause

## **October 20, 2009: Week Nine: Damages**

### **Topics:**

- A. Damages Generally
- B. Damages in Informed Consent Cases

### **Reading:**

#### ***New Jersey Medical Malpractice Law,***

[Sec. 76] Damages in Medical Malpractice Cases

[Sec. 77] Delay in Treatment

[Sec. 78] Pain and Suffering

[Sec. 79] Hedonic Damages

[Sec. 80] Disability

[Sec. 81] Economic Loss

[Sec. 82] Medical Bills

[Sec. 83] Medical Liens

## **October 27, 2009: Week Ten: Damages [Continued]**

### **Topics:**

- A. Wrongful Birth and Life
- B: Injuries to a Fetus/preconception Injuries
- C: Loss of a Fetus
- D: Injuries to a Child
- E: Wrongful Death
- F: Wrongful Death of a Child
- G: Wrongful Birth
- H: Emotional Distress
- I: Emotional Distress of Relatives

### **Reading:**

#### ***New Jersey Medical Malpractice Law,***

- [Sec. 84] Injuries to a Fetus/Preconception Injuries
- [Sec. 85] Loss of a Fetus
- [Sec. 86] Injuries to a Child
- [Sec. 87] Wrongful Death
- [Sec. 88] Wrongful Death of a Child
- [Sec.89] Wrongful Death after a Prior Medical Malpractice Suit
- [Sec. 90] Wrongful Birth
- [Sec. 91] Emotional Distress
- [Sec. 92] Emotional Distress of Relatives
- Model Jury Charge 5.50F, Wrongful Birth or Life

## **November 3, 2009: Week Eleven: Pre-suit Investigation in Medical Malpractice Cases**

### **Topics:**

- A: Pre-suit Investigation of a Medical Malpractice Claim
- B: The Statutory and Administrative Code Regulations, Regarding Medical Records
- C: Legibility Requirements for Medical Records
- D: Incident Reports
- E: Pre-suit Investigation of Serious Preventable Adverse Events
- F: Peer Review/committee Reports
- G: Sentinel Event Reports
- H: Pre-suit Interviews of Health Care Professionals
- I: Declining a Medical Malpractice Case

## **November 3, 2009 [continued]**

### **Reading:**

#### ***New Jersey Medical Malpractice Law,***

- [Sec. 96] Pre-Suit Investigation of a Medical Malpractice Claim
- [Sec. 97] The Statutory and Administrative Code Regulations Regarding Medical Records
- [Sec. 98] Legibility Requirements for Medical Records
- [Sec. 99] Incident Reports
- [Sec. 100] The Patient Safety Act, N.J.S.A. 26:2H-12.23
- [Sec. 101] Pre-Suit Investigation of Serious Preventable Adverse Events
- [Sec. 102] Peer Review/Committee Reports
- [Sec. 103] Sentinel Event Reports
- [Sec. 104] Pre-Suit Interviews of Health Care Professionals
- [Sec. 105] Declining a Medical Malpractice Case

## **November 10, 2009: Week Twelve: The Pleadings and Defenses in Medical Malpractice Cases**

### **Topics:**

- A: The Pleadings and Defenses in Medical Malpractice Cases
- B: Comparative Negligence and Avoidable Consequences
- G: Latent Disease/recurrent Cancer and The Statute of Limitations
- H: Charitable and Other Immunities
- I: The Notice of Tort Claim
- J: Crossclaims

### **Reading:**

#### ***New Jersey Medical Malpractice Law,***

- [Sec. 106] The Pleadings and Defenses in Medical Malpractice Cases
- [Sec. 107] Parties
- [Sec. 108] Service on Absent Defendants
- [Sec. 109] Comparative Negligence and Avoidable Consequences
- [Sec. 110] Affidavit of Non-Involvement
- [Sec. 119] Charitable and Other Immunities
- [Sec. 120] Tort Claims Immunity
- [Sec. 121] The Notice of Tort Claim
- [Sec. 122] Workers' Compensation Defenses
- [Sec. 123] Lack of Jurisdiction
- [Sec. 124] Crossclaims
- [Sec. 125] Representation of Multiple Defendants
- [Sec. 126] Counterclaims by Defendants
- [Sec. 127] The Entire Controversy Doctrine
- [Sec. 128] Voir Dire in Medical Malpractice Cases

**November 17, 2009: Week Thirteen: Pleadings and Defenses in Medical Malpractice Cases [continued]**

**Topics:**

- A: The Statute of Limitations
- B: The Discovery Rule
- C: Infancy/parents' Claim for Injuries to a Child and The Statute of Limitations
- D: The Statute of Limitations for Wrongful Death

**Reading:**

- [Sec. 111] The Statute of Limitations
- [Sec. 112] The Discovery Rule
- [Sec. 113] Failure to Advise or Concealment of Malpractice and the Statute of Limitations
- [Sec. 114] Continuing Treatment and the Statute of Limitations
- [Sec. 115] Incompetency/Insanity and the Statute of Limitations
- [Sec. 116] Infancy/Parents' Claim for Injuries to a Child and the Statute of Limitations
- [Sec. 117] The Statute of Limitations for Wrongful Death
- [Sec. 118] Latent Disease/Recurrent Cancer and the Statute of Limitations

**November 24, 2009: Week Fourteen: Pre-trial Discovery in Medical Malpractice Cases**

**Topics:**

- A. Pre-trial Discovery: Interrogatories and Depositions
- B. Miscellaneous Discovery Issues; Experts; Subsequent Treating Doctors
- C: Depositions of Defendants and Expert Witnesses

**Reading:**

***New Jersey Medical Malpractice Law,***

- [Sec. 129] Pretrial Discovery in Medical Malpractice Cases
  - [Sec. 130] Priority of Discovery
  - [Sec. 131] Obtaining The Plaintiff's Medical Records, and Interviewing Plaintiff's Medical Professionals
  - [Sec. 132] Use of a Subpoena to Obtain Medical Records
  - [Sec. 133] Interrogatories
  - [Sec. 134] Production of Expert Reports
  - [Sec. 135] Use of an Adversary's Expert
  - [Sec. 136] Depositions of Parties
  - [Sec. 137] Depositions of Experts
  - [Sec. 138] Material Change in Testimony by a Witness
  - [Sec. 139] Depositions and Use of the Opinions of Treating Doctors
  - [Sec. 140] Depositions of Subsequent Treating Psychiatrists or Mental Health Care Professionals
  - [Sec. 141] Opinions in Medical Records
  - [Sec. 142] Medical Examiner's/Autopsy Reports
  - [Sec. 143] Records and Reports of the Board of Health or the Board of Medical Examiners
  - [Sec. 144] Scope of the Cross-Examination of Expert Witnesses
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## APPENDIX

### STATUTES:

***N.J.S.A. 2A:14-2* 2 years; actions for injuries to person by wrongful act**

Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this state shall be commenced within 2 years next after the cause of any such action shall have accrued.

***N.J.S.A. 2A:14-2.1* 2 years; action by parent or other person for injury to minor child; joinder with action on behalf of minor child**

Where a parent or other person has a claim for damages suffered by him because of an injury to a minor child caused by the wrongful act, neglect or default of any person within this State, an action at law upon such claim may be commenced by the said parent or other person within the same period of time as provided by law in the case of the said minor child so injured, provided that, if an action is commenced by or on behalf of the said minor child, the said claim of the parent or other person shall be asserted and maintained in such action brought on behalf of the injured minor child either as a plaintiff or third party plaintiff and if not so asserted shall be barred by the judgment in the action brought on behalf of said injured minor child.

***N.J.S.A. 2A:31-3* Limitation of actions**

Every action brought under this chapter shall be commenced within 2 years after the death of the decedent, and not thereafter.

***N.J.S.A. 2A:53A-7* Non-profit corporations and associations organized for religious, charitable, educational or hospital purposes; liability for negligence**

a. No nonprofit corporation, society or association organized exclusively for religious, charitable or educational purposes or its trustees, directors, officers, employees, agents, servants or volunteers shall, except as is hereinafter set forth, be liable to respond in damages to any person who shall suffer damage from the negligence of any agent or servant of such corporation, society or association, where such person is a beneficiary, to whatever degree, of the works of such nonprofit corporation, society or association; provided, however, that such immunity from liability shall not extend to any person who shall suffer damage from the negligence of such corporation, society, or association or of its agents or servants where such person is one unconcerned in and unrelated to and outside of the benefactions of such corporation, society or association.

Nothing in this subsection shall be deemed to grant immunity to any health care provider, in the practice of his profession, who is a compensated employee, agent or servant of any nonprofit corporation, society or association organized exclusively for religious, charitable or educational purposes.

b. No nonprofit corporation, society or association organized exclusively for hospital purposes or its trustees, directors, officers or volunteers shall, except as is hereinafter set forth, be liable to respond in damages to any person who shall suffer damage from the negligence of any agent or servant of such corporation, society or association, where such person is a beneficiary, to whatever degree, of the works of such nonprofit corporation, society or association; provided, however, that such immunity from liability shall not extend to any

person who shall suffer damage from the negligence of such corporation, society, or association or of its agents or servants where such person is one unconcerned in and unrelated to and outside of the benefactions of such corporation, society or association; but nothing herein contained shall be deemed to exempt the agent, employee or servant individually from their liability for any such negligence.

c. Nothing in this section shall be deemed to grant immunity to: (1) any trustee, director, officer, employee, agent, servant or volunteer causing damage by a willful, wanton or grossly negligent act of commission or omission, including sexual assault and other crimes of a sexual nature; (2) any trustee, director, officer, employee, agent, servant or volunteer causing damage as the result of the negligent operation of a motor vehicle; or (3) an independent contractor of a nonprofit corporation, society or association organized exclusively for religious, charitable, educational or hospital purposes.

### ***N.J.S.A. 2A:53A-8 Liability to beneficiary***

Notwithstanding the provisions of the foregoing paragraph, any nonprofit corporation, society or association organized exclusively for hospital purposes shall be liable to respond in damages to such beneficiary who shall suffer damage from the negligence of such corporation, society or association or of its agents or servants to an amount not exceeding \$250,000, together with interest and costs of suit, as the result of any one accident and to the extent to which such damage, together with interest and costs of suit, shall exceed the sum of \$250,000 such nonprofit corporation, society or association organized exclusively for hospital purposes shall not be liable therefor.

### ***N.J.S.A. 2A:53A-26 et seq. THE "AFFIDAVIT OF MERIT" STATUTE***

#### ***N.J.S.A. 2A:53A-26. "Licensed person" defined***

As used in this act, "licensed person" means any person who is licensed as:

- a. an accountant pursuant to P.L.1977, c. 144 (C.45:2B-1 et seq.);
- b. an architect pursuant to R.S.45:3-1 et seq.;
- c. an attorney admitted to practice law in New Jersey;
- d. a dentist pursuant to R.S.45:6-1 et seq.;
- e. an engineer pursuant to P.L.1938, c. 342 (C.45:8-27 et seq.);
- f. a physician in the practice of medicine or surgery pursuant to R.S.45:9-1 et seq.;
- g. a podiatrist pursuant to R.S.45:5-1 et seq.;
- h. a chiropractor pursuant to P.L.1989, c. 153 (C.45:9-41.17 et seq.);
- i. a registered professional nurse pursuant to P.L.1947, c. 262 (C.45:11-23 et seq.);
- j. a health care facility as defined in section 2 of P.L.1971, c. 136 (C.26:2H-2);
- k. a physical therapist pursuant to P.L.1983, c. 296 (C.45:9-37.11 et seq.);
- l. a land surveyor pursuant to P.L.1938, c. 342 (C.45:8-27 et seq.);
- m. a registered pharmacist pursuant to R.S.45:14-1 et seq.;
- n. a veterinarian pursuant to R.S. 45:16-1 et seq.; and
- o. an insurance producer pursuant to P.L.1987, c. 293 (C.17:22A-1 et seq.).

Amended by L.2001, c. 372, § 1, eff. Jan. 8, 2002.

#### ***N.J.S.A. 2A:53A-27. Affidavit required in certain actions against licensed persons***

In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession

or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of 2. P.L.2004, c. 17 (C.2A:53A-41). In all other cases, the person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

***N.J.S.A. 2A:53A-28. Sworn statement in place of affidavit permitted***

An affidavit shall not be required pursuant to section 2 of this act if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant has failed to provide plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

***N.J.S.A. 2A:53A-29. Failure to provide affidavit or statement***

If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to section 2 or 3 of this act, it shall be deemed a failure to state a cause of action.

***N.J.S.A. 2A:82-41 Person against whom claim is asserted; right of examination***

Any person against whom a claim is asserted for compensation or damages for personal injuries or death resulting from personal injuries, either under the workmen's compensation act of the state of New Jersey, chapter fifteen of Title 34 of the Revised Statutes, or at law, or his insurance carrier, shall be permitted to examine the records of a hospital in reference to such injured or deceased person.

***N.J.S.A. 2A:82-42 Injured person or claimant; right of examination***

Any person who has been injured, or his legal representative, who has asserted, or who is about to assert a claim for compensation or damages for personal injuries or death resulting therefrom, shall be permitted to examine the records of any hospital pertaining to the claim of such injured or deceased person.

**N.J.S.A. 2A:82-43 Attorneys and agents; application of law**

The provisions of sections 2A:82-41 and 2A:82-42 of this title shall apply not only to such claimant, or person against whom such claim has been asserted and his insurance carrier, but also to their respective attorneys and duly authorized agents, subject to reasonable rules and regulations promulgated by any such hospital.

**N.J.S.A. 2A:53A-37 et seq. THE NEW JERSEY MEDICAL CARE ACCESS AND RESPONSIBILITY AND PATIENTS FIRST ACT**

**N.J.S.A. 2A:53A-37. Short title**

This act shall be known and may be cited as the “*New Jersey Medical Care Access and Responsibility and Patients First Act.*”

**N.J.S.A. 2A:53A-38. Legislative findings**

The Legislature finds and declares that:

a. One of the most vital interests of the State is to ensure that high-quality health care continues to be available in this State and that the residents of this State continue to have access to a full spectrum of health care providers, including highly trained physicians in all specialties;

b. The State’s health care system and its residents’ access to health care providers are threatened by a dramatic escalation in medical malpractice liability insurance premiums, which is creating a crisis of afford ability in the purchase of necessary liability coverage for our health care providers;

c. One particularly alarming result of rising premiums is that there are increasing reports of doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures, and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens;

d. The reasons for the steep increases in the cost of medical malpractice liability insurance are complex and involve issues related to: the State’s tort liability system; the State’s health care system, which includes issues related to patient safety and medical error reporting; and the State’s regulation and requirements concerning medical malpractice liability insurers;

e. It is necessary and appropriate for the State to take meaningful and prompt action to address the various interrelated aspects of these issues that are impacted by, or impact on, the State’s health care system; and

f. To that end, this act provides for a comprehensive set of reforms affecting the State’s tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and to enhance patient safety at health care facilities.

### **N.J.S.A. 2A:53A-39. Referral to complementary dispute resolution**

The judge presiding over a medical malpractice action, or the judge's designee, shall, within 30 days after the discovery end date, determine whether referral to a complementary dispute resolution mechanism may encourage early disposition or settlement of the action. If the judge makes such a determination, the matter shall be referred to complementary dispute resolution pursuant to Rule 1:40 of the Rules Governing the Courts of the State of New Jersey. Nothing in this section shall be construed to limit the authority of the judge to refer an action to complementary dispute resolution prior to the discovery end date.

### **N.J.S.A. 2A:53A-40. Affidavit of noninvolvement**

a. A health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant, and could not have caused the alleged malpractice, either individually or through its servants or employees, in any way.

b. A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

c. If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including a reasonable attorney fee. The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.

d. If the court determines that a plaintiff falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or the plaintiff's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the submission of the false objection or inaccurate statement, including a reasonable attorney fee. The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.

e. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes; and a health care facility licensed pursuant to P.L.1971, c. 136 (C.26:2H-1 *et seq.*)

**N.J.S.A. 2A:53A-41. Expert testimony; criteria; waiver of specialty**

In an action alleging medical malpractice, a person shall not give expert testimony or execute an affidavit pursuant to the provisions of P.L.1995, c. 139 (C.2A:53A-26 *et seq.*) on the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:

a. If the party against whom or on whose behalf the testimony is offered is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association and the care or treatment at issue involves that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the person providing the testimony shall have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, as the party against whom or on whose behalf the testimony is offered, and if the person against whom or on whose behalf the testimony is being offered is board certified and the care or treatment at issue involves that board specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the expert witness shall be:

(1) a physician credentialed by a hospital to treat patients for the medical condition, or to perform the procedure, that is the basis for the claim or action; or

(2) a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association who is board certified in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, and during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to either:

(a) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, the active clinical practice of that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(b) the instruction of students in an accredited medical school, other accredited health professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) both.

b. If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:

(1) active clinical practice as a general practitioner; or active clinical practice that encompasses the medical condition, or that includes performance of the procedure, that is the basis of the claim or action; or

(2) the instruction of students in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is licensed; or

(3) both.

c. A court may waive the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association and board certification requirements of this section, upon motion by the party seeking a waiver, if, after the moving party has demonstrated to the satisfaction of the court that a good faith effort has been made to identify an expert in the same specialty or subspecialty, the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in, or full-time teaching of, medicine in the applicable area of practice or a related field of medicine.

d. Nothing in this section shall limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

e. In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.

f. An individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit pursuant to the provisions of P.L.1995, c. 139 (C.2A:53A-26 *et seq.*), which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure, shall be liable to a civil penalty not to exceed \$10,000 and other damages incurred by the person and the party for whom the person was testifying as an expert.

#### **N.J.S.A. 2A:53A-42. Motion for additur or remittitur; standard of review**

A judge presiding over an action alleging medical malpractice, in which the jury has rendered a verdict in favor of the complaining party, shall, upon a motion by any party for additur or remittitur on the issue of the quantum of damages, consider the evidence in the light most favorable to the non-moving party and determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

#### **N.J.S.A. 26:2H-12.23 THE PATIENT SAFETY ACT**

##### **N.J.S.A. 26:2H-12.23. Short title**

This act shall be known and may be cited as the "Patient Safety Act."

##### **N.J.S.A. 26:2H-12.24. Legislative findings**

The Legislature finds and declares that:

a. Adverse events, some of which are the result of preventable errors, are inherent in all systems, and the health care literature demonstrates that the great majority of medical errors result from systems problems, not individual incompetence;

b. Well-designed systems have processes built in to minimize the occurrence of errors, as well as to detect those that do occur; they incorporate mechanisms to continually improve their performance;

c. To enhance patient safety, the goal is to craft a health care delivery system that minimizes, to the greatest extent feasible, the harm to patients that results from the delivery system itself;

d. An important component of a successful patient safety strategy is a feedback mechanism that allows detection and analysis not only of adverse events, but also of

“near-misses”;

e. To encourage disclosure of these events so that they can be analyzed and used for improvement, it is critical to create a non-punitive culture that focuses on improving processes rather than assigning blame. Health care facilities and professionals must be held accountable for serious preventable adverse events; however, punitive environments are not particularly effective in promoting accountability and increasing patient safety, and may be a deterrent to the exchange of information required to reduce the opportunity for errors to occur in the complex systems of care delivery. Fear of sanctions induces health care professionals and organizations to be silent about adverse events, resulting in serious under-reporting; and

f. By establishing an environment that both mandates the confidential disclosure of the most serious, preventable adverse events, and also encourages the voluntary, anonymous and confidential disclosure of less serious adverse events, as well as preventable events and near misses, the State seeks to increase the amount of information on systems failures, analyze the sources of these failures and disseminate information on effective practices for reducing systems failures and improving the safety of patients.

### **N.J.S.A. 26:2H-12.25. Definitions**

a. As used in this act:

“Adverse event” means an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

“Anonymous” means that information is presented in a form and manner that prevents the identification of the person filing the report.

“Commissioner” means the Commissioner of Health and Senior Services.

“Department” means the Department of Health and Senior Services.

“Event” means a discrete, auditable and clearly defined occurrence.

“Health care facility” or “facility” means a health care facility licensed pursuant to P.L.1971, c. 136 (C.26:2H-1 *et seq.*) and a State psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

“Health care professional” means an individual who, acting within the scope of his licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes.

“Near-miss” means an occurrence that could have resulted in an adverse event but the adverse event was prevented. “Preventable event” means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

“Serious preventable adverse event” means an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

b. In accordance with the requirements established by the commissioner by regulation, pursuant to this act, a health care facility shall develop and implement a patient safety plan for the purpose of improving the health and safety of patients at the facility. The patient safety plan shall, at a minimum, include:

(1) a patient safety committee, as prescribed by regulation;

(2) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility’s various disciplines and have appropriate competencies, to conduct ongoing analysis and application of evidence-based patient safety practices in order to reduce the

probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures;

(3) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility's various disciplines and have appropriate competencies, to conduct analyses of near-misses, with particular attention to serious preventable adverse events and adverse events; and

(4) a process for the provision of ongoing patient safety training for facility personnel. The provisions of this subsection shall not be construed to eliminate or lessen a hospital's obligation under current law or regulation to have a continuous quality improvement program.

c. A health care facility shall report to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, every serious preventable adverse event that occurs in that facility.

d. A health care facility shall assure that the patient affected by a serious preventable adverse event or an adverse event specifically related to an allergic reaction, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. The time, date, participants and content of the notification shall be documented in the patient's medical record in accordance with rules and regulations adopted by the commissioner. The content of the documentation shall be determined in accordance with the rules and regulations of the commissioner. If the patient's physician determines that the disclosure would seriously and adversely affect the patient's health, then the facility shall assure that the family member, if available, is notified in accordance with rules and regulations adopted by the commissioner. In the event that an adult patient is not informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the physician includes a statement in the patient's medical record that provides the reason for not informing the patient pursuant to this section.

e. (1) A health care professional or other employee of a health care facility is encouraged to make anonymous reports to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, regarding near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section.

(2) The commissioner shall establish procedures for and a system to collect, store and analyze information voluntarily reported to the department pursuant to this subsection. The repository shall function as a clearinghouse for trend analysis of the information collected pursuant to this subsection.

f. Any documents, materials or information received by the department, or the Department of Human Services, as applicable, pursuant to the provisions of subsections c. and e. of this section concerning serious preventable adverse events, near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding;

(2) considered a public record under P.L.1963, c. 73 (C.47:1A-1 *et seq.*) or P.L.2001, c. 404 (C.47:1A-5 *et al.*); or

(3) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events. The information received by the department, or the Department of Human Services, as applicable, shall be shared with the Attorney General in accordance with rules and regulations adopted pursuant to subsection j. of this section, and may be used by the department, the Department of Human Services and the Attorney General for the purposes of this act and for oversight of facilities and health care professionals; however, the departments and the Attorney General shall not use the information for any other purpose. In using the information to exercise oversight, the department, Department of Human Services and Attorney General, as applicable, shall place primary emphasis on assuring effective corrective action by the facility or health care professional, reserving punitive enforcement or disciplinary action for those cases in which the facility or the professional has displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the department, Department of Human Services or the Attorney General, of a pattern of significant substandard performance that has the potential for or actually results in harm to patients.

g. Any documents, materials or information developed by a health care facility as part of a process of self-critical analysis conducted pursuant to subsection b. of this section concerning preventable events, near-misses and adverse events, including serious preventable adverse events, and any document or oral statement that constitutes the disclosure provided to a patient or the patient's family member or guardian pursuant to subsection d. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding; or

(2) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with subsection b. of this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence or wilful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events.

h. Notwithstanding the fact that documents, materials or information may have been considered in the process of self-critical analysis conducted pursuant to subsection b. of this section, or received by the department or the Department of Human Services pursuant to the provisions of subsection c. or e. of this section, the provisions of this act shall not be construed to increase or decrease, in any way, the availability, discoverability, admissibility or use of any such documents, materials or information if obtained from any source or context other than those specified in this act.

i. The investigative and disciplinary powers conferred on the boards and commissions established pursuant to Title 45 of the Revised Statutes, the Director of the Division of Consumer

Affairs in the Department of Law and Public Safety and the Attorney General under the provisions of P.L.1978, c. 73 (C.45:1-14 *et seq.*) or any other law, rule or regulation, as well as the investigative and enforcement powers conferred on the department and the commissioner under the provisions of Title 26 of the Revised Statutes or any other law, rule or regulation, shall not be exercised in such a manner so as to unduly interfere with a health care facility's implementation of its patient safety plan established pursuant to this section. However, this act shall not be construed to otherwise affect, in any way, the exercise of such investigative, disciplinary and enforcement powers.

j. The commissioner shall, pursuant to the "Administrative Procedure Act," P.L.1968, c. 410 (C.52:14B-1 *et seq.*), adopt such rules and regulations necessary to carry out the provisions of this act. The regulations shall establish: criteria for a health care facility's patient safety plan and patient safety committee; the time frame and format for mandatory reporting of serious preventable adverse events at a health care facility; the types of events that qualify as serious preventable adverse events and adverse events specifically related to an allergic reaction; the circumstances under which a health care facility is not required to inform a patient or the patient's family about a serious preventable adverse event or adverse event specifically related to an allergic reaction; and a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General. In establishing the criteria for reporting serious preventable adverse events, the commissioner shall, to the extent feasible, use criteria for these events that have been or are developed by organizations engaged in the development of nationally recognized standards. The commissioner shall consult with the Commissioner of Human Services with respect to rules and regulations affecting the State psychiatric hospitals and with the Attorney General with respect to rules and regulations regarding the establishment of a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General.

k. Nothing in this act shall be construed to increase or decrease the discoverability, in accordance with *Christy v. Salem*, No. A-6448-02T3 (Superior Court of New Jersey, Appellate Division, February 17, 2004)(2004 WL291160), of any documents, materials or information if obtained from any source or context other than those specified in this act.

#### **N.J.S.A. 26:2H-12.25a. Annual report; public access to report via the internet**

The Commissioner of Health and Senior Services and the Commissioner of Human Services shall compile their findings and recommendations for operational changes related to patient safety in health care facilities, based on information reported to the commissioners pursuant to the "Patient Safety Act," P.L.2004, c. 9 (C.26:2H-12.23 *et seq.*). The commissioners shall jointly issue an annual report of their findings and recommendations to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c. 164 (C.52:14-19.1), to be made available on the official Internet website of the Department of Health and Senior Services.

#### **N.J.S.A. 2A:84A-22.1 Definitions; patient-physician privilege**

As used in this act, (a) "patient" means a person who, for the sole purpose of securing preventive, palliative, or curative treatment, or a diagnosis preliminary to such treatment, of his physical or mental condition, consults a physician, or submits to an examination by a physician; (b) "physician" means a person authorized or reasonably believed by the patient to be authorized, to practice medicine in the State or jurisdiction in which the consultation or examination takes

place; (c) "holder of the privilege" means the patient while alive and not under the guardianship or the guardian of the person of an incompetent patient, or the personal representative of a deceased patient; (d) "confidential communication between physician and patient" means such information transmitted between physician and patient, including information obtained by an examination of the patient, as is transmitted in confidence and by a means which, so far as the patient is aware, discloses the information to no third persons other than those reasonably necessary for the transmission of the information or the accomplishment of the purpose for which it is transmitted.

***N.J.S.A. 2A:84A-22.2 Patient and physician privilege***

Except as otherwise provided in this act, a person, whether or not a party, has a privilege in a civil action or in a prosecution for a crime or violation of the disorderly persons law or for an act of juvenile delinquency to refuse to disclose, and to prevent a witness from disclosing, a communication, if he claims the privilege and the judge finds that (a) the communication was a confidential communication between patient and physician, and (b) the patient or the physician reasonably believed the communication to be necessary or helpful to enable the physician to make a diagnosis of the condition of the patient or to prescribe or render treatment therefor, and (c) the witness (i) is the holder of the privilege or (ii) at the time of the communication was the physician or a person to whom disclosure was made because reasonably necessary for the transmission of the communication or for the accomplishment of the purpose for which it was transmitted or (iii) is any other person who obtained knowledge or possession of the communication as the result of an intentional breach of the physician's duty of nondisclosure by the physician or his agent or servant and (d) the claimant is the holder of the privilege or a person authorized to claim the privilege for him.

***N.J.S.A. 2C:21-4.1 Purposeful destruction, alteration or falsification of record relating to care of medical or surgical or podiatric patient in order to deceive or mislead***

A person is guilty of a crime of the fourth degree if he purposefully destroys, alters or falsifies any record relating to the care of a medical or surgical or podiatric patient in order to deceive or mislead any person as to information, including, but not limited to, a diagnosis, test, medication, treatment or medical or psychological history, concerning the patient.

***N.J.S.A. 26:2H-2 Definitions***

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis of treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled, in whole or in part,

directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

***N.J.S.A. 26:8-5 Institutional records***

The person in charge of a hospital, almshouse, lying-in, penal, or other institution, public or private, to which any person resorts for treatment of disease or for confinement, or is committed by process of law, shall make a record of all the personal and statistical particulars relative to each inmate in such institution, at the time of admission, and shall make a complete medical record covering the period of such person's confinement in such institution.

The medical records provided for herein or photographic reproductions thereof shall be retained by the custodian of records of such institution for a period of 10 years following the most recent discharge of the patient, or until the person confined therein reaches the age of 23 years, whichever is the longer period of time. In addition, a discharge summary sheet shall be retained by such custodian of records for a period of 20 years following the most recent discharge of the patient. The discharge summary sheet shall contain the patient's name, address, dates of admission and discharge and a summary of the treatment and medication rendered during the patient's stay. Any X-ray films related to such confinement, or any size reproductions thereof which maintain the clarity of the original shall be retained by such custodian of records for a period of 5 years.

In case of any person admitted or committed for treatment of disease, the physician in charge shall specify, for entry in the record, the nature of the disease and where, in his opinion, it was contracted.

The personal particulars and information required by this section shall be obtained from the individual himself if practicable; and when not, they shall be obtained in as complete a manner as possible from relatives, friends, or other persons acquainted with the facts.

***N.J.S.A. 45:14B-28 Confidential relations and communications***

The confidential relations and communications between and among a licensed practicing psychologist and individuals, couples, families or groups in the course of the practice of psychology are placed on the same basis as those provided between attorney and client, and nothing in this act shall be construed to require any such privileged communications to be disclosed by any such person.

There is no privilege under this section for any communication: (a) upon an issue of the client's condition in an action to commit the client or otherwise place the client under the control of another or others because of alleged incapacity, or in an action in which the client seeks to establish his competence or in an action to recover damages on account of conduct of the client which constitutes a crime; or (b) upon an issue as to the validity of a document as a will of the client; or (c) upon an issue between parties claiming by testate or intestate succession from a deceased client.

***N.J.S.A. 59:8-3 Claims for damages against public entities***

No action shall be brought against a public entity or public employee under this act unless the claim upon which it is based shall have been presented in accordance with the procedure set forth in this chapter.

**N.J.S.A. 59:8-8 Time for presentation of claims**

A claim relating to a cause of action for death or for injury or damage to person or to property shall be presented as provided in this chapter not later than the ninetieth day after accrual of the cause of action. After the expiration of six months from the date notice of claim is received, the claimant may file suit in an appropriate court of law. The claimant shall be forever barred from recovering against a public entity or public employee if:

- a. He failed to file his claim with the public entity within 90 days of accrual of his claim except as otherwise provided in section 59:8-9; or
- b. Two years have elapsed since the accrual of the claim; or
- c. The claimant or his authorized representative entered into a settlement agreement with respect to the claim.

Nothing in this section shall prohibit an infant or incompetent person from commencing an action under this act within the time limitations contained herein, after his coming to or being of full age or sane mind.

**N.J.S.A. 59:8-9 Notice of late claim**

A claimant who fails to file notice of his claim within 90 days as provided in section 59:8-8 of this act, may, in the discretion of a judge of the Superior Court, be permitted to file such notice at any time within one year after the accrual of his claim provided that the public entity or the public employee has not been substantially prejudiced thereby. Application to the court for permission to file a late notice of claim shall be made upon motion supported by affidavits based upon personal knowledge of the affiant showing sufficient reasons constituting extraordinary circumstances for his failure to file notice of claim within the period of time prescribed by section 59:8-8 of this act or to file a motion seeking leave to file a late notice of claim within a reasonable time thereafter; provided that in no event may any suit against a public entity or a public employee arising under this act be filed later than two years from the time of the accrual of the claim.

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**ADMINISTRATIVE CODE:**

**N.J.A.C. 8:43G-4.1 Patient rights**

(a) Every New Jersey hospital patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:

- 1. To receive the care and health services that the hospital is required to provide under N.J.S.A. 26:1-1 et seq. and rules adopted by the Department of Health to implement this law;
- 2. To treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;
- 3. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which the patient is entitled by law;
- 4. To be informed of the names and functions of all physicians and other health care

professionals who are providing direct care to the patient. These people shall identify themselves by introduction or by wearing a name tag;

5. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel;

6. To receive from the patient's physician(s)--in terms that the patient understands--an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the patient's medical record;

7. To give informed, written consent prior to the start of specified nonemergency procedures or treatments only after a physician has explained--in terms that the patient understands--specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. The procedures requiring informed, written consent shall be specified in the hospital's policies and procedures. If the patient is incapable of giving informed, written consent, consent shall be sought from the patient's next of kin or guardian or through an advance directive, to the extent authorized by law. If the patient does not give written consent, a physician shall enter an explanation in the patient's medical record;

8. To refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of this act;

9. To be included in experimental research only when he or she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent patient in accordance with law and regulation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. To be informed if the hospital has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient's treatment;

11. To be informed of the hospital's policies and procedures regarding life-saving methods and the use or withdrawal of life-support mechanisms. Such policies and procedures shall be made available promptly in written format to the patient, his or her family or guardian, and to the public, upon request;

12. To be informed by the attending physician and other providers of health care services about any continuing health care requirements after the patient's discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

13. To receive sufficient time before discharge to have arrangements made for health care needs after hospitalization;

14. To be informed by the hospital about any discharge appeal process to which the patient is entitled by law;

15. To be transferred to another facility only for one of the following reasons, with the reason recorded in the patient's medical record:

i. The transferring hospital is unable to provide the type or level of medical care appropriate for the patient's needs. The hospital shall make an immediate effort to notify the

patient's primary care physician and the next of kin, and document that the notifications were received; or

ii. The transfer is requested by the patient, or by the patient's next of kin or guardian when the patient is mentally incapacitated or incompetent;

16. To receive from a physician an explanation of the reasons for transferring the patient to another facility, information about alternatives to the transfer, verification of acceptance from the receiving facility, and assurance that the movement associated with the transfer will not subject the patient to substantial, unnecessary risk of deterioration of his or her medical condition. This explanation of the transfer shall be given in advance to the patient, and/or to the patient's next of kin or guardian except in a life-threatening situation where immediate transfer is necessary;

17. To be treated with courtesy, consideration, and respect for the patient's dignity and individuality;

18. To freedom from physical and mental abuse;

19. To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;

20. To have physical privacy during medical treatment and personal hygiene functions, such as bathing and using the toilet, unless the patient needs assistance for his or her own safety. The patient's privacy shall also be respected during other health care procedures and when hospital personnel are discussing the patient;

21. To confidential treatment of information about the patient. Information in the patient's records shall not be released to anyone outside the hospital without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, a medical peer review, or the New Jersey State Department of Health. The hospital may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

22. To receive a copy of the hospital payment rates, regardless of source of payment. Upon request, the patient or responsible party shall be provided with an itemized bill and an explanation of the charges if there are further questions. The patient or responsible party has a right to appeal the charges. The hospital shall provide the patient or responsible party with an explanation of procedures to follow in making such an appeal;

23. To be advised in writing of the hospital rules and regulations that apply to the conduct of patients and visitors;

24. To have prompt access to the information contained in the patient's medical record, unless a physician prohibits such access as detrimental to the patient's health, and explains the reason in the medical record. In that instance, the patient's next of kin or guardian shall have a right to see the record. This right continues after the patient is discharged from the hospital for as long as the hospital has a copy of the record;

25. To obtain a copy of the patient's medical record, at a reasonable fee, within 30 days of a written request to the hospital. If access by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician;

26. To have access to individual storage space in the patient's room for the patient's private use. If the patient is unable to assume responsibility for his or her personal items, there shall be a system in place to safeguard the patient's personal property until the patient or next of

kin is able to assume responsibility for these items;

27. To be given a summary of these patient rights, as approved by the New Jersey State Department of Health, and any additional policies and procedures established by the hospital involving patient rights and responsibilities. This summary shall also include the name and phone number of the hospital staff member to whom patients can complain about possible patient rights violations. This summary shall be provided in the patient's native language if 10 percent or more of the population in the hospital's service area speak that language. In addition, a summary of these patient rights, as approved by the New Jersey State Department of Health, shall be posted conspicuously in the patient's room and in public places throughout the hospital. Complete copies of this subchapter shall be available at nurse stations and other patient care registration areas in the hospital for review by patients and their families or guardians;

28. To present his or her grievances to the hospital staff member designated by the hospital to respond to questions or grievances about patient rights and to receive an answer to those grievances within a reasonable period of time. The hospital is required to provide each patient or guardian with the names, addresses, and telephone numbers of the government agencies to which the patient can complain and ask questions, including the New Jersey Department of Health Complaint Hotline at 1-800-792-9770. This information shall also be posted conspicuously in public places throughout the hospital;

29. To be assisted in obtaining public assistance and the private health care benefits to which the patient may be entitled. This includes being advised that they are indigent or lack the ability to pay and that they may be eligible for coverage, and receiving the information and other assistance needed to qualify and file for benefits or reimbursement; and

30. To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her hospitalization. A registered professional nurse so contracted shall adhere to hospital policies and procedures in regard to treatment protocols, and policies and procedures so long as these requirements are the same for private duty and regularly employed nurses. The hospital, upon request, shall provide the patient or designee with a list of local non-profit professional nurses association registries that refer nurses for private professional nursing care.

### ***N.J.A.C. 8:43G-15.3 Medical record patient services***

(a) Health care practitioners who provide clinical services to the patient shall enter clinical/progress notes in the patient's medical record, when the services are rendered.

(b) Notes that provide a full and accurate description of the care provided to the patient shall be made in the medical record at the time clinical services are provided. Notes that provide a description and an evaluation of the patient's response to treatment shall be made in the medical record.

(c) The medical record shall either accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be retrievable by authorized personnel on a computerized system with a restricted access and entry system.

(d) If a patient or the patient's legally authorized representative requests, in writing, a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of request, in accordance with the following:

1. The fee for copying records shall not exceed \$1.00 per page or \$100.00 per record for

the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than \$0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of \$200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

i. A search fee of no more than \$10.00 per patient per request. (Although the patient may have had more than one admission, and thus more than one record is provided, only one search fee shall be permitted for that request. The search fee is permitted even though no medical record is found as a result of the search.); and

ii. A postage charge of actual costs for mailing. No charges shall be assessed other than those permitted in (d)1 and 2 above;

3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and

4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.

5. For purposes of this subsection, "legally authorized representative" means the following:

i. Spouse;

ii. Immediate next of kin;

iii. Legal guardian;

iv. Patient's attorney;

v. Patient's third party insurer; and

vi. Worker's compensation carriers, where access is permitted by contract or law, but limited only to that portion of the medical record which is relevant to the specific work-related incident at issue in the worker's compensation claim.

(e) The fee for copying medical records shall be based on actual costs, which in no case shall exceed \$1.00 per page and \$10.00 per search, in the case of the following:

1. Where the patient has authorized release of his or her medical record to a person or entity other than those identified in (d) above, including but not limited to physicians or other practitioners who provided care to the patient, or attorneys representing such providers; or

2. The patient subsequently requests additional copies of a medical record which has been furnished in accordance with (d) above.

(f) Access to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

(g) The patient shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

### ***N.J.A.C. 13:35-6.5* Preparation of patient records, computerized records, access to or release of information; confidentiality, transfer or disposal of records**

(a) The following terms shall have the following meanings unless the context in which they appear indicates otherwise:

"Authorized representative" means, but is not necessarily limited to, a person who has

been designated by the patient or a court to exercise rights under this section. An authorized representative may be the patient's attorney or an employee of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian who has custody (whether sole or joint) will be deemed to be an authorized representative, except where the condition being treated relates to pregnancy, sexually transmitted disease or substance abuse.

"Examinee" means a person who is the subject of professional examination where the purpose of that examination is unrelated to treatment and where a report of the examination is to be supplied to a third party.

"Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

"Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of treatment or a consultation relating to treatment.

(b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1. To the extent applicable, professional treatment records shall reflect:
  - i. The dates of all treatments;
  - ii. The patient complaint;
  - iii. The history;
  - iv. Findings on appropriate examination;
  - v. Progress notes;
  - vi. Any orders for tests or consultations and the results thereof;
  - vii. Diagnosis or medical impression;
  - viii. Treatment ordered, including specific dosages, quantities and strengths of medications including refills if prescribed, administered or dispensed, and recommended follow-up;
  - ix. The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices;
  - x. Documentation when, in the reasonable exercise of the physician's judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and
  - xi. Documentation of the existence of any advance directive for health care for an adult or emancipated minor, and associated pertinent information. Documented inquiry shall be made on the routine intake history form for a new patient who is a competent adult or emancipated minor. The treating doctor shall also make and document specific inquiry of or regarding a patient in appropriate circumstances, such as when providing treatment for a significant illness, or where an emergency has occurred presenting imminent threat to life, or where surgery is anticipated with use of general anesthesia.
2. Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialed by the licensee.
3. A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:

i. The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;

ii. An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry, and full printed name of the treatment provider. The physician shall finalize or "sign" the entry by means of a confidential personal code ("CPC") and include date of the "signing";

iii. Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as "preliminary" until reviewed, finalized and dated by the responsible physician as provided in (b)3ii above;

iv. The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;

v. The system shall be designed in such manner that, after "signing" by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;

vi. Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner;

vii. A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:

(1) To a physician responsible for the patient's care;

(2) To a representative of the Board of Medical Examiners, the Attorney General or the Division of Consumer Affairs as soon as practicable and no later than 10 days after notice; and

(3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency); and

viii. A licensee wishing to continue a system of computerized patient records, which system does not meet the requirements of (b)3i through vii above, shall promptly initiate arrangements for modification of the system which must be completed by October 19, 1993. In the interim, the licensee shall assure that, on the date of the first treatment of each patient treated subsequent to October 19, 1992, the computer entry for that first visit shall be accompanied by a hard copy printout of the entire computer-recorded treatment record. The printout shall be dated and initialed by the attending licensee. Thereafter, a hard copy shall be prepared for each subsequent visit, continuing to the date of the changeover of computer program, with each page initialed by the treating licensee. The initial printout and the subsequent hard copies shall be retained as a permanent part of the patient record.

(c) Licensees shall provide access to professional treatment records to a patient or an authorized representative in accordance with the following:

1. No later than 30 days from receipt of a request from a patient or an authorized representative, the licensee shall provide a copy of the professional treatment record, and/or billing records as may be requested. The record shall include all pertinent objective data including test results and x-ray results, as applicable, and subjective information.

2. Unless otherwise required by law, a licensee may elect to provide a summary of the record in lieu of providing a photocopy of the actual record, so long as that summary adequately reflects the patient's history and treatment. A licensee may charge a reasonable fee for the preparation of a summary which has been provided in lieu of the actual record, which shall not exceed the cost allowed by (c)4 below for that specific record.

3. If, in the exercise of professional judgment, a licensee has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of the subjective information contained in the professional treatment record or a summary thereof, with an accompanying notice setting forth the reasons for the original refusal, shall nevertheless be provided upon request and directly to:

- i. The patient's attorney;
- ii. Another licensed health care professional;
- iii. The patient's health insurance carrier through an employee thereof; or
- iv. A governmental reimbursement program or an agent thereof, with responsibility to review utilization and/or quality of care.

4. Licensees may require a record request to be in writing and may charge a fee for the reproduction of records, which shall be no greater than \$1.00 per page or \$100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to \$10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record.

5. If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

6. The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

(d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1. The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All x-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.

2. The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient's treatment is the subject of peer review.

3. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

4. The licensee, in the exercise of professional judgment, who has had a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger. Nothing in this paragraph, however, shall be construed to authorize the release of the content of a record containing identifying information about a person who has AIDS or an HIV infection, without

patient consent, for any purpose other than those authorized by N.J.S.A. 26:5C-8. If a licensee, without the consent of the patient, seeks to release information contained in an AIDS/HIV record to a law enforcement agency or other health care professional in order to minimize the threat of danger to others, an application to the court shall be made pursuant to N.J.S.A. 26:5C-5 et seq.

(e) Where the patient has requested the release of a professional treatment record or a portion thereof to a specified individual or entity, in order to protect the confidentiality of the records, the licensee shall:

1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;
2. Assure that the scope of the release is consistent with the request; and
3. Forward the records to the attention of the specific individual identified or mark the material "Confidential."

(f) Where a third party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee's report to the third party relating to the examinee shall be made part of the record. The licensee shall:

1. Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;
2. Forward the report to the individual entity making the request, in accordance with the terms of the examinee's authorization; if no specific individual is identified, the report should be marked "Confidential"; and
3. Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

(g) (Reserved)

(h) If a licensee ceases to engage in practice or it is anticipated that he or she will remain out of practice for more than three months, the licensee or designee shall:

1. Establish a procedure by which patients can obtain a copy of the treatment records or acquiesce in the transfer of those records to another licensee or health care professional who is assuming responsibilities of the practice. However, a licensee shall not charge a patient, pursuant to (c)4 above, for a copy of the records, when the records will be used for purposes of continuing treatment or care.
  2. Publish a notice of the cessation and the established procedure for the retrieval of records in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation; and
  3. Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation, providing information concerning the established procedure for retrieval of records.
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## MODEL MEDICAL MALPRACTICE VOIR DIRE

### Standard Jury Voir Dire Civil [Revised as Promulgated by Directive #4-07]

1. In order to be qualified under New Jersey law to serve on a jury, a person must have certain qualifying characteristics. A juror must be:

Age 18 or older

A citizen of the United States

Able to read and understand the English language.

A resident of \_\_\_\_\_ County (the summoning county)

Also, a juror must not:

Have been convicted of any indictable offense in any state or federal court

And must not have any physical or mental disability which would prevent the person from properly serving as a juror.

Please consider that the Judiciary will provide reasonable accommodations consistent with the Americans with Disabilities Act.

Is there any one of you who does not meet these requirements?

2. a. This trial is expected to last for \_\_\_\_\_. Is there anything about the length or scheduling of the trial that would interfere with your ability to serve?

b. Do you have any medical, personal or financial problem that would prevent you from serving on this jury?

c. Do any of you have a special need or require a reasonable accommodation to help you in listening, paying attention, reading printed materials, deliberating, or otherwise participating as a fair juror? The court will provide reasonable accommodations to your special needs but I will only be aware of any such needs if you let me know about them. My only purpose in asking you these circumstances relates to your ability to serve as a juror. If you have any such request, please raise your hand and I will speak to you at sidebar.

[**Note:** If a juror makes a request, contact the ADA Coordinator to see if the TCA can meet the request right away (e.g., a portable speaker system available immediately) or if the juror's service should be deferred so that the TCA can arrange the accommodation timely (e.g., an ASL interpreter that may require three or four months' reservation in advance).]

3. Introduce the lawyers and the parties. Do any of you know either/any of the lawyers? Has either/any of them or anyone in their office ever represented you or brought any action against you? Do you know Mr./Ms. \_\_\_\_\_?

Names of Parties

4. Read names of potential witnesses. Do you know any of the potential witnesses?

[Note: List witnesses' names here or attached a separate sheet.]

5. I have already briefly described the case. Do you know anything about this case from any source other than what I've just told you?

6. Are any of you familiar with the area or address of the incident?
7. Have you or any family member or close personal friend ever filed a claim or a lawsuit of any kind?
8. Has anyone ever filed a claim or a lawsuit against you or a member of your family or a close friend?
9. Have you or a family member or close personal friend either currently or in the past been involved as a party ... as either a plaintiff or a defendant ... in a lawsuit involving damages for personal injury?
10. A plaintiff is a person or corporation [or other entity] who has initiated a lawsuit. Do you have a bias for or against a plaintiff simply because he or she has brought a lawsuit?
11. (a) A defendant is a person or corporation [or other entity] against whom a lawsuit has been brought. Do you have a bias for or against a defendant simply because a lawsuit has been brought against him or her?  
[Ask if applicable]
  - (b) The defendant is a corporation. Under the law, a corporation is entitled to be treated the same as anyone else and is entitled to be treated the same as a private individual. Would any of you have any difficulty in accepting that principle?
12. The court is aware that there has been a great deal of public discussion about something called Tort Reform (laws that restrict the right to sue or limit the amount recovered). Do you have an opinion, one way or the other, on this subject?
13. If the law and evidence warranted, would you be able to render a verdict in favor of the plaintiff or defendant regardless of any sympathy you may have for either party?
14. Based on what I have told you, is there anything about this case or the nature of the claim itself, that would interfere with your ability to be fair and impartial and to apply the law as instructed by the court?
15. Can you accept the law as explained by the court and apply it to the facts regardless of your personal beliefs about what the law is or should be?
16. Have you ever served on a trial jury before today, here in New Jersey or in any state court or federal court?
17. Do you know anyone else in the jury box other than as a result of reporting here today?
18. Would your verdict in this case be influenced in any way by any factors other than the evidence in the courtroom such as friendships or family relationships or the type of work you do?
19. Have you ever been a witness in a civil matter, regardless of whether it went to trial?
20. Have you ever testified in any court proceeding?
21. New Jersey law requires that a plaintiff has to prove fault of a defendant before he or she is entitled to recover money damages from that defendant. Do you have any difficulty accepting that concept?

**Biographical Question:**

The following questions should be asked of each potential juror, one by one, in the jury box:

You have answered a series of questions about civil trials and civil cases. Now we would like to learn a little bit about each of you. Please tell us the type of work you do; whether you have ever done any type of work which is substantially different from what you do now; whether you've served in the military; what is your educational history; who else lives in your household and the type of work they do, if any; whether you have any children living elsewhere and the type of work they do; which television shows you watch; any sources from which you learn the news, *i.e.* the newspapers you read or radio or TV news stations you listen to; if you have a bumper sticker that does not pertain to a political candidate, what does it say? What you do in your spare time and anything else you feel is important.

**[Note:** This question is intended to be an open-ended question which will allow and encourage the juror to speak in a narrative fashion, rather than answer the question in short phrases. For that reason, it is suggested that the judge read the question in its entirety, rather than part by part. If the juror omits a response to one or more sections, the judge should follow up by asking, in effect: "I notice you didn't mention [specify]. Can you please tell us about that?"]

### **Omnibus Qualification Questions (Two)**

1. Is there anything, whether or not covered in the previous questions, which would affect your ability to be a fair and impartial juror or in any way be a problem for you in serving on this jury?
2. Is there anything else that you feel is important for the parties in this case to know about you?

### **Medical Malpractice**

**Note:** This information is not to be included on printed copies provided to jurors.

It is expected that the parties will submit a few specific questions seeking juror attitudes towards particular injury claims, such as pecuniary loss for wrongful death or a claim for emotional distress, if applicable, or juror attitudes about other particular types of claims, such as wrongful birth or informed consent issues. In particular, wrongful birth claims might require a questionnaire or separate voir dire to address attitudes about termination of pregnancy.

Before asking the questions below, explain that the trial involves a claim of medical negligence, which people sometimes refer to as medical malpractice and that the terms both mean the same thing.

1. Have you, or family member, or a close personal friend, ever had any experience, either so good or so bad, with a doctor or any other health care provider, that would make it difficult for you to sit as an impartial juror in this matter?
2. If the law and the evidence warranted, could you award damages for the plaintiff even if you felt sympathy for the doctor?
3. Regardless of plaintiff's present condition, if the law and evidence warranted, could you render a verdict in favor of the defendant despite being sympathetic to the plaintiff?
4. Have you, any family member, or close personal friend ever worked for:

Attorneys, Doctors, Hospitals or Physical Therapists,

Any type of health care provider

Any ambulance / EMT / Rescue

5. Have you, or any members of your family, been employed in processing, investigating or handling any type of medical or personal injury claims?
6. Is there anything that you may have read in the print media or seen on television or heard on the radio about medical negligence cases or caps or limits on jury verdicts or awards that would prevent you from deciding this case fairly and impartially on the facts presented?
7. This case involves a claim against the defendant for injuries suffered by the plaintiff as a result of alleged medical negligence. Do you have any existing opinions or strong feelings one way or another about such cases?
8. Have any of you or members of your immediate family ever suffered any complications from [specify the medical field involved]?
9. Do you have any familiarity with [specify the type of medical condition involved] or any familiarity with the types of treatment available?
10. Are you, or have you ever been, related (by blood or marriage) to anyone affiliated with the health care field?
11. Have you or any relative or close personal friend ever had a dispute with respect to a health care issue of any kind with a doctor, chiropractor, dentist, nurse, hospital employee, technician or other person employed in the health care field?
12. Have you or any relative or close personal friend ever brought a claim against a doctor, chiropractor, dentist, nurse or hospital for an injury allegedly caused by a doctor, dentist, nurse or hospital?
13. Have you or any relative or close personal friend ever considered bringing a medical or dental negligence action but did not do so?
14. Have you or any relative or close personal friend ever been involved with treatment which did not produce the desired outcome?

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## COURT RULES

### **Rule 4:10-2 Scope of Discovery**

Unless otherwise limited by order of the court in accordance with these rules, the scope of discovery is as follows:

(a) In General. Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence; nor is it ground for objection that the examining party has knowledge of the matters as to which discovery is sought.

(b) Insurance Agreements. A party may obtain discovery of the existence and contents of any insurance agreement under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment. Information concerning the insurance agreement is not by reason of disclosure admissible in evidence at trial. For purposes of this paragraph, an application for insurance shall not be treated as part of an insurance agreement.

(c) Trial Preparation; Materials. Subject to the provisions of R. 4:10-2(d), a party may obtain discovery of documents and tangible things otherwise discoverable under R. 4:10-2(a) and prepared in anticipation of litigation or for trial by or for another party or by or for that other party's representative (including an attorney, consultant, surety, indemnitor, insurer or agent) only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the case and is unable without undue hardship to obtain the substantial equivalent of the materials by other means. In ordering discovery of such materials when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the litigation.

A party may obtain without the required showing a statement concerning the action or its subject matter previously made by that party. Upon request, a person not a party may obtain without the required showing a statement concerning the action or its subject matter previously made by that person. If the request is refused, the person may move for a court order. The provisions of R. 4:23-1(c) apply to the award of expenses incurred in relation to the motion. For purposes of this paragraph, a statement previously made is (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantially verbatim recital of an oral statement by the person making it and contemporaneously recorded.

(d) Trial Preparation; Experts. Discovery of facts known and opinions held by experts, otherwise discoverable under the provisions of R. 4:10-2(a) and acquired or developed in anticipation of litigation or for trial, may be obtained only as follows:

(1) A party may through interrogatories require any other party to disclose the names and addresses of each person whom the other party expects to call at trial as an expert witness,

including a treating physician who is expected to testify and of an expert who has conducted an examination pursuant to R. 4:19 whether or not that person is expected to testify, to state the subject matter on which the expert is expected to testify, to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion, and to furnish, as provided by R. 4:17-4(a), a copy of the report of an expert witness, including a treating physician, and, whether or not that person is expected to testify, of an expert who has conducted an examination pursuant to R. 4:19 or to whom a party making a claim for personal injury has voluntarily submitted for examination without court order.

(2) Unless the court otherwise orders, an expert whose report is required to be furnished pursuant to subparagraph (1) may be deposed as to the opinion stated therein at a time and place as provided by R. 4:14-7(b)(2). Unless otherwise ordered by the court, the party taking the deposition shall pay the expert or treating physician a reasonable fee for the appearance, to be determined by the court if the parties and the expert or treating physician cannot agree on the amount therefor. The fee for the witness's preparation for the deposition shall, however, be paid by the proponent of the witness, unless otherwise ordered by the court.

(3) A party may discover facts known or opinions held by an expert (other than an expert who has conducted an examination pursuant to R. 4:19) who has been retained or specially employed by another party in anticipation of litigation or preparation for trial and who is not expected to be called as a witness at trial only upon a showing of exceptional circumstances under which it is impractical for the party seeking discovery to obtain facts or opinions on the same subject by other means. If the court permits such discovery, it shall require the payment of the expert's fee provided for by R. 4:10-2(d)(2), and unless manifest injustice would result, the payment by the party seeking discovery to the other party of a fair portion of the fees and expenses which had been reasonably incurred by the party retaining the expert in obtaining facts and opinions from that expert.

(e) Claims of Privilege or Protection of Trial Preparation Materials. When a party withholds information otherwise discoverable under these rules by claiming that it is privileged or subject to protection as trial preparation material, the party shall make the claim expressly and shall describe the nature of the documents, communications, or things not produced or disclosed in a manner that, without revealing information itself privileged or protected, will enable other parties to assess the applicability of the privilege or protection.

#### **Rule 4:11-1 Before Action**

(a) Petition. A person who desires to perpetuate his or her own testimony or that of another person or preserve any evidence or to inspect documents or property or copy documents pursuant to R. 4:18-1 may file a verified petition, seeking an appropriate order, entitled in the petitioner's name, showing: (1) that the petitioner expects to be a party to an action cognizable in a court of this State but is presently unable to bring it or cause it to be brought; (2) the subject matter of such action and the petitioner's interest therein; (3) the facts which the petitioner desires to establish by the proposed testimony or evidence and the reasons for desiring to perpetuate or inspect it; (4) the names or a description of the persons the petitioner expects will be opposing parties and their addresses so far as known; (5) the names and addresses of the persons to be examined and the substance of the testimony which the petitioner expects to elicit from each; and (6) the names and addresses of the persons having control or custody of the documents or property to be inspected and a description thereof. The court may also grant a

pre-complaint petition for depositions filed pursuant to this rule by a person asserting that due to extraordinary circumstances, which shall be explained in detail by affidavit, such depositions are necessary to enable compliance with > N.J.S.A. 2A:53a-27 to -29 (Affidavit of Merit Statute).

(b) Notice and Service. At least 20 days before the date of hearing the petitioner shall serve upon each person named in the petition as an expected adverse party, in the manner provided by R. 4:4-4 and R. 4:4-5(a), a notice, with a copy of the petition attached, stating the time and place of the application for the order described in the petition. If it appears to the court after diligent inquiry that such service cannot be made, the court may order service by publication or otherwise, and shall appoint an attorney to represent persons so served, who, if such persons are not otherwise represented, may cross-examine the deponent. Such attorney's compensation may be fixed by the court and charged to the petitioner. The provisions of R. 4:26-2 apply if any expected adverse party is a minor or incompetent.

(c) Order and Examination. If the court finds that the perpetuation of the testimony or evidence or the inspection may prevent a failure or delay of justice, it shall make an order designating or describing the evidence to be preserved, or the documents or property to be inspected or the persons whose depositions may be taken and specifying the subject matter of the examination and whether the depositions shall be taken upon oral examination or written interrogatories. The depositions or inspection may then be taken in accordance with these rules; and the court may make such orders as are provided for by R. 4:18 and R. 4:19.

(d) Use of Deposition. If a deposition to perpetuate testimony is taken under these rules or if, although not so taken, it would be admissible in evidence in the courts of the United States or of the state in which it is taken, it may, in accordance with the provisions of R. 4:16-1 and R. 4:16-2, be used in any action between the same parties or their privies involving the same subject matter, which is subsequently brought in any court of this State having cognizance thereof.

**Rule 4:14-3 Examination and Cross-Examination; Record of Examination; Oath; Objections**

(a) Examination and Cross-Examination. Examination and cross-examination of deponents may proceed as permitted in the trial of actions in open court, but the cross-examination need not be limited to the subject matter of the examination in chief.

(b) Oath; Record. The officer before whom the deposition is to be taken shall put the witness on oath and shall personally, or by some one acting under the officer's direction and in the officer's presence, record the testimony of the witness. The testimony shall be recorded and transcribed on a typewriter unless the parties agree otherwise.

(c) Objections. No objection shall be made during the taking of a deposition except those addressed to the form of a question or to assert a privilege, a right to confidentiality or a limitation pursuant to a previously entered court order. The right to object on other grounds is preserved and may be asserted at the time the deposition testimony is proffered at trial. An objection to the form of a question shall include a statement by the objector as to why the form is objectionable so as to allow the interrogator to amend the question. No objection shall be expressed in language that suggests an answer to the deponent. Subject to R. 4:14-4, an attorney shall not instruct a witness not to answer a question unless the basis of the objection is privilege, a right to confidentiality or a limitation pursuant to a previously entered court order. All objections made at the time of the examination to the qualifications of the officer taking the

deposition or the person recording it, or to the manner of taking it, or to the evidence presented, or to the conduct of any party, and any other objection to the proceedings, shall be noted by the officer upon the deposition. Evidential objections to a videotaped deposition of a treating physician or expert witness which is taken for use in lieu of trial testimony shall be made and proceeded upon in accordance with R. 4:14-9(f).

(d) No Adjournment. Except as otherwise provided by R. 4:14-4 and R. 4:23-1(a) all depositions shall be taken continuously and without adjournment unless the court otherwise orders or the parties and the deponent stipulate otherwise.

(e) Written Questions. In lieu of participating in an oral examination, parties may serve written questions in a sealed envelope on the party taking the deposition and that party shall transmit them to the officer, who shall propound them to the witness and record the answers verbatim.

(f) Consultation With the Deponent. Once the deponent has been sworn, there shall be no communication between the deponent and counsel during the course of the deposition while testimony is being taken except with regard to the assertion of a claim of privilege, a right to confidentiality or a limitation pursuant to a previously entered court order.

#### **Rule 4:17-1 Service, Scope of Interrogatories**

(a) Generally. Any party may serve upon any other party written interrogatories relating to any matters which may be inquired into under R. 4:10-2. The interrogatories may include a request, at the propounder's expense, for a copy of any paper.

(b) Uniform Interrogatories in Certain Actions.

(i) Limitations on Interrogatories. In all actions seeking recovery for property damage to automobiles and in all personal injury cases other than wrongful death, toxic torts, cases involving issues of professional malpractice other than medical malpractice, and those products liability cases either involving pharmaceuticals or giving rise to a toxic tort claim, the parties shall be limited to the interrogatories prescribed by Forms A, B and C of Appendix II, as appropriate, provided, however, that each party may propound ten supplemental questions, without subparts, without leave of court. Any additional interrogatories shall be permitted only by the court in its discretion on motion.

(ii) Demand in Lieu of Service. A party required or desiring to propound uniform interrogatories as provided for by this rule shall do so by a letter of demand served upon all adverse parties in lieu of service of the interrogatories themselves.

(iii) Claims of Privilege, Protection. Privileged information need not be disclosed provided the nature of the privilege is identified. Nor need information be disclosed if it is the subject of an identified protective order issued pursuant to R. 4:10-2.

#### **Rule 4:17-4 Form, Service and Time of Answers**

(a) Form of Answers; By Whom Answered. Except as otherwise provided in this rule, interrogatories shall be answered in writing under oath by the party upon whom served, if an individual, or, if a public or private corporation, a partnership or association, or governmental

agency, by an officer or agent who shall furnish all information available to the party. If a party is unavailable, the interrogatories may be answered by an agent or authorized representative, including a liability carrier who is conducting the defense, whose answers shall bind the party. The party shall furnish all information available to the party and the party's agents, employees, and attorneys. The person answering the interrogatories shall designate which of such information is not within the answerer's personal knowledge and as to that information shall state the name and address of every person from whom it was received, or, if the source of the information is documentary, a full description including the location thereof. Each question shall be answered separately, fully and responsively either in the space following the question or on separate pages. Except as otherwise provided by paragraph (d) of this rule, if in any interrogatory a copy of a paper is requested, the copy shall be annexed to the answer. If the interrogatory requests the name of an expert or treating physician of the answering party or a copy of the expert's or treating physician's report, the party shall comply with the requirements of paragraph (e) of this rule.

(b) Service of Answers; Time; Enlargement of Time. The party served with interrogatories shall serve answers thereto upon the party propounding them within 60 days after being served with the interrogatories. For good cause shown the court may enlarge or shorten such time upon motion on notice made within the 60-day period. Consent orders enlarging the time are prohibited.

(c) Copies; Service by Propounding Party. The original of the answers shall be served upon the propounding party, who shall then serve a copy of the interrogatories and answers upon each of the other parties. Parties against whom default has been entered need not, however, be served, and parties represented by the same attorney need be served with one copy.

(d) Option to Produce Business Records. Where the answer to an interrogatory may be derived or ascertained from or requires annexation of copies of the business records of the party upon whom the interrogatory has been served or from an examination, audit or inspection of such business records, or from a compilation abstract or summary based thereon, and the burden of deriving or ascertaining the answer is substantially the same for the party serving the interrogatory as for the party served, it is a sufficient answer to such interrogatory to specify the records from which the answer may be derived or ascertained and to afford to the party serving the interrogatory reasonable opportunity to examine, audit or inspect such records and to make copies, compilations, abstracts or summaries.

(e) Expert's or Treating Physician's Names and Reports. If an interrogatory requires a copy of the report of an expert witness or a treating physician, the answering party shall annex to the interrogatory an exact copy of the entire report or reports rendered by the expert or treating physician or a complete summary of any oral report. The answering party shall further certify to not knowing of the existence of other reports of that expert or treating physician, either written or oral, and if such become later known or available, they shall be served promptly on the propounding party, but in no case later than the time provided by R. 4:17-7. If the answer to an interrogatory requesting the name and report of the party's expert or treating physician indicates that the same will be supplied thereafter, the propounder may, on notice, move for an order of the court fixing a day certain for the furnishing of that information by the answering party. Such order may further provide that an expert or treating physician whose name or report is not so furnished shall not be permitted to testify at trial.

**Rule 4:17-8 Use, Filing and Effect of Interrogatories**

(a) Use. Answers to interrogatories may be used to the same extent as provided by R. 4:16-1(a) and R. 4:16-1(b) for the use of the deposition of a party. If less than all of the interrogatories and answers thereto are marked or read into evidence by a party, an adverse party may read into evidence any other of the interrogatories and answers or parts thereof necessary for a fair understanding of the parts read into evidence. Interrogatories shall not be marked into evidence without good cause.

(b) Filing. Neither the interrogatories nor the answers shall be filed unless the court so directs at the pre-trial conference or trial.

(c) Pleading Not Stayed. The service of interrogatories shall not stay the time for service of an answering pleading.

**Rule 4:26-4 Fictitious Names; In Personam Actions**

In any action, irrespective of the amount in controversy, other than an action governed by R. 4:4-5 (affecting specific property or a res), if the defendant's true name is unknown to the plaintiff, process may issue against the defendant under a fictitious name, stating it to be fictitious and adding an appropriate description sufficient for identification. Plaintiff shall on motion, prior to judgment, amend the complaint to state defendant's true name, such motion to be accompanied by an affidavit stating the manner in which that information was obtained. If, however, defendant acknowledges his or her true name by written appearance or orally in open court, the complaint may be amended without notice and affidavit. No final judgment shall be entered against a person designated by a fictitious name.

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**UNIFORM INTERROGATORIES: FORM A. UNIFORM INTERROGATORIES TO BE ANSWERED BY PLAINTIFF IN ALL PERSONAL INJURY CASES: SUPERIOR COURT**

(Caption)

1. Full name, present address and date of birth.
2. Describe in detail your version of the accident or occurrence setting forth the date, location, time and weather.
3. Detailed description of nature, extent and duration of any and all injuries.
4. Detailed description of injury or condition claimed to be permanent together with all present complaints.
5. If confined to a hospital, state its name and address, and dates of admission and discharge.
6. If any diagnostic tests were performed, state the type of test performed, name and address of place where performed, date each test was performed and what each test disclosed. Attach a copy of the test results.
7. If treated by any health care provider, state the name and present address of each health care provider, the dates and places where treatments were received and the date of last treatment. Attach true copies of all written reports provided to you by any such health care provider whom you propose to have testify in your behalf.
8. If still being treated, the name and address of each doctor or health care provider rendering treatment, where and how often treatment is received and the nature of the treatment.
9. If a previous injury, disease, illness or condition is claimed to have been aggravated, accelerated or exacerbated, specify in detail the nature of each and the name and present address of each health care provider, if any, who ever provided treatment for the condition.
10. If employed at the time of the accident, state: (a) name and address of employer; (b) position held and nature of work performed; (c) average weekly wages for past year; (d) period of time lost from employment, giving dates; and (e) amount of wages lost, if any.
11. If there has been a return to employment or occupation, state: (a) name and address of present employer; (b) position held and nature of work performed; and (c) present weekly wages, earning, income or profit.
12. If other loss of income, profit or earnings is claimed: (a) state total amount of the loss; (b) give a complete detailed computation of the loss; and (c) state the nature and source of the loss of income, profit and earnings, and the dates of the deprivation.
13. Itemize in complete detail any and all moneys expended or expenses incurred for hospitals, doctors, nurses, diagnostic tests or health care providers, x-rays, medicines, care and appliances and state the name and address of each payee and the amount paid and owed each payee.
14. Itemize any and all other losses or expenses incurred not otherwise set forth.
15. Identify all documents that may relate to this action, and attach copies of each such document.

16. State the names and addresses of all eyewitnesses to the accident or occurrence, their relationship to you and their interest in this lawsuit.

17. State the names and addresses of all persons who have knowledge of any facts relating to the case.

18. If any photographs, videotapes, audio tapes or other forms of electronic recording, sketches, reproductions, charts or maps were made with respect to anything that is relevant to the subject matter of the complaint, describe: (a) the number of each; (b) what each shows or contains; (c) the date taken or made; (d) the names and addresses of the persons who made them; (e) in whose possession they are at present; and (f) if in your possession, attach a copy, or if not subject to convenient copying, state the location where inspection and copying may take place.

19. If you claim that the defendant made any admissions as to the subject matter of this lawsuit, state: (a) the date made; (b) the name of the person by whom made; (c) the name and address of the person to whom made; (d) where made; (e) the name and address of each person present at the time the admission was made; (f) the contents of the admission; and (g) if in writing, attach a copy.

20. If you or your representative and the defendant have had any oral communication concerning the subject matter of this lawsuit, state: (a) the date of the communication; (b) the name and address of each participant; (c) the name and address of each person present at the time of such communication; (d) where such communication took place; and (e) a summary of what was said by each party participating in the communication.

21. If you have obtained a statement from any person not a party to this action, state: (a) the name and present address of the person who gave the statement; (b) whether the statement was oral or in writing and if in writing, attach a copy; (c) the date the statement was obtained; (d) if such statement was oral, whether a recording was made, and if so, the nature of the recording and the name and present address of the person who has custody of it; (e) if the statement was written, whether it was signed by the person making it; (f) the name and address of the person who obtained the statement; and (g) if the statement was oral, a detailed summary of its contents.

22. If you claim that the violation of any statute, rule, regulation or ordinance is a factor in this litigation, state the exact title and section.

23. State the names and addresses of any and all proposed expert witnesses. Set forth in detail the qualifications of each expert named and attach a copy of each expert's current resume. Also attach true copies of all written reports provided to you by any such proposed expert witnesses.

With respect to all expert witnesses, including treating physicians, who are expected to testify at trial and with respect to any person who has conducted an examination pursuant to Rule 4:19, who may testify, state each such witness's name, address and area of expertise and attach a true copy of all written reports provided to you. If a report is not written, supply a summary of any oral report provided to you.

State the subject matter on which your experts are expected to testify.

State the substance of the facts and opinions to which your experts are expected to testify

and a summary of the grounds for each opinion.

24. State whether you have ever been convicted of a crime. YES (\_\_\_\_) or NO (\_\_\_\_).

If the answer is "yes", state: (a) date; (b) place; and (c) nature.

#### TO BE ANSWERED ONLY IN AUTOMOBILE ACCIDENT CASES

25. Do you have insurance coverage and/or PIP benefits under an applicable policy or policies of automobile insurance? As to each such policy provide the name and address of the insurance carrier, policy number, the named insured and attach a copy of the declaration sheet.

If you are making a claim for property damage to a motor vehicle, provide answers to the uniform interrogatories contained in Form B, questions 1 through 18.

#### CERTIFICATION

I hereby certify that the foregoing answers to interrogatories are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

I hereby certify that the copies of the reports annexed hereto provided by either treating physicians or proposed expert witnesses are exact copies of the entire report or reports provided by them; that the existence of other reports of said doctors or experts, written or oral, are unknown to me, and if such become later known or available, I shall serve them promptly on the propounding party.

#### **FORM A(1). UNIFORM INTERROGATORIES TO BE ANSWERED BY PLAINTIFF IN MEDICAL MALPRACTICE CASES ONLY: SUPERIOR COURT**

(Caption)

1. State your full name, address, date and place of birth and Social Security number.
2. State the date on which you first came under the medical care of the defendant(s).
3. State the reason(s) you first consulted the defendant(s).
4. State in detail the medical history you gave the defendant(s).
5. Describe the examination performed by the defendant(s) the first time you came under defendant's medical care.
6. Set forth each date on which you presented yourself to defendant(s) for examination and/or treatment and describe in detail the treatment given to you on each date.
7. State the name of each defendant that you contend was negligent, and state what you contend that each such defendant did that should not have been done and what you contend that each defendant did not do that should have been done, and the dates thereof. Set forth all facts on which you base your contentions. If you are relying on any written documents or records, identify those documents and records, and state the material in each document which you contend demonstrates negligence.
8. State the names and addresses of all persons having knowledge of relevant facts relating to this lawsuit and specify those who are eyewitnesses to any act of negligence.
9. State the names and addresses of any and all proposed expert witnesses. Set forth in detail

the qualifications of each expert named and attach a copy of each expert's current resume. Also attach true copies of all written reports provided to you by any such proposed expert witnesses.

With respect to all expert witnesses, including treating physicians, who are expected to testify at trial, and with respect to any person who has conducted an examination pursuant to Rule 4:19, state each such witness's name, address and area of expertise and attach a true copy of all written reports provided to you. If a report is not written, supply a summary of any oral report provided to you.

State the subject matter on which your experts are expected to testify.

State the substance of the facts and opinions to which your experts are expected to testify and provide a summary of the factual grounds for each opinion.

10. If you or your expert intend to rely on or use in any way at trial any treatise, identify the treatise by title, author and edition and indicate the pertinent portions to be relied on or used at trial.

11. State whether or not you have been admitted to any hospital or other medical treatment facility in the last ten years and if so, state the name of the hospital or facility, the dates of admission and discharge, the illness, disease or condition that caused such admission and the names and addresses of the doctor(s) who treated you during such admission.

12. State whether you have undergone a physical examination in connection with employment or any application for employment in the last ten years. If so, state the date of any such examination, where it was conducted, who conducted the examination and whether there is a report of such physical examination. If a report was made, attach a true copy. If any such physical examination resulted in action being taken on your behalf or against you, please describe such action.

13. State whether you have ever suffered from any injury or disease other than the condition for which you consulted the defendant(s). If so, specify in detail the nature of each such injury or disease and the name and present address of each health care provider, if any, who ever provided treatment for the condition.

14. State whether you have ever had a family physician and if so, state physician's name, address and telephone number. Specify and describe any illness or injury for which the family physician has treated you during the past ten years.

15. State whether you have consulted any other health care provider in the past ten years. If so, specify in detail the nature of the condition for which you consulted the health care provider and the name and present address of each health care provider who ever provided treatment for the condition.

16. State whether any admissions or statements were made by any party to this action or their agents, servants or employees and if so, state:

- (a) whether oral, written or otherwise recorded;
- (b) the date, time and place made;
- (c) if oral, the words used, or a summary of same;
- (d) if written, attach a copy; and

(e) the names and addresses of all persons present at the time and place the statements or admissions were made.

17. State whether you have ever made a claim or filed a lawsuit against anyone arising out of any personal injury and if so, state for each such claim or lawsuit:

- (a) the date and place the injury occurred;
- (b) the court or place of filing;
- (c) the date of filing;
- (d) the names and addresses of all parties and their attorneys;
- (e) the nature and extent of all injuries;
- (f) the docket or claim number; and

(g) the present status of each such lawsuit or claim and if concluded describe the manner in which the lawsuit or claim was concluded and the payment, if any, you received.

18. Describe the injuries you sustained as a result of the negligence claimed in this lawsuit.

19. If you were treated, attended or examined by any physician(s) or others for the injuries identified in response to Question 18, state:

- (a) the names and addresses of all such persons;
- (b) whether you were admitted to a hospital or other medical treatment facility and if so provide the name and address of the facility and the dates of admission and discharge;
- (c) the dates of every treatment or examination and where they took place; and
- (d) state the nature of the medical treatment given by each physician or other person.

20. State whether you are still afflicted with or suffering from the effects of any injury, illness or disability as a result of defendant's negligence. If so, describe in detail.

21. Set forth all claims for economic damages against the defendant(s), including lost wages, and itemize the amounts paid or owed, dates incurred, and the names and addresses of each person to whom paid or owed.

#### CERTIFICATION

I hereby certify that the foregoing answers to interrogatories are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

I hereby certify that the copies of the reports annexed hereto provided by either treating physicians or proposed expert witnesses are exact copies of the entire report or reports provided by them; that the existence of other reports of said doctors or experts, either written or oral, are unknown to me, and if such become later known or available, I shall serve them promptly on the propounding party.

**FORM C. UNIFORM INTERROGATORIES TO BE ANSWERED BY DEFENDANT IN ALL PERSONAL INJURY CASES: SUPERIOR COURT**

1. State: (a) the full name and residence address of each defendant; (b) if a corporation, the exact corporate name; and (c) if a partnership, the exact partnership name and the full name and residence address of each partner.

2. Describe in detail your version of the accident or occurrence setting forth the date, location, time and weather.

3. If you intend to set up or plead or have set up or pleaded negligence or any other separate defense as to the plaintiff or if you have or intend to set up a counterclaim or third-party action, (a) state the facts upon which you intend to predicate such defenses, counterclaim or third-party action; and (b) identify a copy of every document relating to such facts.

4. State the names and addresses of all persons who have knowledge of any relevant facts relating to the case.

5. State (a) the name and address of any person who has made a statement regarding this lawsuit; (b) whether the statement was oral or in writing; (c) the date the statement was made; (d) the name and address of the person to whom the statement was made; (e) the name and address of each person present when the statement was made; and (f) the name and address of each person who has knowledge of the statement.

Unless subject to a claim of privilege, which must be specified: (g) attach a copy of the statement, if it is in writing; (h) if the statement was oral, state whether a recording was made and, if so, set forth the nature of the recording and the name and address of the person who has custody of it; and (i) if the statement was oral and no recording was made, provide a detailed summary of its contents.

6. If you claim that the plaintiff made any statements or admissions as to the subject matter of this lawsuit, state: (a) the date made; (b) the name of the person by whom made; (c) the name and address of the person to whom made; (d) where made; (e) the name and address of each person present at the time the admission was made; (f) the contents of the admission; and (g) if in writing, attach a copy.

7. If you contend that the plaintiff's damages were caused or contributed to by the negligence of any other person, set forth the name and address of the other person and the facts upon which you will rely in establishing that negligence.

8. State the names and addresses of all eye witnesses to the accident or occurrence, their relationship to you and their interest in this lawsuit.

9. If any photographs, videotapes, audio tapes or other forms of electronic recording, sketches, reproductions, charts or maps were made with respect to anything that is relevant to the subject matter of the complaint, describe: (a) the number of each; (b) what each shows or contains; (c) the date taken or made; (d) the names and addresses of the persons who made them; (e) in whose possession they are at present; and (f) if in your possession, attach a copy, or if not subject to convenient copying, state the location where inspection and copying may take place.

10. State the names and addresses of any and all proposed expert witnesses. Set forth in detail the qualifications of each expert named and attach a copy of each expert's current resume. Also attach true copies of all written reports provided to you by any such proposed expert witnesses.

With respect to all expert witnesses, including treating physicians, who are expected to testify at trial, and with respect to any person who has conducted an examination pursuant to Rule 4:19, state each such witness's name, address and area of expertise and attach a true copy of all written reports provided to you. If a report is not written, supply a summary of any oral report provided to you.

State the subject matter on which your experts are expected to testify.

State the substance of the facts and opinions to which your experts are expected to testify and provide a summary of the factual grounds for each opinion.

11. If you contend or intend to contend at the time of trial that the plaintiff sustained personal injuries in any prior or subsequent accident, state: (a) the date of said accident; (b) the injuries you contend that plaintiff sustained; (c) the parties involved in said accident; (d) the source from which you obtained the information; and (e) attach a copy of any written documents regarding this information.

12. If you intend to rely on any statute, rule, regulation or ordinance, state the exact title and section.

13. Pursuant to R. 4:10-2(b), state whether there are any insurance agreements including excess policies under which any person or firm carrying on an insurance business may be liable to satisfy part or all of a judgment that may be entered in this action or to indemnify or reimburse for payments made to satisfy the judgment. YES (\_\_\_\_) or NO (\_\_\_\_).

If the answer is "yes", attach a copy of each insurance agreement or policy, or in the alternative state: (a) number; (b) name and address of insurer or issuer; (c) inception and expiration dates; (d) names and addresses of all persons insured thereunder; (e) personal injury limits; (f) property damage limits; (g) medical payment limits; (h) name and address of person who has custody and possession thereof; and (i) where and when each policy or agreement can be inspected and copied.

14. Identify all documents that may relate to this action, and attach copies of each such document.

15. State whether you have ever been convicted of a crime. YES (\_\_\_\_) or NO (\_\_\_\_).

If the answer is "yes", state: (a) date; (b) place; and (c) nature.

#### CERTIFICATION

I hereby certify that the foregoing answers to interrogatories are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

I hereby certify that the copies of the reports annexed hereto provided by either treating physicians or proposed expert witnesses are exact copies of the entire report or reports provided by them; that the existence of other reports of said doctors or experts, either written or oral, are unknown to me, and if such become later known or available, I shall serve them promptly on the propounding party.

**FORM C(3). UNIFORM INTERROGATORIES TO BE ANSWERED BY DEFENDANT**

## **PHYSICIANS IN MEDICAL MALPRACTICE CASES ONLY: SUPERIOR COURT**

1. Identify and describe the appearance of each and every person who was present in the vicinity of the alleged occurrence, giving the name, address and occupation of each such person and stating your relationship to each.
2. Describe in detail all aspects of your professional medical relationship with the plaintiff, indicating the date of commencement, the nature and extent of your medical relationship prior to the alleged occurrence, and the date and circumstances of the termination of your professional medical relationship.
3. In reference to the condition that forms the basis of the complaint, set forth:
  - (a) the date(s) and circumstances under which you saw plaintiff;
  - (b) any and all medical history given to you;
  - (c) the examination(s) conducted of the plaintiff;
  - (d) your findings on each examination;
  - (e) your prognosis and diagnosis following each examination; and
  - (f) any treatment or medication prescribed.
4. Attach your Curriculum Vitae or describe in detail your education, training, experience, published materials, service on boards and committees, continuing education and certifications, prior work and hospital affiliations, licenses and specialties.
5. Have your full rights or privileges to practice medicine been suspended, revoked or terminated in any state or hospital since you started to practice medicine? If the answer to this question is in the affirmative, state:
  - (a) the reason why your full rights or privileges to practice medicine or any hospital association were suspended, revoked or terminated; and
  - (b) the name of the state or hospital that suspended, revoked or terminated your full rights or privileges to practice medicine.
6. If you have ever been a defendant in a malpractice suit other than the present one, identify the case by name, court and docket number, and summarize the allegations against you and the outcome of the case, including the terms of any settlement.
7. Attach a complete copy of any written records or documents that you have regarding plaintiff, along with a typed transcription of any handwritten records and documents.
8. Attach a copy of all documents that the plaintiff signed consenting to any treatment or procedures performed or prescribed by you, as well as a copy of any literature, material, pamphlets, instructions or other information or documents that you supplied to plaintiff.
9. List all risks that you described to the plaintiff with respect to any treatment or procedures you prescribed or performed.
10. If you contend that the plaintiff's injuries were caused in whole or in part by an inherent defect in a drug, instrument, implement or other type of product or substance, identify each such allegedly defective item, including in your identification:

(a) a complete description of its appearance, and appearance of its container or wrapper, if any;

(b) the name and address of its manufacturer;

(c) the name and address of the dealer or seller who sold it to the person who owned it at the time of the alleged occurrence;

(d) the name, occupation, title, address and professional relationship to you of the person who owned it at the time of the occurrence;

(e) a description of the use to which it is normally put;

(f) its serial number, batch number or other specific identifying characteristics; and

(g) the medical name for this product and a lay description of it and its use.

11. If there were any reviews performed, including investigations undertaken, hearings held or reports prepared, by the hospital, its medical staff or any officer, committee or agency of the hospital or any public body or other person or persons concerning the condition that forms the basis of the complaint, state:

(a) the name and position of the person, persons or committee that performed the review;

(b) the date and time of each review;

(c) the name, address, profession or professional relationship to you of all persons present at each review;

(d) the nature and purpose of each review;

(e) whether the review was recorded; and

(f) the name and address of each person who has any records concerning each review.

12. Did you refer to or rely upon any medical texts or publications in connection with the diagnosis or treatment of plaintiff? If so, identify those items by title, author and publisher.

13. If you or your expert intend to rely on or use in any way at trial any treatise, identify the treatise by title, author and edition and indicate the pertinent portions to be relied on or used at trial.

14. If you claim that the alleged occurrence resulted from the plaintiff's own lack of care, set forth as fully and specifically as you can what acts, conduct or omissions constituted such lack of due care.

15. State the names and addresses of all consultants or other physicians who saw, examined and treated plaintiff at your request for the condition forming the basis of the complaint, and in relation to all such consultations or examinations by other physicians indicate:

(a) the reason you requested consultations or further examination;

(b) when the consultation or examination took place; and

(c) all opinions or reports rendered to you by the consultant or examining physician, and if the reports were oral, set forth the contents in detail.

16. The plaintiff in the complaint alleges that while under your care he/she sustained the injury

and disability which is the subject matter of this lawsuit. In relation to such injury and disability, indicate in your opinion the cause of that injury and disability.

#### CERTIFICATION

I hereby certify that the foregoing answers to interrogatories are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

I hereby certify that the copies of the reports annexed hereto provided by either treating physicians or proposed expert witnesses are exact copies of the entire report or reports provided by them; that the existence of other reports of said doctors or experts, either written or oral, are unknown to me, and if such become later known or available, I shall serve them promptly on the propounding party.

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### MODEL JURY CHARGES

#### 5.50 MEDICAL NEGLIGENCE

##### 5.50A DUTY AND NEGLIGENCE

In this case, the plaintiff(s), [*insert plaintiff(s) name(s)*], contend(s) that the defendants, [*insert defendant(s) name(s)*], was (were) negligent in the diagnosis and [/or] treatment of [*insert name*], and that such negligence was a substantial factor in causing the plaintiff(s), [*insert plaintiff(s) name(s)*], to be injured.

Negligence is conduct which deviates from a standard of care required by law for the protection of persons from harm. Negligence may result from the performance of an act or the failure to act. The determination of whether a defendant was negligent requires a comparison of the defendant's conduct against a standard of care. If the defendant's conduct is found to have fallen below an accepted standard of care, then he or she was negligent.

In this case the defendant(s) is/are [*describe the profession*]. Therefore, to decide this case properly you must know the standard of care imposed by law against which the defendant's (s') conduct as a [*describe the profession*] should be measured.

##### NOTE TO JUDGE

*For the standard of care, the appropriate paragraph of Options A or B (as follows) may be read.*

**[Option A: Specialist.]** The defendant(s) in this case is (are) a medical specialist(s) in the field of [*insert appropriate specialty description*]. Specialists in a field of medicine represent that they will have and employ not merely the knowledge and skill of a general practitioner, but that they have and will employ the knowledge and skill normally possessed and used by the average specialist in the field. Thus, when a physician holds himself/herself out as a specialist and undertakes to diagnose and treat the medical needs of a patient, the law imposes a duty upon that physician to have and to use that degree of knowledge and skill which is normally possessed and used by the average specialist in that field, having regard to the state of scientific knowledge at the time that he/she or she attended the plaintiff.

**[Option B: General Practitioner.]** The defendant(s) in this case is (are) a general practitioner(s). A person who is engaged in the general practice of medicine represents that he/she or she will have and employ knowledge and skill normally possessed and used by the

average physician practicing his/her profession as a general practitioner.

**[Remainder of Charge.]**

Given what I have just said, it is important for you to know the standard of care which a general practitioner/specialist in *[insert appropriate specialty description, if applicable]* is required to observe in his/her treatment of a patient under the circumstances of this case. Based upon common knowledge alone, and without technical training, jurors normally cannot know what conduct constitutes standard medical practice. Therefore, the standard of practice by which a physician's conduct is to be judged must be furnished by expert testimony, that is to say, by the testimony of persons who by knowledge, training or experience are deemed qualified to testify and to express their opinions on medical subjects.

You as jurors should not speculate or guess about the standards of care by which the defendant physician(s) should have conducted himself/herself/themselves in the diagnosis and treatment of the plaintiff. Rather, you must determine the applicable medical standard from the testimony of the expert witness(es) you have heard in this case.

Where there is a conflict in the testimony of the medical experts on a subject, it is for you the jury to resolve that conflict using the same guidelines in determining credibility that I mentioned earlier. You are not required to accept arbitrarily the opinions offered. You should consider the expert's qualifications, training, and experience, as well as his/her understanding of the matters to which he/she or she testified.

Where an expert has offered an opinion upon an assumption that certain facts are true, it is for you, the jury, to decide whether the facts upon which the opinion is based are true. The value and weight of an expert's testimony in such instances is dependent upon, and no stronger than, the facts upon which it is predicated.

When determining the applicable standard of care, you must focus on accepted standards of practice in *[insert general practice or specialty involved]* and not on the personal subjective belief or practice of the defendant doctor.

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. Therefore, whether the defendant doctor was negligent depends not on the outcome, but on whether he/she adhered to or departed from the applicable standard of care. *Ibid.*

**NOTE TO JUDGE**

*Where the defendant has satisfied the burden of proving that medical judgment is involved in the case, insert Charge 5.50G, Medical Judgment, here.*

If you find that the defendant(s) has (have) complied with the accepted standard of care, then he/she/they is/are not liable to the plaintiff regardless of the result. On the other hand, if you find that the defendant(s) has (have) deviated from the standard of care resulting in injury or damage to plaintiff, then you should find defendant(s) negligent and return a verdict for plaintiff.

**NOTE TO JUDGE**

*The standard charge for proximate cause and burden of proof should be used, deleting, however, the word "malpractice" where used and inserting in its place the word "negligence." Likewise, in those cases in which a jury will be permitted to supply the standard of care without the need for expert testimony, the standard charge should be used, but the phrase "guilty of malpractice" should be deleted and the word "negligence" inserted in its place.*

*As to any other charge which may be relevant to a case involving professional negligence, the Committee suggests that the use of the term "malpractice" or the phrase "guilty of malpractice" not be used and that the general term "negligence" be used in its place.*

## **5.50B COMMON KNOWLEDGE MAY FURNISH STANDARD OF CARE**

*Negligence is the failure to comply with the standard of care to protect a person from harm. Negligence in a doctor's medical practice, which is called malpractice, is the doctor's failure to comply with the standard of care in the care and treatment of his/her patient. Usually it is necessary to establish the standard of care by expert testimony, that is, by testimony of persons who are qualified by their training, study and experience to give their opinions on subjects not generally understood by persons who lack such special training or experience. In the usual case the standard of care by which to judge the defendant's conduct cannot be determined by the jury without the assistance of expert medical testimony.*

*However, in some cases, such as the case at hand, the jury may determine from its common knowledge and experience the standard of care by which to judge the defendant's conduct. In this case plaintiff contends that the defendant violated the duty of care he/she owed to the plaintiff by doing \_\_\_\_\_ [or by failing to do the following \_\_\_\_\_]. In this case, therefore, it is for you, as jurors, to determine, based upon common knowledge and experience, what skill and care the average physician practicing in the defendant's field would have exercised in the same or similar circumstances. It is for you as jurors to say from your common knowledge and experience whether the defendant deviated from the standard of care in the circumstances of this case.*

### **NOTE TO JUDGE**

*Where there has been expert medical testimony as to the standard of care, but the standard is one which can also be determined by the jury from its common knowledge and experience, the jury should determine the standard of care after considering all the evidence in the case, including the expert medical testimony, as well as its own common knowledge and experience.*

After determining the standard of care required in the circumstances of this case, you should then consider the evidence to determine whether the defendant has complied with or departed from that standard of care. If you find that defendant has complied with that standard of care he/she is not liable to the plaintiff, regardless of the result. If you find that defendant has not complied with that standard of care, resulting in injury or damage to the plaintiff, then you should find defendant negligent and return a verdict for plaintiff.

### **Cases and Notes:**

#### **a) Common Knowledge**

The common knowledge doctrine was applied in *Martin v. Perth Amboy General Hospital*, 104 N.J. Super. 335 (App. Div. 1969), where a laparotomy pad was left in plaintiff's body during an operation; *Tramutola v. Bortone*, 63 N.J. 9 (1973), where plaintiff discovered that a needle had been left in her chest during surgery; *Steinke v. Bell*, 32 N.J. Super. 67 (App. Div. 1954), where a dentist removed the wrong tooth; *Becker v. Eisenstodt*, 60 N.J. Super. 240 (App. Div. 1960), where the defendant used a caustic substance instead of an anesthetic; *Terhune v. Margaret Hague Maternity Hospital*, 63 N.J. Super. 106 (App. Div. 1960), where plaintiff was burned as a result of the improper administration of an anesthetic during childbirth; *Nowacki v. Community Medical Center*, 279 N.J. Super. 276 (App. Div. 1995), where plaintiff alleged that she fell while attempting to lift herself onto a treatment table; *Tierney v. St. Michael's*, 214 N.J. Super. 27 (App. Div. 1986), *certif. den.*, 107 N.J. 114 (1987), where plaintiff's infant crawled out

of a crib while hospitalized at the defendant hospital; *Winters v. Jersey City Medical Center*, 120 N.J. Super. 129 (App. Div. 1972), where the court held that one does not need an expert witness to testify that the bed rails should have been in the up position for an elderly person who fell out of bed. The common knowledge doctrine was applied to a failure to communicate an abnormal finding and the signing of an incorrect discharge summary in *Jenoff v. Gleason*, 215 N.J. Super. 349 (App. Div. 1987). In *Rosenberg by Rosenberg v. Cahill*, 99 N.J. 318 (1985), the common knowledge doctrine was not applied to the failure to observe a tumor in an x-ray.

The court rejected the plaintiff's reliance on the common knowledge doctrine in *Posta v. Chueng-Loy*, 306 N.J. Super. 182 (App. Div. 1997), involving hernia surgery.

See also, *Sanzari v. Rosenfeld*, 34 N.J. 128 (1961), *Jones v. Stess*, 111 N.J. Super. 283 (App. Div. 1970), *Klimko v. Rose*, 84 N.J. 496 (1980).

b) *Res ipsa loquitur*

There are three requirements which must be demonstrated in order to apply the doctrine of *res ipsa loquitur*:

- (1) The occurrence must be one which ordinarily bespeaks negligence;
- (2) The instrumentality causing the injury must have been within defendant's exclusive control; and
- (3) There must be no indication that the plaintiff's injury was in any way the result of his or her own voluntary act or neglect.

A detailed analysis of the doctrine of *res ipsa* is found in *Gould v. Winokur*, 98 N.J. Super. 554 (Law Div. 1968), *aff'd*, 104 N.J. Super. 329 (App. Div. 1969), *certif. den.*, 53 N.J. 582 (1969). See also, *Buckelew v. Grossbard*, 87 N.J. 512 (1981).

The difference between the *res ipsa* doctrine and the common knowledge doctrine is that the *res ipsa* doctrine requires expert testimony to prove the first element, *i.e.*, that the occurrence does not usually happen in the absence of negligence. *Smallwood v. Mitchell*, 264 N.J. Super. 295 (App. Div. 1993), *certif. den.*, 134 N.J. 481 (1993).

The logical extension of the *res ipsa* and common knowledge doctrines is the conclusion that there are cases where the facts are such that at least one defendant must be liable as a matter of law. The genesis of this concept in New Jersey is found in *Anderson v. Somberg*, 67 N.J. 291 (1975), *cert. den.*, 423 U.S. 929 (1975). See also, *Chin v. St. Barnabas Medical Center*, 160 N.J. 454 (1999).

The doctrine of *res ipsa loquitur* was deemed applicable in *Yerzy v. Levine*, 108 N.J. Super. 222 (App. Div. 1970), *aff'd*, 57 N.J. 234 (1970), where the common bile duct had been completely severed during gall bladder surgery; *Pearson v. St. Paul*, 220 N.J. Super. 110 (App. Div. 1987), where plaintiff's sixteen year old daughter died after arthroscopic knee surgery.

The doctrine of *res ipsa loquitur* was deemed inapplicable in *Toy v. Rickert*, 53 N.J. Super. 27 (App. Div. 1958), where plaintiff alleged that the defendant negligently administered a shot of penicillin into plaintiff's right buttock causing nerve damage; in *Renrick v. Newark*, 74 N.J. Super. 200 (App. Div. 1962), where plaintiff alleged that the defendant negligently injected a drug resulting in severe burning of both forearms and widespread scarring; *Posta v. Chueng-Loy*, 306 N.J. Super. 182 (App. Div. 1997), involving hernia surgery.

c) Common knowledge can be employed in some cases although expert medical testimony is also offered as to the standard of care and defendant's alleged departure therefrom. See *Sanzari v. Rosenfeld*, *supra*, 34 N.J. at 138 and 143.

### **5.50C INFORMED CONSENT (Competent Adult and No Emergency),**

A doctor must obtain the patient's informed consent before the doctor may treat or operate on the patient. The doctor has a duty to explain, in terms understandable to the patient, what the doctor intends to do before subjecting the patient to a course of treatment or an operation. The purpose of this legal requirement is to protect each person's right to self-determination in matters of medical treatment.

A doctor has a duty to evaluate the relevant information and disclose all courses of treatment that are medically reasonable under the circumstances. In order to obtain the patient's informed consent, the doctor must tell the patient not only about the alternatives that the doctor recommends, but also about all medically reasonable alternatives that the doctor does not recommend. A doctor does not comply with the duty of informed consent by disclosing only the treatment alternatives that the doctor recommends. Accordingly, the doctor must discuss all medically reasonable courses of treatment, including non-treatment, and the probable risks and outcomes of each alternative. By not discussing these alternatives, the doctor breaches the patient's right to make an informed choice and effectively makes the choice for the patient. The doctor has a duty to explain, in words the patient can understand, all material medical information and risks. Medical information or a risk of a medical procedure is material when a reasonable patient in the plaintiff's position would be likely to attach significance to it in deciding whether or not to submit to the treatment.

A doctor is responsible for any injuries suffered by the patient, if the doctor did not adequately explain all medically reasonable courses of treatment, including non-treatment, in what the doctor knows or should know to be the patient's medical position or condition. The doctor is not required to disclose to the patient all the details of a proposed operation or treatment or all the possible risks, no matter how small or remote. The doctor is not required to communicate those dangers known to the average person or those dangers the patient has already discovered. Taking into account what the doctor knows or should know to be the patient's need for information, the doctor must disclose the medical information and risks which a reasonably prudent patient would consider material or significant in making the decision about what course of treatment, if any, to accept. Such information would generally include a description of the patient's physical condition, the purposes and advantages of the proposed surgery or treatment, the material risks of the proposed treatment and the material risks if such surgery or treatment is not provided, as well as the available options or alternatives that are medically reasonable under the circumstances and the advantages and risks of each alternative.

The plaintiff must prove all of the following elements: (1) the defendant doctor failed to give the plaintiff all of the information that a reasonable person in the plaintiff's position would expect a doctor to disclose so that the plaintiff might make an informed decision about the course of treatment; (2) the undisclosed risk (of the treatment)/(of non-treatment) occurred; (3) a reasonable person under the circumstances of this case would not have consented to (or would have chosen to undergo) the treatment or operation had he/she been so informed; and (4) the course of treatment or operation (or failure to operate or treat) was a proximate cause in producing plaintiff's injuries or conditions.

Although the plaintiff's testimony may be considered on the question as to whether he/she would have consented, the issue to be resolved is not what this plaintiff would have done. You must decide whether a reasonably prudent person would not have consented (or chosen

another course of treatment), if provided with material information which you find the doctor failed to provide in this case.

If, however, you find that the defendant doctor gave all the information which a reasonable patient in the plaintiff's position would expect to receive at the time the consent was given, or that the undisclosed risk did not occur, or that the information which was omitted or not disclosed would not have caused a reasonably prudent patient to refuse consent to the procedure or operation, or that the course of treatment or operation, or failure to operate or treat, was not a proximate cause in producing the plaintiff's injuries or conditions, then your verdict should be for the defendant on this issue.

### **5.50E PRE-EXISTING CONDITION — INCREASED RISK/LOSS OF CHANCE — PROXIMATE CAUSE**

#### **NOTE TO JUDGE**

**In a series of cases, including *Fosgate v. Corona*, 66 N.J. 268 (1974); *Evers v. Dollinger*, 95 N.J. 399 (1984); *Scafidi v. Seiler*, 119 N.J. 93 (1990); *Gardner v. Pawliw*, 150 N.J. 359 (1997), and most recently *Reynolds v. Gonzales*, 172 N.J. 266 (2002), the New Jersey Supreme Court has established a modified standard of proximate cause for use in certain medical negligence cases. The following charge is to be used in cases where it is alleged that the plaintiff has a preexisting condition which creates a risk of harm and the defendant's negligence increases the risk of harm by depriving the plaintiff of a chance of recovery. Furthermore, in *Reynolds*, supra, the Supreme Court held that failure to specifically explain the charge in the context of the facts of the case was reversible error. Therefore, to assist trial judges and practitioners this Model Civil Charge uses typical medical negligence theories as illustrative examples.**

**Additionally, in cases involving an allegation that the failure to perform a diagnostic test increased the risk of harm from a preexisting condition, the trial court must also give that portion of the charge derived from *Gardner*, supra, as indicated below.**

In this case, [insert here a detailed factual description of the case, such as, (1) the plaintiff contends that she told the defendant that she felt a lump in her breast in January of 2000, that the defendant was negligent in not ordering a mammogram or other test for cancer until January 2001, and that as a result of the delay the cancer spread to her lungs, liver and brain, and is now likely to cause her death; or (2) the plaintiff contends that her husband went to the defendant hospital emergency room after suffering a heart attack. The plaintiff further asserts that the defendant negligently misdiagnosed her husband's heart attack, and sent her husband home, where he died.]

If you determine that the defendant was negligent, then you must also decide what is the chance that: [(1) the plaintiff would not be dying of cancer; or (2) the plaintiff's husband would not have died of the heart attack et cetera], if the defendant had not been negligent. Thus, if you decide that the defendant was negligent, then you must decide to what extent were the plaintiff's injuries caused by the preexisting medical condition and to what extent were the injuries caused by the defendant's negligence.

When the plaintiff came to the defendant, he/she had a preexisting condition [here describe the condition, e.g., breast cancer; heart attack et cetera] which by itself had a risk of causing the plaintiff the harm he/she ultimately experienced in this case. However, the plaintiff claims that

the defendant's negligence increased that risk of harm and contributed to the ultimate injury [here describe the ultimate harm]. To establish that the defendant's negligence was a cause of his/her injuries or damages, the plaintiff must first prove that the defendant's negligence increased the risk of harm posed by plaintiff's preexisting condition.

Second, the plaintiff must prove that the increased risk was a substantial factor in producing the ultimate harm or injury. If the negligent act was only remotely or insignificantly related to the ultimate harm or injury, then the negligent act does not constitute a substantial factor. However, the defendant's negligence need not be the only cause, nor even a primary cause, of an injury for the negligence to be a substantial factor in producing the ultimate harm or injury. Whether the increased risk was a substantial factor is to be reflected in the apportionment of damages between the increased risk and the preexisting condition.

If under all of the circumstances here [here insert specific circumstances such as the delay in the diagnosis of the breast cancer or the heart attack] you find that the plaintiff may have suffered lesser injuries if the defendant was not negligent, then the defendant is liable for the plaintiff's increased injuries. On the other hand, if you find that the plaintiff would have suffered the same injuries even if the defendant was not negligent, then the defendant is not liable to the plaintiff.

**[Add where the allegation is that the failure to perform a diagnostic test increased the risk of harm:]**

If you determine that the defendant was negligent in not having a diagnostic test performed, in this case [here indicate the test(s)], but it is unknown whether performing the test would have helped to diagnose or treat a preexistent condition, the plaintiff does not have to prove that the test would have resulted in avoiding the harm. In such cases the plaintiff must merely demonstrate that the failure to give the test increased the risk of harm from the preexistent condition. A plaintiff may demonstrate an increased risk of harm even if such tests are helpful in a small proportion of cases.

**[In all cases continue here:]**

If you find that the plaintiff has proven that the defendant was negligent, the plaintiff is not required to quantify or put a percentage on the extent to which the defendant's negligence added to all of the plaintiff's final injuries. In cases where the defendant's negligence accelerated or worsened the plaintiff's preexisting condition, the defendant is responsible for all of the plaintiff's injuries unless the defendant is able to reasonably apportion the damages. If the defendant claims that all or part of the plaintiff's injuries would have occurred anyway, then the defendant, and not the plaintiff, has the burden of proving what percentage of the plaintiff's injuries would have occurred even if the defendant had not been negligent. If the injuries can be so apportioned, then the defendant is responsible only for the amount of ultimate harm caused by the negligence.

For example, if the defendant claims that: [(1) the plaintiff would still have suffered the spread of her cancer even if the diagnosis had been made in January 2001; or (2) that the plaintiff's husband still would have died of a heart attack even if treated earlier], and if the defendant can prove that an apportionment can be reasonably made, separating those injuries the plaintiff would have suffered anyway, even with timely treatment, from those injuries the plaintiff suffered due to the delay in treatment, then the defendant is only liable for that portion/percentage of the injuries the defendant proves is related to the delay in treatment of the

plaintiff's original condition. On the other hand, if you find that the defendant has not met the defendant's burden of proving that plaintiff's injuries can be reasonably apportioned, then the defendant is responsible for all of the plaintiff's harm or injury.

When you are determining the amount of damages to be awarded to the plaintiff, you should award damages for all of the plaintiff's injuries. Your award should not be reduced by your allocation of harm. The adjustment in damages, which may be required, will be performed by the court.

#### **NOTE TO JUDGE**

**The trial court should give an ultimate outcome charge in conjunction with a Scafidi charge. Fischer v. Canario, 143 N.J. 235, 251 (1996), citing Roman v. Mitchell, 82 N.J. 336, 345 (1980). Noting that the purpose of an ultimate outcome charge is to inform the jury about the impact of its decision, the Fischer Court explained that juries should understand the impact of their findings. Therefore, the Fischer Court concluded that the trial court's failure to give the ultimate outcome charge, as reflected in Model Civil Charge 7.31, was error.**

#### **JURY INTERROGATORIES**

1) Did the defendant, Dr. \_\_\_\_\_, deviate from accepted standards of medical practice?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is "Yes," proceed to interrogatory 2.

If your answer is "No," return your verdict for the defendant.

2) Did the defendant's, Dr. \_\_\_\_\_'s, deviation increase the risk of harm posed by the plaintiff's preexisting condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is "Yes," proceed to interrogatory 3.

If your answer is "No," return your verdict for the defendant.

3) Has the defendant proven that some portion of the plaintiff's ultimate injury would have occurred, even if the defendant's treatment was proper?

Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is "Yes," proceed to question 4.

If your answer is "No," proceed to interrogatory 5.

4) State whether the increased risk was a substantial factor in causing the plaintiff's damages by stating, in percentages, what portion of the ultimate injury is a result from:

A. The pre-existing condition \_\_\_\_\_%

B. Dr. \_\_\_\_\_'s deviation from the standard of care \_\_\_\_\_%

Total 100 %

The total must equal 100%. If 100% of the damages are determined to be due to the preexisting condition, then return your verdict for the defendant. If any percentage of the damages are the result of the defendant(s) fault, then proceed to interrogatory 5.

5) What amount of money would fairly and reasonably compensate the plaintiff for his/her:

Past pain and suffering \$ \_\_\_\_\_

Future pain and suffering	\$ _____
Past medical bills	\$ _____
Future medical bills	\$ _____
Past lost income	\$ _____
Future lost income	\$ _____

6) What amount of money would fairly and reasonably compensate the plaintiff's spouse [per quod claimant] for his/her loss of \$ \_\_\_\_\_ services:

**5.50F WRONGFUL BIRTH AND LIFE (Updated)**

**NOTE TO JUDGE**

In *Canesi v Wilson*, 158 N.J. 490 (1999), the Supreme Court mandated that an informed consent charge be given in every wrongful birth case. The standard for counseling in all wrongful birth cases was expressly found to be the reasonable patient standard and not the professional standard of care. The *Canesi* Court held that a physician is required to ascertain enough of a patient's background "to assess what information might be useful to the patient's deliberative process and then to discuss that information with her . . . the reasonably prudent patient standard thus takes into account each woman's unique circumstances." *Id.* at 510. The Court explained that "because the patient's protectable interest is the personal right of self-determination, the doctor's duty of disclosure must be sufficient to enable her to make an informed and meaningful decision concerning whether or not to continue the pregnancy." *Id.* at 502.

The *Canesi* Court instructed that "[t]he violation of the interest in self-determination that undergirds a wrongful birth cause of action consists of the parents' lost opportunity to make the personal decision of whether or not to give birth to a child who might have birth defects." *Schroeder v. Perkel*, *supra*, 87 N.J. at 66. The claim in a wrongful birth action can arise when a physician fails to provide adequate genetic counseling, see *id.* at 63, fails to detect a discoverable fetal defect or to inform the parents thereof, see *Berman v. Allan*, 80 N.J. 421 (1979), fails to interpret test results properly, see *Procanik v. Cillo*, 97 N.J. 339 (1984), or fails to warn of a child being born with a defect, see *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483, 491 (Wash. 1983); see also *Williams v. University of Chicago Hosp.*, 688 N.E.2d 130, 133 (Ill. 1997) (stating that in wrongful birth actions, parents allege that they would not have carried fetus "to term if it had not been for the defendant's negligence in prenatal testing, genetic prognosticating, or counseling [them] as to the likelihood of giving birth to a physically or mentally impaired child") (internal quotation and citation omitted.)) *Canesi*, *supra*, 158 N.J. at 501-502.

This case involves a claim that the defendant is liable for the wrongful birth or life of the plaintiff's child. The plaintiff contends that the defendant failed to tell her that by continuing her pregnancy she ran the risk of [here state the condition], and that had she known of the risk, she would have terminated the pregnancy. A woman has the right to decide for herself whether to continue or terminate her pregnancy. The claim here is that the plaintiff was deprived of the right to make the personal decision of whether to give birth to a child who might have birth defects. In this case Dr. [here insert physician's name] had a duty to explain, in words the patient could understand, all material information and risks necessary for the plaintiff to have made an informed decision concerning whether or not to continue the pregnancy. A doctor is required to obtain enough information about a patient's background and her reasons for seeing the doctor to

determine what information is material to the patient and to discuss that information with her. Medical information is “material” when a reasonable woman, in what the physician knows or should know to be the patient’s position, could attach significance to a risk of a birth defect in deciding whether to terminate the pregnancy or give birth to the child.

**Option A:** [Use option A where the claim is that the defendant failed to recommend or provide sufficient information about genetic counseling or screening; failed to perform a prenatal test, negligently interpreted the prenatal test, failed to perform follow-up testing et cetera.]

In this case, the plaintiff contends that the doctor failed to [here describe the allegations, i.e., failed to provide the information that a reasonable patient would expect to be told about genetic counseling or screening, failed to recommend or provide sufficient information about genetic counseling or screening, failed to do follow up testing, failed to interpret an ultrasound or other prenatal test properly, et cetera]. As a result, the plaintiff was not advised that by continuing her pregnancy she ran the risk of giving birth to a child with [state the condition], and that had she known of the risk of the birth defect she would have terminated the pregnancy. To prevail in a wrongful birth claim, the plaintiff must prove all of the following elements:

- (1) the defendant negligently [describe the allegation, e.g., failed to recommend or provide sufficient information that a reasonable patient would expect to be told about genetic counseling or screening, failed to perform a prenatal test, negligently interpreted the prenatal test, failed to perform follow-up testing et cetera]; and
- (2) if the test was properly performed [or interpreted et cetera], in some cases it would have disclosed the possibility of [state the condition]; and
- (3) if the plaintiff was advised of the possibility of a [state the condition] birth defect, she would have terminated the pregnancy.

**Option B:** [Use option B only where the allegation is that the defendant failed to disclose the risks of a birth defect associated with taking a particular medicine while pregnant.]

In this case, the plaintiff contends that the doctor failed to [describe the allegations, e.g., failed to disclose the risks of a birth defect associated with taking a particular medicine while pregnant et cetera]. As a result, the plaintiff was not advised that by continuing her pregnancy she ran the risk of giving birth to a child with [state the condition], and that had she known of the risk of the birth defect she would have terminated the pregnancy.

To prevail in a wrongful birth claim involving a birth defect resulting from taking a prescribed medicine while pregnant, the plaintiff must prove all of the following elements:

- (1) that the undisclosed risk of the medication was material to a woman in the plaintiff’s position;
- (2) that the risk materialized; and
- (3) had the plaintiff known of that risk, she would have terminated her pregnancy.

[The remainder of charge — all cases:]

The plaintiff does not have to prove that any doctor’s negligence caused her child’s birth defect. The question is whether the doctor’s failure to disclose the risk of a birth defect deprived the plaintiff(s) of [her or their] right to decide whether to give birth to a child who could possibly have a birth defect., If you conclude that the plaintiff would have had an abortion, if warned of the risk of a birth defect, the plaintiff is entitled to damages consisting of both:

- (1) the special medical expenses and other extraordinary expenses attributable to raising a

child with a birth defect over the child's lifetime; and

(2) the emotional injury and anguish that the plaintiffs have suffered and will suffer in the future caused by losing the option to terminate the pregnancy and being compelled to take on the lifetime tasks and burdens of raising a disabled child.

### **5.50G MEDICAL JUDGMENT**

A doctor may have to exercise judgment when diagnosing and treating a patient. However, alternative diagnosis/treatment choices must be in accordance with accepted standard medical practice. Therefore, your focus should be on whether standard medical practice allowed judgment to be exercised as to diagnosis and treatment alternatives and, if so, whether what the doctor actually did to diagnose or treat this patient was accepted as standard medical practice. If you determine that the standard of care for treatment or diagnosis with respect to [specify what type(s) treatment or diagnosis is involved] did not allow for the choices or judgments the defendant doctor made here, then the doctor would be negligent.

### **5.50H ALTERATION OF MEDICAL RECORDS**

Physicians have a duty to ensure that all treatment records accurately reflect the treatment or 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 against the law in this State to alter medical records with the intent to deceive or mislead anyone. In this case you have heard evidence that Dr. [insert the doctor's name] altered his records in the following manner: [here describe the actions].

The alteration of medical records is admissible as evidence of a defendant's own belief that the actual records do not support his defense. If you find that Dr. [insert the doctor's name] 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. [insert the doctor's name] believed that the original record would have been unfavorable in the trial of this matter.

#### **NOTE TO JUDGE**

See also, Model Civil Charge 5.50I, Fraudulent Concealment of Medical Records.

The Rosenblit Court explained:

In sum, where an adversary has intentionally hidden or destroyed (spoliated) evidence necessary to a party's cause of action and that misdeed is uncovered in time for trial, plaintiff is entitled to a spoliation inference that the missing evidence would be unfavorable to the wrong-doer and may also amend his or her complaint to add a claim for fraudulent concealment.

Id. at 411.

The Appellate Division stated in *In re Jasclevich License Revocation*, 182 N.J. Super. 455, 471-472 (App. Div. 1982):

We are persuaded that a physician's duty to a patient cannot but encompass his affirmative obligation to maintain the integrity, accuracy, truth and reliability of the patient's medical record. His obligation in this regard is no less compelling than his duties respecting diagnosis and treatment of the patient since the medical community must, of necessity, be able to rely on those records in the continuing and future care of that patient. Obviously, the rendering of that care is prejudiced by anything in those records which is false, misleading or inaccurate. We hold, therefore, that a deliberate falsification by a physician of his patient's medical record,

particularly when the reason therefore is to protect his own interests at the expense of his patient's, must be regarded as gross malpractice endangering the health or life of his patient. In appropriate cases the court may also charge False in One - False in All, see Model Civil Charge 1.12M.

### **5.50I FRAUDULENT CONCEALMENT OF MEDICAL RECORDS**

Upon request, physicians have a duty to provide a patient or a patient's representative with a true, unaltered and complete copy of all treatment records for any treatment or 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 against the law in this State to alter medical records with the intent to deceive or mislead anyone.

In this case you have heard evidence that Dr. [insert the doctor's name] concealed or altered his records in the following manner: [here describe the actions].

The elements that must be established by a plaintiff in a claim for Fraudulent Concealment of Medical Records are:

- (1) that the defendant had a legal obligation to disclose evidence in connection with an existing or pending litigation;
- (2) that the evidence was material to the litigation;
- (3) that the plaintiff could not reasonably have obtained access to the evidence from another source;
- (4) that the defendant intentionally withheld, altered or destroyed the evidence with the purpose to disrupt the litigation; and
- (5) that the plaintiff was damaged in the underlying action by having to rely on an evidential record that did not contain the evidence defendant concealed.

#### **NOTE TO JUDGE**

This charge should be followed by damages charges appropriate to the case, which may include punitive damages. See footnote 5, below.

The Rosenblit Court explained:

In sum, where an adversary has intentionally hidden or destroyed (spoliated) evidence necessary to a party's cause of action and that misdeed is uncovered in time for trial, plaintiff is entitled to a spoliation inference that the missing evidence would be unfavorable to the wrong-doer and may also amend his or her complaint to add a claim for fraudulent concealment. Where the hiding or destruction is not made known until after the underlying litigation, in which plaintiff's case has been lost or impaired due to the missing evidence, a separate tort action for fraudulent concealment will lie.

Id. at 411.

The trial should be bifurcated in Fraudulent Concealment cases. The Rosenblit Court added:

[T]hose counts will require bifurcation because the fraudulent concealment remedy depends on the jury's assessment of the underlying cause of action. In that instance, after the jury has returned a verdict in the bifurcated underlying action, it will be required to determine whether the elements of the tort of fraudulent concealment have been established, and, if so, whether damages are warranted.

The Appellate Division stated in *In re Jasclevich License Revocation*, 182 N.J. Super. 455, 471-472 (App. Div. 1982):

We are persuaded that a physician's duty to a patient cannot but encompass his affirmative

obligation to maintain the integrity, accuracy, truth and reliability of the patient's medical record. His obligation in this regard is no less compelling than his duties respecting diagnosis and treatment of the patient since the medical community must, of necessity, be able to rely on those records in the continuing and future care of that patient. Obviously, the rendering of that care is prejudiced by anything in those records which is false, misleading or inaccurate. We hold, therefore, that a deliberate falsification by a physician of his patient's medical record, particularly when the reason therefore is to protect his own interests at the expense of his patient's, must be regarded as gross malpractice endangering the health or life of his patient.