SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1642-15T2

THE ESTATE OF ANNA MARIE CYCKOWSKI BY ITS EXECUTOR STEVEN CYCKOWSKI,

Plaintiff-Respondent/
Cross-Appellant,

v.

JAY STYLMAN, M.D.,

Defendant-Appellant/
Cross-Respondent,

and

SANIEA F. MAJID, M.D., JOSEPH FELDMAN, D.P.M., and ST. MICHAELS MEDICAL CENTER,

Defendants.

Argued May 9, 2017 - Decided June 23, 2017

Before Judges Reisner, Rothstadt and Mayer.

On appeal from the Superior Court of New Jersey, Law Division, Essex County, Docket No. L-7062-13.

David Parker Weeks argued the cause for appellant/cross-respondent (Ruprecht Hart

Weeks & Ricciardulli, attorneys; Mr. Weeks, of counsel and on the brief; Andrea G. Miller-Jones, on the brief).

James Lynch argued the cause for respondent/cross-appellant (Lynch, Lynch, Held & Rosenberg, attorneys; Mr. Lynch, on the brief).

PER CURIAM

Anna Marie Cyckowski (Ms. Cyckowski or the patient), a seventy-four year old woman, experienced complications after her esophagus was punctured during surgery to repair a hiatal hernia. She died a few weeks later. Plaintiff, her estate, claimed that the operating surgeon, defendant Dr. Jay Stylman, did not render proper medical treatment after the surgery. Plaintiff also claimed lack of informed consent. The jury returned a no-cause verdict on the informed consent claim. However, the jury found that defendant deviated from accepted medical standards in treating Ms. Cyckowski. The jury also found that the deviation was a substantial factor in causing her injuries, and defendant did not prove that some portion of her injuries would have occurred even if he had not deviated.

Defendant appeals from the resulting December 7, 2015 judgment, consisting of $200,000 in pain and suffering damages, plus about $240,000 in medical expenses. Plaintiff filed a protective cross-appeal, asserting that if we reverse the

malpractice judgment and remand the case for a re-trial, we should also order a re-trial of the informed consent claim.

In challenging the verdict, defendant presents the following points of argument:

> I. DEFENDANT'S MOTION FOR A DIRECTED VERDICT THAT DEFENDANT HAD PROVEN SOME PORTION OF PLAINTIFF'S INJURIES WOULD HAVE OCCURRED EVEN IF DEFENDANT HAD NOT BEEN NEGLIGENT SHOULD HAVE BEEN GRANTED
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> II. THE JURY'S FINDING THAT NO PORTION OF PLAINTIFF'S INJURIES WAS DUE TO THE PRE-EXISTING CONDITION WAS AGAINST THE WEIGHT OF THE EVIDENCE
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> III. THE TESTIMONY OF GASTROENTEROLOGIST DR. ELFANT SHOULD HAVE BEEN LIMITED, NOT BARRED IN ITS ENTIRETY
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> IV. THE FACT THAT DR. STYLMAN HAD NOT PREVIOUSLY PERFORMED THIS SPECIFIC PROCEDURE LAPAROSCOPICALLY AS PRIMARY SURGEON SHOULD NOT HAVE BEEN PRESENTED TO THE JURY
>
> V. DR. BELSLEY'S PERSONAL INFORMED CONSENT PRACTICES SHOULD NOT HAVE BEEN ALLOWED TO BE ELICITED BY PLAINTIFF'S COUNSEL
>
> VI. THE WHOLLY INADEQUATE RECORD PROVIDED BY THE COURT PREJUDICED DR. STYLMAN'S ABILITY TO CONTEST ALL APPEALABLE ISSUES RAISED AT TRIAL DUE TO A COMPLETE LACK OF RECORDING OF KEY SIDE-BAR DISCUSSIONS

Defendant did not perfect the appeal as to his point VI, by filing a motion to reconstruct the trial record. See R. 2:5-5(a). Nor has he articulated which of the un-recorded sidebar rulings

allegedly constituted, or might have constituted, prejudicial error. Consequently, we decline to further address this point. After reviewing the record including the trial transcripts, we find no merit in any of defendant's remaining appellate arguments, and we affirm on the appeal. We therefore need not address the cross-appeal.

I

To put the legal issues in context, we set forth the most pertinent trial evidence. In brief summary, plaintiff did not contend that defendant was negligent in puncturing the patient's esophagus, which was a known but uncommon risk of the surgery. Rather, plaintiff contended that when the patient showed signs of complications after the surgery, defendant did not promptly take steps to rule out the possibility that she had a punctured esophagus and treat the condition if it existed. According to plaintiff's evidence, the appropriate steps would have included performing follow-up surgery within a day or two to locate a possible puncture, and promptly bringing in a gastroenterologist to further examine the patient after the second surgery did not reveal the location of the hole. Plaintiff asserted that, because the punctured esophagus was not timely discovered and properly treated, the patient developed a horrendous infection, and other

painful and debilitating symptoms which eventually led to her death.

Dr. Angelo Scotti, plaintiff's expert in internal medicine and infectious diseases, described the patient's condition and the development of the infection. Dr. Scotti explained that Ms. Cyckowski had a hiatus hernia, which he described as "an opening where the esophagus goes and some of the intestinal contents can get up into the chest wall." During the surgery to repair this problem, she suffered a perforation of her esophagus. The perforation allowed bacteria to enter the mediastinum, which eventually developed into a mediastinal infection.

Dr. Scotti testified that the infection eventually entered her blood stream, which caused her to go into septic shock, i.e., "her blood pressure dropped and her entire body was responding to this infection." According to Dr. Scotti, Ms. Cyckowski continued to get sicker and eventually died from complications of the surgery.

Dr. Scotti explained that an esophageal perforation is a medical emergency, because "you have acid from the stomach that goes through the hole and starts destroying tissues because acid is for digesting things. And then the bacteria there get in there and set up infection and that's what happened here." He provided the following analogy for an esophageal perforation:

> If you're in a boat and you have a hole in your boat and you really want to stay afloat and you keep bailing, bailing, bailing, well, if you have an esophageal perforation, you aren't plugging the hole. So that water keeps coming in, you bail it out, it keeps coming in. So if you plug the hole in the boat, then the water stops and you can bail it out and you'll have a floating boat.
>
> So, again, when you have a perforation of the esophagus and that infection is being set up and you have a collection of infection, like, abscess, if you close the perforation, then between the antibiotics and your immune system you have a good chance of healing that. But if [it] keeps open, you still have bacteria and acid coming into the area, so you're fighting a losing battle. You're [basically] bailing a boat that still has a hole in it.

Dr. Scotti further testified that bacteria continues to enter through the perforation even if the "patient has antibiotics, a feeding tube, and drains" and the infection cannot be eradicated. He then detailed Ms. Cyckowski's decline starting on April 10 through her release from the hospital at the end of May. During that testimony, he detailed how the lack of appropriate treatment allowed the patient to develop septic shock:

> Q: She had now gone from the 10th to the 27th with continued contamination from this open perforation. Is that fair to say?
>
> A: Of her esophagus into her mediastinum, yes.

> Q: Do you have an opinion as to the affect this had on the patient?
>
> A: Well, it drastically decreases her prognosis. In other words, she's at more risk of dying. Just to start back when she had septic shock on 4/16, April 16th, when you have septic shock, if you don't get treatment for septic shock, you -- you start dying. Septic shock is 100 percent fatal if it's not treated. And the mortality increases by 7 percent for each hour of treatment that's missed. So if it's delayed an hour you increase your [mortality] to 7 percent, by two hours it's 14 percent.
>
> Now, she didn't die at that point because they were at least partially treating her. They were giving antibiotics and they were giving fluids. So they were partially keeping up with this contamination, but not enough to cure her because of the perforation.

He opined that, throughout this time period, the infection was getting worse, Ms. Cyckowski was getting sicker and her prognosis was worsening. Dr. Scotti concluded that had the perforation been blocked "within three or four, five days of surgery," Ms. Cyckowski probably would have healed completely. Dr. Scotti explained that, had the perforation been diagnosed and treated earlier:

> [S]he would have avoided the -- all the other procedures. She would have avoided having -- she would have avoided dying for one thing. But she would have avoided the various procedures that were done. The plural infusion, they had to put a chest tube and

> take her infusion. She probably would have avoided intubation, so she wouldn't have had the tube in and would not have gotten pneumonia. She would have avoided the shock, so she wouldn't have had a central venous line. Basically, all of the procedures that she had to keep her alive would have been avoided. She would avoided being transferred to another hospital because she most likely would have recovered and left the hospital after her surgery.

Dr. Scotti testified that, on May 22, Ms. Cyckowski was transferred to the Kendrick subacute rehabilitation center, where she was "pretty much bedridden." While at this facility, "she developed decubitus ulcers . . . [that] are the pressure sores you get when you're laying on bony prominences for a period of time."

Finally, Dr. Scotti explained the association between her death and the esophageal perforation:

> I mean, when she went into the hospital she was cleared medically and reasonably so. In other words, she was judged a reasonable medical risk. She had, you know, none of these. She had a history of asthma and she had no serious heart disease. And then she goes on to die a cardiovascular death, you know, weeks -- months after her surgery. But she never gets better.
>
> So the surgery, the perforation sets up a crescendo. The mediastinal infection, systemic infection, shock, respiratory failure, urinary tract infection, decubitus ulcers, all of those things result in really taxing your body and put you on an inflammatory response -- that's inflammatory response we talked about. That inflammatory response makes your heart work harder, it

> makes you more likely to clot. So some combination of those things caused her to die. There was no autopsy, so I can't pinpoint of what all the things I mentioned which one of those or which combination caused her to die.

Dr. Robert Aldoroty, a board certified general surgeon, testified about defendant's deviation from accepted medical standards in treating the patient after the surgery. Dr. Aldoroty testified that esophageal perforation is a known risk to Ms. Cyckowski's operation. It is important to be aware of the potential of an esophageal perforation, because of "the potential enormity of the complications" of a perforation.

Dr. Aldoroty detailed the events starting with Ms. Cyckowski's surgery. He opined that defendant was not necessarily negligent in the surgery, because "[perforation] can happen under the best of circumstances." However, Dr. Aldoroty explained that defendant deviated from the standard of care with respect to his post-operative treatment:

> So the issue really, the first issue is the delay in getting Ms. Cyckowski to the remedial surgery. Okay? It's four or five days delay. It's entirely unacceptable. We spoke about this, but any surgeon who operates on the esophagus is doing paraesophageal hernias. When a patient isn't doing well, an esophagus perforation is in the short list. And it's in the short list because delays in diagnosis and treatment of an esophageal perforation have significant health consequences for the patient.

> . . . I'm not upset with the postoperative day one unless an esophageal perforation wasn't in Dr. Stylman's mind, and I don't know what was in Dr. Stylman's mind. But what's in the chart is reasonable.
>
> But postoperative day two, where she goes into florid respiratory distress and needs to be intubated and sent to an ICU, there is a short list of postoperative complications that can do that: pulmonary embolus, esophageal perforation, cardiac event, myocardial infarction, a heart attack, pneumothorax. And that's the short list. . . .
>
> My problem at that point is that she's sitting in an ICU and no one is ordering any tests to find anything out. And Dr. Stylman should have that short list and should be clunking through it very expeditiously in the first few hours.
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> . . . .
>
> So I think in my opinion any reasonable doctor or surgeon would have gotten a CT of the chest, abdomen and pelvis
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> . . . .
>
> And would have gotten a CT that was appropriate, appropriately done to look for pulmonary embolus. The ICU would have taken care of the EKG, the proponent ruling out the cardiac event.

Dr. Aldoroty concluded that the surgeon should notify the members of the ICU of the potential surgical complications and to recommend the appropriate testing. In order to rule out an esophageal perforation, Dr. Aldoroty said that defendant should have ordered a CT scan. Dr. Aldoroty opined that defendant

deviated from the standard of care by not ordering a CT scan on post-operative days two and three. Then when he ordered a scan, and realized Ms. Cyckowski had an esophageal perforation, it was a deviation not to perform the surgery immediately.

Further, Dr. Aldoroty testified that defendant deviated from the standard of care by failing to call a gastroenterologist from April 15 through April 24. He testified that had the perforation been diagnosed earlier, on April 12 or 13, "the more likely it is that the patient will recover quicker . . . and will be less likely to succumb from the perforation." He concluded that Ms. Cyckowski's death was ultimately due to the delay in diagnosing the esophageal perforation.

Plaintiff also presented Dr. Peter Salvo, who gave detailed testimony concerning the pain and suffering Ms. Cyckowski experienced and the timing of her suffering. Dr. Salvo first described the pain that Ms. Cyckowski suffered starting a few days after the surgery. He testified that later, during her hospital stay, Ms. Cyckowski developed decubitus ulcers, which cause significant pain. Dr. Salvo provided the following opinion regarding her pain while she was at Kindred:

> I think there are two things you need to know. I think that no pain medicine is 100 percent effective. You would like to take down the pain as much as you can. But those of us who deal in pain every day realize that pain is

> one of the most fundamental deep-seeded neurologic reflexes we have. . . .
>
> So we try to get at the pain as best we can. Narcotics work. They make your life better, truly they do. But they don't make it 100 percent better.
>
> And she was described as feeling short of breath. That's -- that's not pain, that's distress. She said on the 10th of June "I can't breathe." She was anxious. She complained of pain in her sacral area where that decubitus was on May 6th. On May 27th she had lower extremity pain. On the 31st of May she complained of buttock pain. She had facial grimacing on the 24th of June.
>
> I think it's fair to say that not every note at Kindred says that she was in terrible pain and that's probably true. Pain comes and goes. But her baseline, her general life was painful. And sometimes it was worse, sometimes it was better, sometimes the meds worked better, sometimes they didn't. This is biology, it's not physics. The best you can do is often, unfortunately, good enough, that's it.

Defendant's case was directed at establishing that he did not deviate from the standard of care. In his testimony, defendant detailed the procedure he performed on Ms. Cyckowski and concluded, "it went very well." The first day after the surgery, defendant believed Ms. Cyckowski was doing well. The second day after surgery, April 12, defendant noted in his chart: "[p]atient sedated, relatively stable, on vent support. Increased fluid -- increased fluids rather. Abdomen soft, non-tender. Continue CRR

management." Defendant explained that something happened that affected "her ability to breathe properly where the carbon dioxide was building up in her lungs. And that's an emergency that requires a ventilator to support her, which they did in the ICU."

At this point, defendant did not believe Ms. Cyckowski had an infection, because she did not show any signs of one. On April 14, defendant testified that a culture came back positive for bacteria in Ms. Cyckowski's lungs, and he ordered a CT scan. Defendant was notified early in the morning on April 15 that Ms. Cyckowski had a leak in her esophagus in the surgical area. But defendant did not report to the hospital to perform surgery immediately, for two reasons. First, he wanted to review the films with a radiologist, and second, performing surgery in the middle of the night does not generally lead to the best results for the patient.

Defendant testified that the second procedure, on April 15, was "a much more serious, dangerous, complicated procedure . . . ." During the procedure, defendant placed multiple drains in Ms. Cyckowski to remove any fluid build-up in her abdomen, but he did not locate the perforation in the esophagus. At this time, defendant believed that the hole would heal since he inserted the drains.

After the procedure on April 15, defendant did not immediately attempt to put a stent in because he thought it was too risky given Ms. Cyckowski's condition. Defendant explained his thought process each day from April 16 through April 25, telling the jury why he though his actions were reasonable based on the circumstances. He explained that he did not call the gastroenterologist until April 25, because "the signs were pointing to the fact that it seemed like the drainage was decreasing. . . . And it seemed like everything was going along in the right direction as far as the . . . leak was going while there were many other problems that were happening at the same time."

Next, defendant called his only expert, Dr. Scott Belsley, a board certified general surgeon. Dr. Belsley testified that the surgery was "straightforward" and initially everything was fine after the surgery. He testified that it was appropriate to obtain a CT scan on April 14 and it was important that defendant inserted drains, "because the vast majority of all these perforations heal by just letting the body do its own thing."

Dr. Belsley testified that defendant performed the initial operation on April 10 in accordance with the standard of care. Further, he testified that the first sign of an infection was from

the "positive respiratory culture" on April 14. He went on to explain:

> Even having said that then we can argue okay, is that normal bacteria, is that abnormal bacteria? So, when you're trying to decide what's happening while it's happening, in these situations you put the patient on antibiotics, you get some x-rays, you run some cultures and you're trying to figure out while it's happening, and it's not -- during the whole process. But I would say on the 14th, that's when we would have a -- a really positive indication that there was an infection.

He opined that defendant did not deviate from the standard of care by not diagnosing the infection and perforation before April 15. He also opined that Ms. Cyckowski suffered a delayed perforation, because if the perforation had occurred during surgery, she would have had an elevated heart rate and a fever sooner.

Regarding the second operation on April 15, Dr. Belsley explained that defendant was not negligent in waiting until the morning instead of performing the operation in the middle of the night. He also testified that defendant was not negligent in refraining from calling in a gastroenterologist prior to April 27. Dr. Belsley primarily based that opinion on his view that the typical treatment provided by gastroenterologists - the placement of stents to block the puncture - was ineffective. He admitted,

however, that his was a minority view in the medical profession. In Dr. Belsley's experience, esophageal perforations will heal "greater than 90 percent of the time with drainage alone . . . ."

Dr. Belsley summarized his opinion regarding defendant's overall treatment of Ms. Cyckowski:

> There was absolute no deviation in any aspect in this case.
>
> . . . .
>
> I mean the basis of -- is a very serious medical problem, surgical problem, which is likely going to kill a sick patient within two years, it's a very risky operation. This is a known complication of the operation, this is accepted. This is what every surgeon will say yes, of course it can happen. It's not common, but yes, this is a possibility. And when they did notice this, when they have absolute evidence with the CAT scan, they got all the right people involved, they did got rushing in in [sic] the middle of the night, he performed a very smart, very technically correct operation to deal with the problem. [He] had specialists that were taking care of her throughout the hospitalization, but unfortunately she succumbed. She was a very sick lady.

Dr. Belsley testified that Ms. Cyckowski's death "was related to her preexisting conditions." Further he explained that "you can't basically reduce it to one event, and discount all of the preexisting things." He was not asked to quantify or apportion which of the patient's injuries were attributable to her pre-existing conditions and which were attributable to any deviations,

assuming, hypothetically, that defendant had deviated from accepted medical standards.

II

Defendant's first two points concern his right to apportionment of damages under Scafidi v. Seiler, 119 N.J. 93, 108 (1990), which applies when a defendant's malpractice aggravates or increases the risk posed by a patient's pre-existing medical condition. Initially, defendant contends he was entitled to a directed verdict on apportionment. See R. 4:40-1. We review the issue de novo, and find no error in the trial court's decision. See Smith v. Millville Rescue Squad, 225 N.J. 373, 397 (2016).

In the trial court, plaintiff agreed that this was a case to which Scafidi applied, because there was no dispute that Ms. Cyckowski had one or more pre-existing conditions, which plaintiff contended were aggravated by defendant's malpractice. However, as set forth in Scafidi, defendant had the burden of proof on the apportionment issue:

> [W]here the malpractice or other tortious act aggravates a preexisting disease or condition, the innocent plaintiff should not be required to establish what expenses, pain, suffering, disability or impairment are attributable solely to the malpractice or tortious act, but that the burden of proof should be shifted to the culpable defendant who should be held responsible for all damages unless he can demonstrate that the damages for which he is

> responsible are capable of some reasonable apportionment and what those damages are.
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> [Scafidi, supra, 119 N.J. at 110 (quoting Fosgate v. Corona, 66 N.J. 268, 272-73 (1974)).]

At the close of the evidence, defense counsel moved for a directed verdict on jury question #8, which asked whether defendant had proven that some portion of the patient's injuries would have occurred, even if defendant had not deviated from the standard of care. Defense counsel argued that plaintiff's expert, Dr. Aldoroty, had testified that even if defendant had realized earlier that more surgery was needed and had performed the surgery on April 12 instead of April 15, "the attendant recovery from that surgery would [still] have taken place." The judge reserved decision on the motion, and denied it immediately after the jury returned its verdict.[1] See R. 4:40-2(a) (the trial court may reserve decision on a motion for a directed verdict and decide it within ten days after the jury returns its verdict).

We find no error in the result. On a motion for judgment under Rule 4:40-1, "[t]he court must accept as true all evidence supporting the position of the non-moving party, according that

[1] The judge indicated that she would provide reasons for her decision, as is required, but would do so at a later time. See Atlas v. Silvan, 128 N.J. Super. 247, 250 (App. Div. 1974). From the record provided to us, it is not clear whether the judge did so.

party the benefit of all legitimate inferences that can be deduced from such evidence. If reasonable minds could differ, the court must deny the motion." Rena, Inc. v. Brien, 310 N.J. Super. 304, 311 (App. Div. 1998); see Dolson v. Anastasia, 55 N.J. 2, 5-6 (1969). Viewing the evidence in the light most favorable to plaintiff, the jury did not necessarily need to find that the three-day delay from April 12 to April 15 constituted the deviation that caused the patient's injuries. Plaintiff also presented evidence that defendant negligently delayed for ten days after the surgery before calling in a gastroenterologist on April 25. Defendant's Rule 4:40-1 motion did not even address that deviation or the resulting injuries and suffering caused by that delay.

Moreover, defendant's case, as presented through his witnesses, was that there was no deviation. He did not present testimony that, even if there had been a deviation, a certain percentage of the patient's injury was attributable to the pre-existing condition. Neither defendant nor Dr. Belsley provided any testimony that would have enabled the jury to make the percentage apportionment Scafidi requires.

It was defendant's burden to present that evidence. "If a defendant seeks to reduce his liability by asserting that part of the harm is not attributable to his tortious conduct, the burden of proving both that the plaintiff's injury is capable of

apportionment and what the apportionment should be should rest on the defendant." Anderson v. Picciotti, 144 N.J. 195, 211 (1996) (citation omitted); see also Holdsworth v. Galler, 345 N.J. Super. 294, 305-06 (App. Div. 2001). In addition, even if defendant had presented testimony on apportionment, it would have been the jury's province to decide if the testimony was credible. As a result, we conclude that defendant was not entitled to a directed verdict on question #8.

Defendant's second argument - that the jury's verdict as to question #8 was against the weight of the evidence - was waived for purposes of appeal when he failed to file a motion for a new trial on that ground. R. 2:10-1; Gebroe-Hammer Assocs. v. Sebbag, 385 N.J. Super 291, 295 (App. Div.), certif. denied, 188 N.J. 219 (2006). Moreover, even if we consider the issue, the verdict was not a miscarriage of justice. R. 2:10-1.

III

Next, defendant argues that the trial judge should not have barred the testimony of Dr. Elfant, a board certified gastroenterologist. We review a trial judge's decision to admit or exclude expert testimony for abuse of discretion. See Townsend v. Pierre, 221 N.J. 36, 52-53 (2015). We find none here, and we affirm substantially for the reasons stated by the trial judge in

ruling on plaintiff's in limine motion on October 28, 2015. We add these comments.

Defendant was a board certified general surgeon. He concedes that under the New Jersey Medical Care Access and Responsibility and Patients First Act (PFA), N.J.S.A. 2A:53A-41, he could not present the testimony of a gastroenterologist to opine as to the standard of care or as to whether defendant's conduct met that standard. See Nicholas v. Mynster, 213 N.J. 463, 468 (2013). Defendant argues that Dr. Elfant was not going to testify about the standard of care, but rather was going to testify about proximate cause and damages. However, having read Dr. Elfant's expert report, we conclude that it was clearly aimed at establishing the standard of post-operative care for a patient who has undergone hiatal hernia surgery and establishing that defendant did not deviate from that standard. In fact, the report began by stating: "Plaintiff's expert alleges a number of deviations in the care of Mrs. Cyckowski which I would like to address[.]"

Moreover, in arguing the in limine motion, defense counsel did not make a proffer that Dr. Elfant would testify about proximate cause and damages. He stated:

> The only thing I intend to elicit from Elfant is that he is a gastroenterologist[,] is familiar with and often will treat

> perforations conservatively before stenting. And that's after the 15th of April 2012. And it's not saying anything about standard of care. It's just saying this is a recognized treatment.

The judge rejected that argument, noting that "since that care was not performed by a gastroenterologist, a general surgeon should address that issue on behalf of the defense." We agree. On the record presented to the trial judge at the time she decided the in limine motion, it was clear that the defense proposed to use Dr. Elfant's testimony as a back-door means of providing standard-of-care testimony prohibited by the PFA. It was not an abuse of discretion to grant plaintiff's pre-trial motion to bar the expert.[2]

IV

Defendant's remaining two arguments relate to evidence of his lack of prior experience with the type of surgery he performed on Ms. Cyckowski, and to a testifying expert's practice with respect to obtaining informed consent from patients. We conclude that the

[2] Defendant's appellate arguments, concerning possible additional issues about which Dr. Elfant might have testified without violating the PFA, should have been presented to the trial court at the appropriate time - during the argument of the in limine motion. We will not consider those arguments on appeal, because they were not presented to the trial court. See Nieder v. Royal Indem. Ins. Co., 62 N.J. 229, 234 (1973).

arguments are without sufficient merit to warrant discussion beyond these brief comments. R. 2:11-3(e)(1)(E).

The evidence was primarily presented to support the informed consent claim. Plaintiff asserted that defendant misrepresented to the patient that he had prior experience in performing the surgery when, according to plaintiff, he had no such experience. See Howard v. Univ. of Med. & Dentistry of N.J., 172 N.J. 537, 555-57 (2002). Because the jury returned a no-cause verdict on the informed consent claim, any errors in admitting evidence on that issue would have been harmless. R. 2:10-2.

Evidence that defendant had never performed this surgery before was also relevant to whether he might, for that reason, have been unfamiliar with the proper way to deal with an esophageal puncture, which was a known but uncommon risk of the surgery. Thus, it was pertinent to the malpractice claim. It was up to the jury to decide what weight, if any, to give that evidence.

Affirmed.