SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1814-22

DEBRA FURPHY and
ANDREW FURPHY,

Plaintiffs-Appellants,

v.

BAYSHORE COMMUNITY HOSPITAL, GLORIA M. BORJA, RN, SATWAT KAUR, RN, LESLIE KOWAL, RN, SARA KRISTINSSON, RN, TAMARA KRAUSE, RN, JOSEPHINE LOPEZ, RN, KAREN VETRANO, RN, and ALISSA SCAROLA, RN,

Defendants,

and

AYESHA H. OULD-HAMMOU, MD, and THE DOCTOR'S OFFICE, PC,

Defendants-Respondents.

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Submitted March 19, 2024 – Decided June 10, 2024

Before Judges Haas and Natali.

On appeal from the Superior Court of New Jersey, Law Division, Monmouth County, Docket No. L-2506-16.

Rudnick, Addonizio, Pappa & Casazza, attorneys for appellants (Mark F. Casazza and Greg S. Gargulinski, of counsel and on the brief).

Law Offices of Joseph A. DiCroce, LLC, attorneys for respondents (Joseph A. DiCroce and Steven B. Farman, of counsel and on the brief).

PER CURIAM

In this medical malpractice action, plaintiff Debra Furphy[1] appeals from the Law Division's March 8, 2023 judgment in favor of defendants Ayesha Ould-Hammou, M.D. and The Doctor's Office, P.C. (TDO) (collectively, defendants) which it entered after a jury returned a no cause verdict on plaintiff's claims that Dr. Ould-Hammou failed to diagnose and treat properly methicillin-resistant staphylococcus aureus (MRSA), ultimately resulting in plaintiff's paralysis from the chest down. Before us, plaintiff argues the trial court erred by (1) improperly charging the jury as to medical judgment, (2) failing to declare a mistrial based on defense counsel's "improper and false comments" in summation regarding hospital records which were not in evidence, and (3) providing deficient and

[1] For ease of reading, we refer to plaintiff in the singular, but acknowledge Andrew Furphy, her husband, has also asserted a per quod claim.

prejudicial curative instructions with respect to defendants' summation. Because we conclude (1) the medical judgment charge was appropriate based on the testimony adduced at trial, (2) defense counsel's summation was not so unduly prejudicial as to mandate a mistrial, and (3) the court's curative instructions were not an abuse of its discretion, we affirm.

I.

After several pre-trial dismissals, the matter proceeded to a fourteen-day jury trial against Dr. Ould-Hammou and TDO only. Plaintiff testified she injured her spine in a horseback riding accident years prior to the incident in this case. She stated in July 2014, she was "having issues with [her] low back" despite undergoing treatment over the years including nerve block injections "about every three months" and placement of a dorsal column stimulator.[2]

Plaintiff testified that on July 10, 2014, she was scheduled for a nerve block injection with her pain management doctor, but because she was having "issues walking" and "intractable pain," her doctor "wasn't comfortable doing the injections" and instead sent her to Bayshore, where she was admitted. She explained she received an IV in her left inner elbow, also known as the

[2] A dorsal column stimulator is an implanted device intended to alleviate back pain which works by sending electrical pulses to painful nerves. As plaintiff explained, the pulses "create[] a static-like feeling" that replaces pain.

antecubital fossa (ACF). She confirmed she was discharged from Bayshore on July 13th.

Plaintiff described the skin around the IV at the time of its removal as "red and hot and swollen." Further, she stated "when they took the IV out, there were two strings of yellow pus that came out, or what [she] identified as pus." Plaintiff testified over the next few days, the redness, heat, pain, and swelling continued and "appeared to be spreading around the area." By July 21, 2014, approximately one week after her discharge, she stated the area appeared to have an abscess.

Plaintiff testified while she was in the shower, she was "checking [the area] with two fingers, going around it in a circle with light pressure and it popped, and a large amount of pus came out." She estimated the amount of pus was "about the size of a ping pong ball if you put it all together." Plaintiff described her left ACF at that time as "red" and "swollen" with "an indent-like hole that was about the size of a silver dollar that was ringed by . . . the swollen area." She explained, "it was pretty deep and . . . pretty large and it was a depression in the skin" with a quarter of an inch-sized hole "at the end where all the pus came out." Plaintiff clarified "the indent was where the . . . pus was, and . . . the hole that was at the site of where the needle had gone in, where the

pus escaped, . . . opened up from the very small puncture hole where the needle was to a larger area where the pus had escaped."

The same day, plaintiff stated, she went to TDO, a "multipurpose office where you can either make an appointment with your normal doctor or you can walk in if there's an emergency or an unexpected sickness," and saw Dr. Ould-Hammou. Dr. Ould-Hammou testified she was one of three physicians on staff at TDO, where she started practicing in 2000. She also confirmed she treated plaintiff as a walk-in patient on July 21, 2014. Dr. Ould-Hammou explained she specifically remembered plaintiff as she was "the only patient in our entire practice of twenty-thousand patients who ha[d] a service dog."

Plaintiff testified she informed the doctor of her back pain which was "worse that day" and "about the arm with the IV and . . . everything coming out of it." Specifically, she stated she told Dr. Ould-Hammou she had "been in Bayshore for a few days because of the back pain and when [she] was released, the IV looked like it had been infected." Plaintiff added she told the doctor "the sore spot got bigger" and "redder" over the "next several days." Contrary to plaintiff's testimony, Dr. Ould-Hammou testified plaintiff presented with "shortness of breath, back pain, and anxiety," but had not mentioned her arm,

redness, "anything about being in the shower" or that she expressed any pus from her ACF.

Plaintiff further testified Dr. Ould-Hammou examined her arm in "maybe one to two minutes" by holding her arm straight, lifting the gauze off, looking at the area, and replacing the same used gauze. Plaintiff also acknowledged the doctor had also conducted a "full physical," including examination of her head, neck, chest, and lungs.

Dr. Ould-Hammou estimated her visit with plaintiff was "at least thirty minutes" as "it took [plaintiff] a little while to get the history" and she then "did a complete evaluation." She stated there were no "pertinent positive" findings upon examination of plaintiff's head, neck, chest, lungs, cardiovascular system, reflexes, and muscle strength. Additionally, Dr. Ould-Hammou testified plaintiff's temperature, pulse, respiration, and blood pressure were "within normal limits." The doctor noted none of the medications plaintiff reported taking could mask a fever.

When Dr. Ould-Hammou examined plaintiff's left ACF, she explained she noticed "redness, swelling, and tenderness" at the IV site, but no purulent discharge,[3] abscess or "cratering" of the skin in the area, including when she

[3] Purulent discharge refers to pus.

pressed on it to test for tenderness. She testified she observed no open wound in the area, and if she had observed a wound of the type described by plaintiff, she would have sent plaintiff to the hospital. Dr. Ould-Hammou denied replacing the used gauze and stated she would not have done so.

Dr. Ould-Hammou confirmed she "reach[ed] a differential diagnosis" after examining plaintiff, which included "mild cellulitis" in the left ACF. She explained there was no need to conduct blood work as the cellulitis was "localized," or to take a culture as there was no purulent discharge to be cultured.

Dr. Ould-Hammou testified she "ruled out the possibility of MRSA based on the way it looked." She estimated about a quarter of patients presenting with an infection would have "some kind of skin infection" and noted she had diagnosed MRSA before. Dr. Ould-Hammou explained MRSA typically shows "redness, swelling, tenderness" at a "much more pronounced" level compared to other skin bacteria, and is typically "associated with purulent discharge," abscesses, and boils. Dr. Ould-Hammou admitted "cellulitis can be caused by MRSA." She confirmed she was aware plaintiff had been in the hospital "about a week" prior to her visit and that the cellulitis was at the site where she had an IV.

Dr. Ould-Hammou stated she was familiar with the Infectious Diseases Society of America's (IDSA) "Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections" prior to her treatment of plaintiff, and she "routinely" looks at guidelines and follows them in her practice. The guidelines, which were admitted into evidence, distinguish between purulent and non-purulent appearance with respect to skin and soft tissue infections, and further specify the types of appropriate medication based on level of infection.

To treat the cellulitis, Dr. Ould-Hammou testified she prescribed cefdinir, a cephalosporin antibiotic. She admitted cefdinir would not "cover for MRSA" but would treat methicillin sensitive staphylococcus aureus (MSSA) and "multiple other bacteria." Significantly, she explained she considered medication that would cover for MRSA, but would only prescribe same when "appropriate clinically" as "indiscriminate use of antibiotics for all patients to cover every single bacteria is not an appropriate way to practice medicine."

Plaintiff testified "over the next couple of days" following her visit to TDO, she noticed "the depression was not as large as it was," having shrunk to the size of a quarter, her arm was "swelling even more," and the hole "was getting larger and larger." Around the same time, she stated, she felt "a lot of

pain up through the [right] shoulder area near the joint," which she had not experienced before. By August 1, 2014 plaintiff testified the hole in her ACF was about "half an inch across" and "you could start to . . . see the interior of the arm." Additionally, she reported the redness had spread down toward her wrist.

Plaintiff also testified she was admitted to the emergency room at Bayshore on August 5, 2014, based on the condition of her arm combined with her shoulder and neck pain. Dr. Nasir Ahmad, an infectious disease specialist at Bayshore, testified regarding his observations of plaintiff on August 6, 2014, which included "a dime-sized wound" at the left ACF "that is deep with exposed tendon" but "no obvious purulence" or "surrounding inflammation." He testified he "highly suspect[ed] staphylococcus aureus [MRSA or MSSA] abscess of the right chest wall," as a result of an infected vein after discharge from the hospital and the spreading of bacteria in the blood.

Although he did not form an impression about how long plaintiff had been infected, Dr. Ahmad noted "when you have staph aureus infection in the blood, you get sick within a few days" as "it cannot stay in your blood for long and not make you sick." Dr. Ahmad's notes were admitted into evidence, and those notes reflected that plaintiff reported she was hospitalized at Riverview Medical Center (Riverview) rather than Bayshore in July 2014.

Subsequently, plaintiff was discharged from Bayshore to a skilled nursing facility and then re-hospitalized at two separate hospitals after her condition worsened. Ultimately, she underwent two spinal surgeries in October 2014. Plaintiff presented the de bene esse testimony of Dr. Gino Chiappetta, the orthopedic surgeon who operated on her. He confirmed his examination of plaintiff revealed infection in the spine and around the dorsal column stimulator, "a compression of the spinal cord" and no function in "the muscles in her legs or below the belly button." Plaintiff was discharged and returned home in January 2015. Unfortunately, she continues to suffer paralysis from the chest down.

Both parties presented multiple experts. Plaintiff offered Dr. Richard Ellin, an expert in internal medicine, and Dr. Arthur Klein, an expert in infectious diseases. Defendants offered Dr. John Russo, an expert in internal medicine, Dr. Bruce Farber, an expert in infectious disease and internal medicine, and Dr. David Strayer, an expert in anatomic pathology. Each was qualified as an expert in their respective fields.

Dr. Ellin testified that compared to MSSA, MRSA "tends to be a more serious bacteria" and is "more commonly associated with being in the hospital." He stated risk factors for MRSA included recent hospitalization and IV drug use

while symptoms associated with MRSA included open wounds and pus. Dr. Ellin admitted neither open wounds nor pus were mentioned in the records from plaintiff's July 21, 2014 visit to TDO. He testified his review of the records did not show Dr. Ould-Hammou made any differential diagnosis, or "a list of potential diagnoses," with respect to plaintiff's left ACF infection.

Dr. Ellin opined that Dr. Ould-Hammou's "choice of cefdinir as an antibiotic for the cellulitis that she described did not meet the standard of care" because MRSA "is one of the more common causes of that cellulitis" when a patient had recently been hospitalized and has cellulitis "overlying an area of previous penetrating trauma." He concluded Dr. Ould-Hammou "need[ed] to prescribe a treatment that the MRSA would be most likely to respond to," and cefdinir would not have any effect against MRSA. On cross-examination, Dr. Ellin conceded, however, "the choice of what antibiotic to use required Dr. [Ould-]Hammou to exercise medical judgment based on the facts that she was presented with."

Dr. Klein testified MRSA is "more commonly associated with being in the hospital" and "with the puncturing of veins like with an IV" than other staph bacteria. He explained "there are fewer drugs that will work" on MRSA, and cefdinir does not have "any efficacy at all against MRSA."

Dr. Klein opined Dr. Ould-Hammou "did not perform to the standard of care as expected of an internist with regards to the diagnosis, treatment, diagnostic plan, and follow-up of [plaintiff]." Specifically, he stated the doctor failed to consider in her diagnosis that the injury was "a result of an IV that had gone bad, which would make it far more likely than not that MRSA was involved" or that plaintiff had "just come out of the hospital, which would also increase the risk of MRSA being the causative bacteria here rather than a strep or an MSSA." He added "[t]he fact that this started at a former IV site and that [plaintiff] came from hospital in and of themselves are sufficient to consider that it's going to be MRSA," and fever and pus are not required for a doctor to "cover for MRSA."

Dr. Klein also concluded Dr. Ould-Hammou failed to properly treat plaintiff's condition as "MRSA requires a different set of antibiotics than does a regular cellulitis" and cefdinir would not treat MRSA. He confirmed the IDSA guidelines indicate cephalosporin, a medication class of which cefdinir is a part, is "an appropriate antibiotic for patients suffering from cellulitis." He also agreed that Dr. Ould-Hammou "had to exercise her medical judgment in treating" plaintiff and "in prescribing cefdinir."

Contrariwise, Dr. Russo opined Dr. Ould-Hammou "complied with the standard of care" and her "choice of antibiotics was well within the standard of care of a soft tissue infection." He confirmed Dr. Ould-Hammou had "the right to use medical judgment in terms of her treatment in this case" and a doctor would "have to use their medical judgment" in determining whether an infection is cellulitis or MRSA.

Dr. Russo also testified the presentation of plaintiff's ACF was consistent with cellulitis because there was no complaint of pain, no discharge, no fever, no purulence, and "very localized" redness, swelling and tenderness. He specified a presentation with purulence would lead to "a whole different sequence" of treatment including taking cultures and prescribing different antibiotics. On cross, he conceded if plaintiff mentioned pus coming out of her arm in the shower, that would change his opinion and in that circumstance, the doctor should prescribe "medication that would be effective against MRSA."

Dr. Farber also opined that Dr. Ould-Hammou did not "deviate from accepted standards of medical care in terms of her care and treatment" of plaintiff and the doctor was "permitted to exercise her medical judgment" with respect to same. He noted, based on his review of the records, plaintiff's chief complaint on July 21, 2014 was shortness of breath, not arm pain, and she had

no fever, which was relevant because "fever often accompanies infection" and the chief complaint did not "suggest any focal sign of infection."

Further, Dr. Farber stated the standard of care did not require Dr. Ould-Hammou to conduct any further tests, as doctors generally do not take cultures of skin, and blood cultures would not be indicated "unless there's fever, chills, sweats, [or] systemic illness." He added a physician dealing with MRSA "always uses judgment" in doing so.

Dr. Farber explained it was not effective to treat for both MSSA and MRSA, so a doctor must use their judgment to select which seems most likely. He noted the antibiotics used to treat MRSA are "much less effective than the treatment of non-MRSA" infections. Here, he highlighted the lack of purulence, ulceration, or "deep open wound" which, in his view, made Dr. Ould-Hammou's treatment decision appropriate. He noted the IDSA "and everyone else" generally believed treatment for MRSA was required only where the patient presents with purulence. He acknowledged "recent hospitalization," a recent IV, an "infection at the very site of the recent hospitalization," and "hardware in [the] spine" were all risk factors for MRSA.

Dr. Strayer testified as to the differences between hospital-acquired and community-acquired MRSA, and opined "it was the vast overwhelming majority

of probability . . . that [plaintiff had] community-acquired MRSA" as a result of skin conditions and scratching. He also stated the time between plaintiff's discharge from the hospital and the time she saw Dr. Ould-Hammou indicated the infection "was not a particularly aggressive one," as "staph infections of this type do not just sit."

At the charge conference, defendants requested the court give the medical judgment charge, Model Jury Charges (Civil), 5.50G, "Medical Judgment" (Jun. 2014).[4] They contended "[t]here was numerous testimony from almost every physician for the defense on medical judgment," specifically as to determining which type of infection plaintiff had, which antibiotic would be appropriate, and what type of follow-up instructions to provide. Plaintiff objected, arguing the mere use of the word 'judgment' in the experts' testimony did not implicate the charge where medical judgment was not demonstrated by the facts. She asserted the charge required the doctor consider an alternative, and exercise judgment to the contrary, which Dr. Ould-Hammou's testimony did not reflect she had done.

[4] Throughout her brief, plaintiff refers to charge 5.50E when discussing the medical judgment charge. This appears to be in error, as charge 5.50E is titled "Pre-Existing Condition – Increased Risk/Loss of Chance – Proximate Cause," an issue not present or raised in this case.

The court determined the medical judgment charge was appropriate as to diagnosis and treatment, but not follow-up instructions, which it found was not a medical judgment but a question of standard of care. Relying upon Velazquez v. Portadin, 163 N.J. 677, 687 (2000), the court noted "the judgment charge should be limited to cases in which the physician exercised judgment in selecting among acceptable courses of action." It further stated, under Velazquez, 163 N.J. at 690, the court must "analyze the parties' testimony and theories in detail on the record to determine whether the charge is appropriate and if so, to what specific issues." Accordingly, it asked counsel to "assist the court in framing tailored objective statements of those issues which do involve legitimate disputes—disputed issues of judgment or two schools of thought."

The court found "there were two schools of thought, not only with the diagnosis" but also with treatment. Specifically, it explained "that was clearly laid out in the testimony of the experts and whether or not there was pus coming from the wound or non-pus coming from the wound, and whether or not to make a judgment call with regard to the diagnosis, as well as the treatment."

The court ultimately charged the jury as follows:

> A doctor may have to exercise judgment when diagnosing or treating a patient. However, alternative diagnosis or treatment choices must be in accordance with accepted standards of medical practice. Therefore,

> your focus should be on whether accepted standards of medical practice allowed judgment to be exercised as to diagnosis and treatment alternatives, and if so, whether what the doctor actually did do to diagnose or treat this patient was accepted as standard medical practice.
>
> If you determine that the accepted standards of medical practice for treatment or diagnosis, with respect to the diagnosis of an infection at the site of the previous placement of an IV and the antibiotic chosen to treat [plaintiff]'s condition on July 21, 2014, considering the risk factors [plaintiff] presented with, and the clinical appearance of [plaintiff], did not allow for the diagnosis and/or treatment alternatives that Dr. Ould-Hammou made here, then the doctor would be negligent.
>
> If you determine that the accepted standards of medical practice for treatment or diagnosis with respect to the diagnosis of an infection at the site of a previous placement of an IV, and the antibiotic chosen to treat [plaintiff]'s condition on July 21, 2014, considering the risk factors [plaintiff] presented with, and the clinical appearance of [plaintiff], did allow for the diagnosis and/or treatment alternatives that Dr. Ould-Hammou made here, then the doctor would not be negligent. Any determination as to medical judgment applies only to the diagnosis and treatment of [plaintiff], and not to any follow-up care.

Both parties objected to comments made in the other's summations. During defendants' summation, counsel made the following statements:

> [Plaintiff] also said that while she was in the hospital at Bayshore prior to seeing Dr. [Ould-]Hammou, that when the nurse was supposedly taking out the IV, that a string of pus came out, and I think what on cross-

> examination was that it was—could fill up a thimble, with the amount of pus that came out.
>
> Now, you're going to have records from Bayshore. There's not one mention of a pus string coming out of her arm. Matter of fact, what [plaintiff] does here at the time of trial, she doesn't say a string of pus. She says there were two strings of pus that came out, if you'll recall what she testified to. So not one, now two. When [plaintiff] comes here to trial, and why would she say there was [sic] two strands? Because it makes the situation worse. But there's no records of this. Zero.
>
> [emphasis supplied.]

Following the summation, plaintiff objected to those comments, arguing "[t]here are no records from Bayshore Hospital that are going into evidence in this case." Plaintiff's counsel stated although he did not believe it was "intentional or designed to do anything specific," the statements would "mislead the jury as to the evidence." Accordingly, plaintiff requested a curative instruction that the jury would not have those records, "that they are to disregard any testimony about the content of Bayshore records, what they say, or don't say," and further requested the court give the instruction prior to plaintiffs' summation. The court agreed to give a curative instruction but determined it would be given as part of its charge, reasoning an immediate instruction would "highlight" the issue.

Defendants also objected to numerous comments made in plaintiff's summation, including that the defense experts were "part of [defense counsel's] office's stable," Dr. Russo was a "Have Gun – Will Travel" expert, the jury couldn't trust anything from defendants, Dr. Ould-Hammou should have apologized to plaintiff, plaintiff's husband's lack of recollection may have been a "coping mechanism" related to post-traumatic stress disorder (PTSD), there was a "bad smell" with respect to Dr. Russo's testimony, the defense had engaged in a "big deception," Dr. Ould-Hammou "put[] [plaintiff] in a prison for the rest of her life," and counsel "ask[ing] the jurors to put themselves in the shoes of [plaintiff]." Defendants moved for a mistrial, arguing the cumulative effect of the comments was "prejudicial and highly inflammatory." The court denied defendants' application, noting although it was "concerned about some of the statements made, concerned enough to have recorded them [it]self as they were made," it would instead give a curative instruction.

The court gave its curative instructions as to both summations as part of its jury charge. Specifically, with respect to defendants' summation, it instructed the jury:

> [y]ou heard in defendants' closing arguments that there were records from Bayshore Hospital that you would be considering as evidence. Those records are, in fact, limited, and the only records that are in evidence are

> those of Dr. Ahmad, and that's the evidence that you would consider as Dr. Ahmad's records, as opposed to all of Bayshore Hospital records.

As to plaintiff's summation, the court gave the following instructions:

> there was a comment made during the course of plaintiff's closing argument regarding the possibility . . . that Mr. Furphy suffered from PTSD, or was using a coping mechanism, and that's why he couldn't remember things in his testimony. There was no evidence at all that Mr. Furphy suffers from PTSD or was using a coping mechanism, and that was an unfair comment by counsel in summation that you should not consider.
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> . . .
>
> While you may consider [the attorneys'] comments, nothing that the attorneys say is evidence, and their comments are not binding upon you.
>
> If you heard any implication during closing arguments that there was any collusion amongst the defendants, their experts, and their counsel, that [defendants' counsel] had a stable of experts, that there was a bad smell, or that Dr. [Ould-]Hammou should be sorry, that was also unfair comment that should not, in fact, be considered by you during your deliberations.

During deliberations, the jury asked only one question: "[a]re there discharge summary papers from [July 13, 2014] from Bayshore," and if so, if the jury could see them. The court instructed the jury on the record "[t]here are no discharge papers in evidence" and it could "only see what's in evidence."

Subsequently, one of the jurors stated in open court "what threw that off was—we're, in our heads, going from Bayshore. But then, when we're reading one of the things it said release from Riverview. And we remembered that there was mention of Riverview Hospital. So, we just wanted to make sure we got our facts straight."

As noted, the jury returned a no cause verdict. As to whether plaintiff "proved by a preponderance of the credible evidence that [Dr. Ould-Hammou] deviated from accepted standards of medical care in diagnosing and/or treating [p]laintiff," the jury answered "no" by an eight-to-one vote. As to whether plaintiff "proved by a preponderance of the credible evidence that [Dr. Ould-Hammou] deviated from accepted standards of medical care with regard to follow up care for plaintiff," it also answered "no" by a seven-to-two vote. Subsequently, the court entered judgment in favor of defendants on March 8, 2023. This appeal followed.

II.

We next detail the appropriate standards guiding our review. Generally, "we apply a narrow scope of review to civil jury verdicts" and "do not set them aside and order a new trial unless there has been a proven manifest injustice." Jacobs v. Jersey Cent. Power & Light Co., 452 N.J. Super. 494, 502 (App. Div.

2017). Where a litigant contests a jury charge at trial, we review an appeal of the charge for harmless error. Est. of Kotsovska by Kotsovska v. Liebman, 221 N.J. 568, 592 (2015). That is, we will "reverse on the basis of [a] challenged error unless the error is harmless." Ibid. (quoting Toto v. Ensuar, 196 N.J. 134, 144 (2008)). An error is harmful when it is "clearly capable of producing an unjust result." Ibid. (quoting R. 2:10-2). In reviewing such challenges, we "examine the charge as a whole, rather than focus on individual errors in isolation." Ibid. (quoting Toto, 196 N.J. at 144).

"The abuse of discretion standard applies to the trial court's rulings during counsel's summation." Litton Indus., Inc. v. IMO Indus., Inc., 200 N.J. 372, 392-93 (2009). A trial court abuses its discretion when "the decision was 'made without a rational explication, inexplicably departed from established practices, or rested on an impermissible basis.'" Kotsovska, 221 N.J. at 588 (quoting Flagg v. Essex Cnty. Prosecutor, 171 N.J. 561, 571 (2002)).

On an appeal regarding a curative instruction, "we defer to the discretion of the trial judge who has the 'feel of the case.'" NuWave Inv. Corp. v. Hyman Beck & Co., 432 N.J. Super. 539, 567 (App. Div. 2013), aff'd o.b., 221 N.J. 495 (2015) (quoting Khan v. Singh, 397 N.J. 184, 202 (App. Div. 2007)). Where, in making an objection, a party requests a curative instruction but not a mistrial,

we examine the court's decision not to grant a mistrial for plain error. State v. Greene, 242 N.J. 530, 554 (2020). Plain error is that which is "clearly capable of producing an unjust result." T.L. v. Goldberg, 238 N.J. 218, 232 (2019); see also R. 2:10-2.

Before us, plaintiff contends the court erred by giving the medical judgment jury charge "because the testimony adduced at trial failed to support such a charge." Relying upon Das v. Thani, 171 N.J. 518, 527 (2002), she maintains a doctor's decision constitutes a medical judgment only when it involves "misdiagnosis or the selection of one or two or more generally accepted courses of treatment." Here, plaintiff argues the facts and testimony demonstrate the case "does not involve a legitimate judgment call or two school's [sic] of thought." Specifically, she asserts it is impossible to "exercise judgment between two alternatives when you never consider an alternative in the first place." (emphasis in original). Unlike the "classic situation" of "medication v[ersus] surgery," plaintiff contends here "there is only one school of thought, to consider the patient, the history, the clinical presentation along with any risk factors to arrive at a likely, and alternate, diagnosis and treat . . . the patient to protect against all diagnoses."

In requesting we affirm, defendants maintain the medical judgment charge was appropriate. They argue Dr. Ould-Hammou used her medical judgment in considering the appropriate diagnosis in light of plaintiff's presentation and "the possible risk of MRSA from an infection at the IV site from a recent hospitalization," and in selecting "how best to treat plaintiff's infection." Particularly, highlighting the testimony of Dr. Ould-Hammou and Dr. Farber, they note the medical judgment here "involved consideration of whether to cover for the possibility of MRSA based on the location of the infection site and the knowledge of plaintiff's recent hospitalization, even though the infection presented as MSSA." Defendants also assert plaintiff failed to "cite any specific evidence" or testimony "calling into question the notion that there were different schools of thought with regard to diagnosis/treatment of plaintiff's infection." We agree with defendants.

"Our law has long recognized the critical importance of accurate and precise instructions to the jury." Piech v. Layendecker, 456 N.J. Super. 367, 376 (App. Div. 2018) (quoting Washington v. Perez, 219 N.J. 338, 350 (2014)). "A jury is entitled to an explanation of the applicable legal principles and how they are to be applied in light of the parties' contentions and the evidence produced in the case." Prioleau v. Ky. Fried Chicken, Inc., 223 N.J. 245, 256

(2015) (quoting Viscik v. Fowler Equip. Co., 173 N.J. 1, 18 (2002)). When charging the jury, the court must "set forth in clear understandable language the law that applies to the issues in the case." Toto, 196 N.J. at 144; see also Kotsovska, 221 N.J. at 591.

A jury charge is the "road map that explains the applicable legal principles, outlines the jury's function, and spells out 'how the jury should apply the legal principles charged to the facts of the case.'" Toto, 196 N.J. at 144 (quoting Viscik, 173 N.J. at 18). To create such a road map, the court tailors the jury charge to the facts of the case. Kotsovska, 221 N.J. at 592. Although it is axiomatic that accurate and understandable jury instructions are essential to a fair trial, see Velazquez, 163 N.J. at 688, "[a] party is not entitled to have a jury charged in words of his [or her] own choosing." Mohr v. B.F. Goodrich Rubber Co., 147 N.J. Super. 279, 283 (App. Div. 1977). "We recognize that not all errors in a jury charge inexorably require a new trial [as] [w]e must consider the charge as a whole, whether counsel voiced any contemporaneous objection, see Rule 1:7-2, and the likelihood that the flaw was so serious that it was likely to have produced an unfair outcome." Piech, 456 N.J. Super. at 377 (citing Viscik, 173 N.J. at 18).

It is well-settled that medical professionals "must act with that degree of care, knowledge, and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field." Velazquez, 163 N.J. at 686. Nevertheless, we acknowledge "good treatment will not necessarily prevent a poor result." Ibid. (quoting Schueler v. Strelinger, 43 N.J. 330, 344 (1964)). Thus, a malpractice action "cannot be predicated solely on the course pursued" where a doctor uses their medical judgment to select among options which have "substantial support as proper practice by the medical profession." Ibid. (quoting Schueler, 43 N.J. at 346).

As our Supreme Court explained, "[t]o constitute a medical judgment, a medical decision generally must involve 'misdiagnosis or the selection of one of two or more generally accepted courses of treatment.'" Das, 171 N.J. at 527 (quoting Velazquez, 163 N.J. at 687). The course of treatment chosen "must be an 'equally acceptable approach' in order not to be considered a deviation from the appropriate standard of care." Id. at 527-28 (quoting Velazquez, 163 N.J. at 690).

"[A] medical judgment charge that does not specify what action may qualify as an appropriate exercise of judgment may result in an overly broad charge that has 'the potential to improperly insulate defendants from liability.'"

Id. at 528 (quoting Velazquez, 163 N.J. at 690-91). "The '[c]ourt and counsel should analyze the parties' testimony and theories in detail, on the record, to determine whether the [medical judgment] charge is applicable at all and, if so, to which specific issues,'" and then tailor the charge accordingly. Ibid. (alterations in original) (quoting Velazquez, 163 N.J. at 690). For example, "[i]f a case involves judgment issues on some theories of liability, but not on others, the charge should be tailored to those facts." Velazquez, 163 N.J. at 689 (quoting Model Jury Charges (Civil), 5.36A, 2 Medical Malpractice, Duty and Negligence (Apr. 1999)).

The medical judgment jury charge is inappropriate where the dispute involves the doctor's performance of a procedure or treatment, rather than the doctor's selection of the appropriate course of action. See Velazquez, 163 N.J. at 689-90; Aiello v. Muhlenberg Reg'l Med. Ctr., 159 N.J. 618, 632-33 (1999). In Velazquez, a case alleging the defendant obstetrician failed to appropriately monitor a fetal heartbeat after administering a drug to accelerate labor, the Supreme Court determined the charge was not implicated because "the heart of the case was about whether there was a deviation from the standard of care." 163 N.J. at 690. Specifically, it reasoned "[a]ll experts agreed that monitoring

was required" and if the monitoring was not readable, absent another monitoring technique, the labor-accelerating drug "should have been stopped." Id. at 689.

Similarly, in Aiello, 159 N.J. at 632-33, the Court determined the charge was inappropriate where plaintiff alleged the defendant surgeon inserted a needle beyond the operative field while performing a tubal ligation. The Court explained there was no testimony "suggesting that defendant should have performed the tubal ligation using a different procedure or that the result suffered by plaintiff was a 'mistake' attributable to the selection of one medical procedure rather than another," and "[t]he experts disagreed only on whether defendant performed the selected procedure in a negligent manner." Id. at 632.

Here, in contrast, we are satisfied the trial record supported the court's decision to instruct the jury with the medical judgment charge. As noted, the court instructed the jury that medical judgment applied with respect to Dr. Ould-Hammou's diagnosis and treatment of plaintiff.

As defendants' expert Dr. Russo testified, in deciding how to diagnose plaintiff, Dr. Ould-Hammou was required to exercise her judgment. Indeed, Dr. Ould-Hammou explicitly stated she "ruled out the possibility of MRSA based on the way [plaintiff's ACF] looked," revealing she considered multiple options and determined a MRSA diagnosis was not warranted based on the facts known

to her at that time. Because plaintiff actually was later diagnosed with MRSA, this is clearly a case of "misdiagnosis" as stated in Das, 171 N.J. at 527.

The expert testimony also demonstrated two schools of thought with respect to which risk factors and symptoms necessitated a MRSA diagnosis. Plaintiff's expert Dr. Klein testified "[t]he fact that this started at a former IV site and that [plaintiff] came from hospital in and of themselves are sufficient to consider that it's going to be MRSA," and a MRSA diagnosis does not necessarily require fever or pus. On the other hand, Dr. Russo opined a non-MRSA diagnosis was appropriate because plaintiff did not present with "complaint of pain or discomfort," discharge, "evidence of a fever," or purulence. He also highlighted plaintiff's "very localized" redness, swelling and tenderness. Unlike Velazquez, where the experts all agreed fetal monitoring was required, and Aiello, where the experts disagreed only as to whether performance of the selected procedure was negligent, here the experts fundamentally disagreed as to whether plaintiff's presentation and risk factors dictated a MRSA diagnosis.

We reach a similar conclusion with respect to treatment. Plaintiff's experts, Dr. Ellin and Dr. Klein, each confirmed Dr. Ould-Hammou's choice of antibiotic required her to exercise medical judgment based on the facts

presented. Defendants' expert Dr. Farber explained it was not effective to treat for both MSSA and MRSA, so a doctor must use their judgment to select which seems most likely. Dr. Ould-Hammou also testified she considered medication that would cover for MRSA, but declined to prescribe it as "indiscriminate use of antibiotics for all patients to cover every single bacteria is not an appropriate way to practice medicine." Additionally, the IDSA guidelines list multiple medications which would be appropriate for cellulitis and MRSA.

Further, the charge given by the court was appropriately tailored to the facts. The court expressly stated medical judgment was applicable only to the diagnosis and treatment of plaintiff, not to the follow-up instructions she received. It also specified the diagnosis was "of an infection at the site of the previous placement of an IV," the treatment was "the antibiotic chosen," and in both, Dr. Ould-Hammou had to consider "the risk factors [plaintiff] presented with, and the clinical appearance of [plaintiff]." This charge "specif[ied] what action may qualify as an appropriate exercise of judgment" to avoid an "overly broad charge." Das, 171 N.J. at 528 (quoting Velazquez, 163 N.J. at 690-91).

Having determined the court did not err in charging the jury with medical judgment, we cannot conclude there was a harmful error requiring reversal. We

are convinced the charge was not "clearly capable of producing an unjust result." Kotsovska, 221 N.J. at 592 (quoting R. 2:10-2).

III.

Next, plaintiff argues defendants' improper comments during summation with respect to the Bayshore records were "so prejudicial that it resulted in a miscarriage of justice" and the court erred by not granting a mistrial. Relying upon Bender v. Adelson, 187 N.J. 411, 431 (2006), she notes a summation may not "misstate the evidence nor distort the factual picture." Plaintiff contends defendants' counsel made a "false statement" about documents "unquestionably known not to be in evidence" regarding "a significant fact at issue in this case—what was the condition of [plaintiff's] left arm upon discharge" from Bayshore on July 13, 2014. She asserts the statement "significantly impacted the jury" as the jury's only question in deliberations was to "ask to see the very records that counsel mentioned in his summation."

Defendants respond their counsel's statement in summation did not mislead the jury or influence the outcome of the case. In support, they maintain the condition of plaintiff's arm on July 21, 2014 when she was seen by Dr. Ould-Hammou was the crucial factual issue, not the condition of her arm at discharge from Bayshore approximately one week before. They contend any confusion

was created by plaintiff's witness, Dr. Ahmad, who mistakenly wrote plaintiff had been discharged from "Riverview" rather than Bayshore in his notes regarding his August 6, 2014 examination of plaintiff. According to defendants, the jurors' comments "clearly" indicate they were referring to Dr. Ahmad's notes.

Further, defendants argue plaintiff's position regarding the summation before the trial court is markedly different than that presented here. Specifically, they stress plaintiff did not request a mistrial, only a curative instruction, and plaintiff's counsel stated he was "not saying [the comment] was intentional or designed to do anything specific." Again, we agree with defendants.

It is well-settled "[c]ounsel is allowed broad latitude in summation." Hayes v. Delamotte, 231 N.J. 373, 387 (2018) (quoting Colucci v. Oppenheim, 326 N.J. Super. 166, 177 (App. Div. 1999)). However, "[t]hat latitude is not without its limits, and 'counsel's comments must be confined to the facts shown or reasonably suggested by the evidence introduced during the course of the trial.'" Ibid. (quoting Colucci, 326 N.J. Super. at 177). While counsel "may draw conclusions even if the inferences that the jury is asked to make are improbable, perhaps illogical, erroneous, or even absurd," Bender, 187 N.J. at 431 (quoting Colucci, 326 N.J. Super. at 177), counsel may not "misstate the evidence nor distort the factual picture," Hayes, 231 N.J. at 387 (quoting

Colucci, 326 N.J. Super. at 177). Notably, "[f]leeting comments, even if improper, may not warrant a new trial, particularly when the verdict is fair." Jackowitz v. Lang, 408 N.J. Super. 495, 505 (App. Div. 2009).

"To remedy the prejudice caused by untrue statements or inferences, trial courts may, depending on the severity of the prejudice, issue a curative instruction or grant a mistrial." NuWave, 432 N.J. Super. at 567 (quoting Bender, 187 N.J. at 433). A mistrial is "an extraordinary remedy that should be exercised only to prevent manifest injustice." Belmont Condo. Ass'n, Inc. v. Geibel, 432 N.J. Super. 52, 97 (App. Div. 2013). "In addressing a motion for a mistrial, the judge is ordinarily in the best position 'to gauge the effect of a prejudicial comment on the jury in the overall setting.'" Barber v. ShopRite of Englewood & Assocs., Inc., 406 N.J. Super. 32, 51 (App. Div. 2009) (quoting State v. Winter, 96 N.J. 640, 647 (1984)). To determine whether a mistrial is appropriate, the court considers:

> whether or not the error is such that manifest injustice would result from continuance of the trial and submission of the case to the jury. . . . [and] whether or not the prejudice resulting from the error is of a nature which can be effectively cured by a cautionary instruction or other curative steps.
>
> [Belmont Condo. Ass'n., 432 N.J. Super. at 96-97 (quoting Pressler & Verniero, Current N.J. Court Rules, cmt. 5.1 on R. 3:20-1 (2013)).]

Applying these substantive principles, because it was not disputed the July 13th Bayshore records were not in evidence, we agree with plaintiff defendants' counsel's comments to the contrary were improper. By informing the jury they would be able to review those records, counsel "misstate[d] the evidence" contrary to Hayes, 231 N.J. at 387. As noted, however, plaintiff sought only a curative instruction, not a mistrial, in her original objection to defendants' summation and accordingly her claim asserting the court erred by not granting a mistrial must be reviewed for plain error. Greene, 242 N.J. at 554.

We are satisfied defendants' counsel's comments were not so prejudicial as to result in manifest injustice if the trial continued. While improper, the comments were brief and the records referenced were not related to the crucial issues in the case—Dr. Ould-Hammou's diagnosis and treatment of plaintiff—but instead provided background for how plaintiff alleged the infection began. Contrary to plaintiff's characterization, the condition of plaintiff's arm at discharge from Bayshore on July 13, approximately one week before Dr. Ould-Hammou's treatment, was not a central factual dispute in the case. Plaintiff's counsel conceded the comments were not intentional or "designed to do anything specific," and plaintiff sought only a curative instruction rather than a mistrial.

We conclude the curative instruction given adequately redressed any harm caused by defendants' counsel's comments. As part of the charge, the jury was informed summations are not evidence or binding. The instruction specifically referenced defendants' summation when it properly advised the jury that the only records from Bayshore in evidence were those of Dr. Ahmad. Although plaintiff requested the instruction be given immediately following defendants' summation, the court was well within its discretion to give the instruction as part of its jury charge. The comments occurred during closing arguments, just before the charges being read, and the jury was not left with an erroneous impression for any extended period of time.

Although we acknowledge the jury's sole question was about these records, a juror explained the question arose from confusion caused by references to hospitalization at Riverview, presumably in Dr. Ahmad's notes. In light of the court being "in the best position 'to gauge the effect of [this] prejudicial comment on the jury in the overall setting," Barber, 406 N.J. Super. at 51 (quoting Winter, 96 N.J. at 647), we cannot find the court's failure to sua sponte grant a mistrial was "clearly capable of producing an unjust result," T.L., 238 N.J. at 232.

Finally, plaintiff contends in the alternative, even if the court did not err in failing to declare a mistrial, its curative instructions regarding both summations, taken as a whole, were "so grossly deficient that it had a clear prejudicial impact on the jury's decision which requires a new trial." She asserts the instructions failed to address defendants' counsel's "egregious false statements" because they were not given immediately following defendants' summation nor sufficiently specific. In contrast, plaintiff stresses the court did grant "an immediate curative instruction to defendant[s]" in response to plaintiff's counsel's summation comments. Further, she maintains the curative instruction as to her summation erroneously included relatively stronger phrasing, that the statements were "unfair comment" on the evidence, while the instruction as to defendants' summation did "not implicate any impropriety." Again, plaintiff stresses the jury's question constitutes "evidence of prejudice and confusion."

Defendants respond the curative instructions were neutral, non-prejudicial, and the timing was "appropriate given the court's wide discretion in controlling the proceedings." They argue the alleged errors occurred "in the context of closing arguments," not during testimony, and the "jurors were instructed at the outset of the charge that the comments of counsel were not

evidence." Additionally, defendants contend the court's instruction on plaintiff's summation was fair and warranted.

As noted, "when weighing the effectiveness of curative instructions, a reviewing court should give . . . deference to the determination of the trial court." Khan, 397 N.J. at 202-03 (quoting Winter, 96 N.J. at 647). Our Supreme Court explained in Winter, 96 N.J. at 647, "[t]he adequacy of a curative instruction necessarily focuses on the capacity of the offending evidence to lead to a verdict that could not otherwise be justly reached."

In light of the deference accorded the court in its determination of the appropriate remedy for summation comments, we are convinced nothing in the record demonstrates the curative instructions given were inappropriate or unduly prejudicial. Turning first to the instruction in response to defendants' summation, as noted, defendants' counsel's fleeting comments involved background information not central to Dr. Ould-Hammou's treatment of plaintiff and thus would not likely "lead to a verdict that could not otherwise be justly reached." Winter, 96 N.J. at 647. Additionally, as detailed supra, the instruction was both sufficiently specific and given as a part of the jury charge, immediately following both summations, to avoid any lengthy period of confusion for the jury.

Even considering the instruction together with that given in response to plaintiff's summation, we find no impropriety or prejudice to either party. The court's more strongly worded instruction addressing the improper comments in plaintiff's summation did not result in undue prejudice and, simply put, was appropriate to address counsel's comments. In contrast to defendants' counsel's fleeting comments, the inappropriate commentary about defense counsel and defendants' experts in plaintiff's summation permeated the entire argument. Additionally, plaintiff's counsel also made several other inflammatory comments during summation which "concerned [the court] enough to have recorded them [it]self as they were made." The court therefore properly exercised its discretion to give a lengthier instruction which adequately responded to these extensive improper comments.

We fully recognize the severity of plaintiff's injuries and the permanent effect on her life, but are nevertheless convinced the court did not err in its charge to the jury or in its curative instructions.

Affirmed.