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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: ALICE SCHLESINGER PART IA PART 16
Justice

Index Number : 102420/2009
ANGUEIRA, LORAINE
vs.
UNIVERSITY MEDICAL CENTER
SEQUENCE NUMBER : 003
SUMMARY JUDGMENT

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____

The following papers, numbered 1 to _____, were read on this motion to/for _____

Notice of Motion/Order to Show Cause — Affidavits — Exhibits _____ | No(s). _____

Answering Affidavits — Exhibits _____ | No(s). _____

Replying Affidavits _____ | No(s). _____

Upon the foregoing papers, it is ordered that this motion ~~is~~ by defendant for summary judgment is granted to the extent provided in the accompanying memorandum decision and is otherwise denied.

FILED
JUL 06 2012
NEW YORK
COUNTY CLERK'S OFFICE

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE
FOR THE FOLLOWING REASON(S):

JUL 02 2012

Dated: July 2, 2012

ALICE SCHLESINGER J.S.C.

1. CHECK ONE: ..... ☐ CASE DISPOSED ☒ NON-FINAL DISPOSITION
2. CHECK AS APPROPRIATE: .....MOTION IS: ☐ GRANTED ☐ DENIED ☒ GRANTED IN PART ☐ OTHER
3. CHECK IF APPROPRIATE: ..... ☐ SETTLE ORDER ☐ SUBMIT ORDER
☐ DO NOT POST ☐ FIDUCIARY APPOINTMENT ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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LORAINE ANGUEIRA,

Plaintiff,

-against-

NEW YORK UNIVERSITY MEDICAL CENTER
HOSPITAL FOR JOINT DISEASES,

Defendant.

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Index No. 102420/09
Motion Seq. No. 003

SCHLESINGER, J.:

Before this Court in this medical malpractice action is a motion for summary judgment by the sole defendant NYU Hospitals Center s/h/a New York University Medical Center Hospital for Joint Diseases (NYU). The plaintiff Loraine Angueira claims that NYU is responsible for having become infected with a Methicillin-resistant Staphylococcus aureus (MRSA) during a spinal fusion surgical procedure that she underwent on February 5, 2007. The surgery was performed by Dr. Jean-Pierre Farcy, an orthopedic surgeon who had been treating Ms. Angueira since 2006 for unrelenting pain in her hips that radiated down to her legs.

NYU's motion is supported by an affirmation from Dr. Michael S. Phillips, who is board certified in Internal Medicine and Infectious Diseases. He is associated with NYU School of Medicine where he is an Attending Associate Professor in Infectious Diseases and with NYU Langone Medical Center where he is the Director of Infection Prevention and Control for the hospital.

The plaintiff's opposition papers are supported by a lengthy affidavit from Dr. William R. Jarvis, which includes eight paragraphs devoted to the doctor's credentials and

experience in dealing with infectious diseases. Dr. Jarvis is board certified in Pediatrics and is a Fellow of the Infectious Diseases Society of America and the Society of Healthcare Epidemiologists of America. For over twenty years, ending in 2003, he worked as an Epidemic Intelligence Service Officer at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. During most of the time at the CDC he served in the Hospital Infection Program, where he held a number of leadership positions, including for seventeen years Chief of the Epidemiology Branch. Dr. Jarvis was also a Clinical Associate Professor of Medicine at Emory University School of Medicine and at the Rollins School of Public Health at Emory.

Since 2003 Dr. Jarvis has been President of Jason and Jarvis Associates, LLC, which provides consulting services in infectious diseases, infection control, and related matters. He is also Chair of the Food & Drug Administration's General Hospital and Personal Use Committee.

Additionally, Dr. Jarvis has authored and co-authored over 400 peer-reviewed medical journal articles and fifty book chapters and has edited three books on infectious disease and control and healthcare epidemiology. Further, and relevant to his credentials to opine about issues here, he has been very active in establishing surveillance systems for the detection and control of infections, including surgical site infections (SSI), and in the development of the SSI Risk Index.

Further, Dr. Jarvis has been very involved in investigating Staphylococcus aureus and in writing guidelines for its prevention. In this regard, he states in his affidavit that he has conducted numerous studies documenting the efficacy of active surveillance cultures, contact precautions, and hand hygiene in the control of strains of this bacteria.

The credentials of the experts make it clear that both Dr. Phillips and Dr. Jarvis are well-qualified to give opinions as to the appropriate standards of care here. A significant issue in connection with the expert affidavits is whether, as defendant argues in its Reply, the primary opinion put forth by Dr. Jarvis on behalf of the plaintiff is a new, revamped theory not mentioned earlier that should not be allowed to defeat defendant's motion for summary judgment.

I do not agree with the defendant's argument. Dr. Jarvis opines that NYU departed from good and accepted standards of care, as they existed in 2007, by failing to administer the first dose of an antimicrobial prophylaxis known as Clindamycin by intravenous (IV) within the recommended sixty minutes before the surgical incision. Dr. Jarvis also submits that NYU departed by failing to provide a second dose of this antimicrobial agent within three to six hours of the initial prophylactic infusion.

In support of his opinion, Dr. Jarvis points to several hospital records, including the operative report and the pre-surgical nurse's notes, to show that 600 mg of Clindamycin was administered by IV at 9:00 a.m., but the surgical "incision time" was at 10:09 a.m., outside the sixty-minute window that he asserts is the standard of care. As to the alleged departure regarding the second dose, the records show that the dose was not given until 5:00 p.m., about two hours after the surgery was completed or eight hours after the first dose, rather than during the three-to-six hour window urged by Dr. Jarvis.

Dr. Jarvis elaborates on why he believes "with a reasonable degree of medical certainty, that these departures were a proximate cause and substantial contributing factor to Ms. Angueira's MRSA infection in her surgical wound; and the resulting osteomyelitis, irrigation and debridement surgeries, removal of hardware, antimicrobial therapies, physical pain, mental anguish and other injuries and damages" (¶13).

NYU's counsel, as alluded to earlier, argues that these two alleged departures relating to the timing of the antibiotic are based on a new theory completely different from the originally asserted theory, which was "that the defendant was negligent in somehow allowing/facilitating/causing Ms. Angueira to contract and develop a MRSA infection ... (in) that the plaintiff herself believes that she contracted MRSA from her roommate." (¶18 of Affirmation of Dana A Tenenbaum in support of the motion).

Consistent with this characterization of plaintiff's theory of the case are the statements by Dr. Phillips in his affirmation attached as Exhibit A to the moving papers. There, after relating the plaintiff's course between February 5 and February 9, 2007, Dr. Phillips states: "At no time during the post-operative period ... is the plaintiff placed in a room with a patient known to be infected with MRSA" (¶6).

Dr. Phillips then discusses Ms. Angueira's somewhat rocky recovery from the surgery, until finally on March 1, 2007 the hospital recognized that the plaintiff's surgical site was infected with MRSA (¶9). The patient remained at the hospital until April 3, 2007, undergoing incisions and drainages at various times. She was readmitted on July 27, 2007 where she remained until August 3, 2007. These hospitalizations, Dr. Phillips acknowledged, were all caused by Ms. Angueira's unrelenting MRSA infection.

Dr. Phillips then explains (at ¶11 *et seq.*) that in his official capacity as Director of Infection Prevention and Control and after having thoroughly read the plaintiff's Bill of Particulars, he perceived the "gist of the allegations" by the plaintiff to be that the hospital was negligent in allowing Ms. Angueira to come in contact with a patient infected with MRSA or in failing to maintain a sterile operative field. He describes both claims as "completely meritless."

Dr. Phillips explains in the ensuing paragraphs of his affirmation that extensive research was conducted to determine if the claim involving contact with another MRSA-infected patient had any basis, and it was determined that there was no epidemiologic link. He further elaborates on the details of the search, which was also the subject of his deposition testimony, and asserts that there was no evidence to support the plaintiff's claim in this regard.

In ¶15, Dr. Phillips briefly discusses the alternative claim regarding the operative field and opines that all steps were taken pre-operatively to maintain a sterile environment. He explains that all proper standards were practiced and that "the infection prevention and control policy to prevent the transmission of Drug-Resistant Organisms was in effect and followed". Here he makes reference to Exhibit O to the motion, which is a three-page general instruction sheet on contact precautions for resistant bacteria. In his opinion, there is no evidence to suggest that the patient contracted MRSA during the operation. In his conclusion, while he acknowledges that the source of the plaintiff's infection was unknown and states that he believes that the plaintiff was at a higher risk of infection than others because of her extensive surgical history, he opines that when Ms. Angueira was initially admitted to the hospital she was already colonized for MRSA. In other words, Dr. Phillips opines that Ms. Anguiera brought the MRSA bacteria to the hospital with her and that the infection developed and manifested itself after her admission.

Accepting the defendant's characterization of the plaintiff's claims, and assuming that those were indeed the only claims, a finding would be warranted based on Dr. Phillips' affirmation that the defense succeeded in the first instance in establishing a prima facie case for summary judgment. However, such a finding cannot be made if the plaintiff had

asserted other theories of negligence or claims that were not addressed in the moving papers. That, I believe, is what occurred here.

In the plaintiff's opposition papers, counsel attaches as Exhibit 3 the Verified Bill of Particulars (BP), dated July 2, 2009. Response No. 3 in the BP reads in relevant part as follows:

> Defendant NYU Hospital Centers ... by and through its agents ... was negligent and departed from standards of good and accepted medical practice ... in the medical care rendered to Plaintiff ... by the following: ... in failing to prevent a Methicillin Resistant *Staphylococcus* aureus (MRSA) infection in Plaintiff's surgical wound; [and] in failing to provide prophylactic antibiotics to Plaintiff prior to, during and after her surgery...

I find that these two theories regarding NYU's failure to prevent an infection of the surgical wound and its failure to properly dispense prophylactic antibiotics were clearly articulated by the plaintiff in the BP. Thus, the defense was on notice of the plaintiff's claim that Ms. Angueira contracted MRSA during surgery because of the hospital's failure to properly provide prophylactic antibiotics "prior to, during and after the surgery" (Response No. 3).

As alluded to earlier, defense counsel argues that the plaintiff had initially alleged that NYU had departed from accepted standards of care by having allowed the plaintiff to contract MRSA from another patient who was in close proximity to the plaintiff while a patient at the hospital. For this argument, counsel relies on the same Bill of Particulars cited by the plaintiff in the opposition papers, thereby confirming notice of all the claims alleged there. While it is true that the plaintiff did articulate the patient-contact theory there and also apparently testified about it at her deposition, she also asserted other departures,

two of which were quoted above in their entirety. The moving party cannot simply decline to address those other theories by claiming that they are new.

In her Reply, defense counsel intelligently did not rely only on her "new theory" argument. Rather, she asked Dr. Phillips to address the opinions expressed by Dr. Jarvis regarding the proper timing of the prophylaxis, Clindamycin, and provided a second affirmation from him as Exhibit A to the Reply.

There Dr. Philips dismisses Dr. Jarvis' opinions as to the timing of the antibiotics as "complete red herrings [that] have absolutely no bearing on whether the plaintiff developed MRSA as this organism is resistant to it [Clindamycin]" (¶5). However, in attempting to rebut the Jarvis opinion, Dr. Phillips indulges in speculation by making factual allegations not supported by anyone with personal knowledge, such as the nurse who infused the patient with Clindamycin. Specifically, Dr. Phillips concedes that the 9:00 IV infusion and the first incision at 10:09 are more than one hour apart. But then he says that while that analysis "may seem technically accurate at first glance, it is not entirely true." (¶6). Why? Because in his opinion the 9:00 time listed by the nurse as to when the antibiotic was started was actually "the time in which the nurse began the process of setting up the antibiotic," by, for example, hanging up the bag and making other preparations (¶10). Therefore, in his opinion, the drug did not start to be infused into the patient until some time after 9:00, within the requisite one hour of the incision.

Two things should be noted regarding this issue. First, Dr. Phillips does not dispute the one-hour time frame between the drug infusion and the surgical incision that Dr. Jarvis states is the standard of care. Second, he gives absolutely no basis for his conclusion that the nurse did not mean what she said when she noted that the pre-operative antibiotic

infusion began at 9:00 a.m. Nor does Dr. Phillips explain why the placing of the IV bag and the "time it takes to start the infusion process" took more than 9 minutes, making the actual infusion time 9:09 or later and within the one-hour window.

Significantly, Dr. Jarvis in his affidavit on behalf of the plaintiff refers to several journal articles, which he says support his position. The first of these was published in 2004 and is entitled "Anti-microbial Prophylaxis for Surgery: An Advisory Statement from the National Surgical Infection Prevention Project." The other articles he refers to are the June 2004 AAOS (American Academy of Orthopedic Surgeons) Information Statement — Recommendations for the Use of Intravenous Prophylaxis in Primary Total Joint Arthroplasty and the 2006 statement by the CDC's Healthcare Infection Control Practices Advisory Committee entitled "Management of Multidrug-Resistant Organisms in Healthcare Settings. " These articles are included in the opposition papers as Exhibits 17, 18 and 19.

Regarding the assertion by Dr. Jarvis that NYU departed by failing to redose the patient with the antibiotic within 3-6 hours of the surgery, it is unclear what Dr. Phillips is referring to when he claims in the Reply that "the article that Dr. Jarvis relies on does not in fact make that assertion" (¶8). He says this redosing time frame only applies when the surgery takes more than 6 hours to complete, and since the surgery here took only 5 hours and 40 minutes, the recommendation would not apply. With regard to the first two journals named, which deal with the timing of prophylactic antibiotic administration, confirmation of the doctor's claim cannot be located in the articles as Dr. Phillips provides no specific page reference. In contrast, support for the opinion of Dr. Jarvis prominently appears in a chart referring to Clindamycin.

Dr. Phillips also points out that these time frames are merely recommendations that are not necessarily synonymous with standard of care. However, Dr. Jarvis makes it very

clear that he reaches his opinions not based solely on the articles he cites, but also based on his own extensive education, training and experience, which makes him familiar with the appropriate standards of care as they existed in 2007 (¶10). He says that the articles support his opinions but do not form the basis for them.

Dr. Jarvis also explains why he believes that the plaintiff would not have developed MRSA deep in her wound if the doses of Clindamycin had been properly given, even though later wound cultures showed the MRSA to be Clindamycin resistant. He states that multiple studies have shown that a MRSA strain exposed to Clindamycin but not properly managed can lead to resistance to this drug. In other words, the plaintiff's infection may well have been responsive to Clindamycin if the drug had been properly and timely administered in the first instance.

But not surprisingly, Dr. Phillips dismisses this argument as obscure, speculative, vague and unscientific. He insists that the administration of Clindamycin here was totally irrelevant because the strain of MRSA that caused the infection was clearly resistant to that particular antibiotic at all times. Dr. Phillips says that his review of the medical records shows that this "morphing" discussed by Dr. Jarvis simply did not occur. Although he acknowledges and agrees that certain strains of staph aureus can exhibit "inducible Clindamycin resistence", he says that there is no evidence that such resistance can occur where, as here, Clindamycin is used as a prophylaxis.

The above dispute, as pointed out by counsel in Reply, goes to the issue of causation. NYU, pursuant to the opinion of Dr. Phillips, argues that the fact that the plaintiff's strain of MRSA turned out to be resistant to Clindamycin shows that "the timing of the administration of the Clindamycin is a complete red herring ... as it would not have changed the outcome whatsoever".

I find that the opinions of both experts on the issue of Clindamycin resistance are somewhat speculative. Dr. Jarvis opines for the plaintiff that the purpose of the dosing and redosing is to prevent "colonization" or the growth of intraoperative microorganisms causing infection. And the two experts apparently agree that the most likely time of contamination of any surgical site infection is during the surgery itself; Dr. Phillips made such a statement in his deposition, and it is clearly here also that the infection settled deep in the wound, which is typical of intraoperative infections.[1]

As to the dispute regarding the timing of the Clindamycin, both before and after the surgery, there is a legitimate difference of opinion on a real issue in the case. I find that the defendant was not prejudiced in the manner or when this departure was presented by the plaintiff. As stated earlier, the Bill of Particulars did refer to failures regarding the infusion of prophylaxis drugs, although the timing of that infusion was not specifically spelled out. Also, there was no need for the plaintiff to develop the prophylactic timing issue during discovery, as the entire claim relied exclusively on the records. Finally, Dr. Phillips, in the Reply, dealt with the affidavit of Dr. Jarvis and in fact had the last word on the subject. For reasons already stated, I did find Dr. Phillips' Reply Affirmation to be somewhat speculative and wanting in certain respects. Of course, his first affirmation in the moving papers turned out to be irrelevant in that it failed to address the viable issue

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[1]Another departure articulated by Dr. Jarvis and ignored by Dr. Phillips, but not by counsel, one relates to certain procedures allegedly in effect in 2007 dealing with multidrug-resistant organisms such as MRSA. Here I agree with the defense position that this departure is truly speculative, being almost a throw-away presented at the end of the Jarvis affidavit based on the article attached as Exhibit 19. Also, it seems to contradict the earlier expressed opinions by Dr. Jarvis that the MRSA infection began during surgery. Therefore, I find that this alleged departure is not viable.

in this case that NYU allegedly failed to prevent MRSA from infecting the plaintiff's wound by failing to properly time the prophylaxis infusion.

As to the alleged departure dealing with contact with an infected person, that claim was satisfactorily addressed by the defendant in the moving papers and the defendant did succeed in laying out a prima facie case supporting summary judgment. Since the plaintiff did not address the point at all in the opposition, that claim is hereby dismissed.

As to the alleged departure of failing to maintain a sterile field, that claim directly relates to the alleged failure to properly administer the Clindamycin and therefore should remain. The action will continue as triable issues of fact exist regarding Dr. Jarvis' opinion that NYU departed from the standard of care regarding the timing of the two infusions of Clindamycin and that this failure allowed the MRSA infection to root at the surgical site and deep into the wound.

Finally, with regard to the subsequent resistance that Ms. Angueira developed to the Clindamycin on the issue of causation, I find that both expert opinions on this subject should be heard and determined by the fact finders. As a matter of law, the Court cannot rely on the opinion of Dr. Phillips offered on behalf of the defense that the patient's later-revealed resistance proves that the timing of the infusions was irrelevant.

Accordingly, it is hereby

ORDERED that the defendant's motion for summary judgment is granted to the extent of severing and dismissing the plaintiff's claims that she contacted MRSA from contact with an infected person and/or due to the defendant's failure to follow procedures for multidrug-resistant organisms, and the motion is otherwise denied; and it is further

ORDERED that counsel shall appear in Room 222 on July 11, 2012 at 9:30 a.m. as previously scheduled prepared to discuss settlement and select a trial date.

Dated: July 2, 2012

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J.S.C.

ALICE SCHLESINGER

FILED

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