SUPREME COURT OF THE STATE OF NEW YORK **Index No.: 10761/2004**
COUNTY OF RICHMOND **PART DCM 3** **Motion No.: 1**

JEAN SPAGNOLE and NICHOLAS SPAGNOLE,

Plaintiffs

DECISION & ORDER
HON. JOSEPH J. MALTESE

against

STATEN ISLAND UNIVERSITY HOSPITAL and FRANK ROSELL, M.D.,

Defendants

The following items were considered in the review of this motion for summary judgment

Papers	Numbered
Notice of Motion and Affidavits Annexed	1
Answering Affidavits	2
Replying Papers	3
Exhibits	Attached to Papers
Memorandum of Law	

Upon the foregoing cited papers, the Decision and Order on this Motion is as follows:

In this medical malpractice action, the defendants move this court for an order pursuant to CPLR § 3212 granting summary judgment and dismissing the plaintiffs' complaint. The plaintiffs oppose this motion.

This action, sounding in medical malpractice, is to recover damages for the injuries allegedly suffered by the plaintiffs, to wit: a sternal wound infection and a "post-operative mediastinitis" following the plaintiff Jean Spagnole's triple coronary artery bypass surgery performed by the defendant, Frank Rosell, M.D.

On October 9, 2002, the plaintiff Jean Spagnole, who is a diabetic, underwent cardiac catherization at Staten Island University Hospital [hereinafter "SIUH"]. The results of the catherization revealed substantial blockages in three coronary arteries. The defendant, Dr. Rosell is a cardiothoracic surgeon who consulted with the plaintiff on November 9, 2002 and recommended triple coronary bypass surgery, which was performed two days later on November 11, 2002 at SIUH.

According to Dr. Rosell's examination before trial, which was held on November 9, 2004, he disclosed the risks of surgery to the plaintiff, including the risk of infection and

complication. He testified that after he consulted the plaintiffs with respect to the known risks of the surgery, the plaintiff consented to the procedure.

The defendants, in support of their motion, rely upon the affirmation of Eugene A. Grossi, M.D., who is board certified in cardiothoracic surgery. Dr. Grossi states that he is a practicing cardiothoracic surgeon who is also a professor of surgery at New York University Hospital. Furthermore, Dr. Grossi states that he is the Chief of the Cardiothoracic Surgery Section of the VA New York Harbor Healthcare System,and has studied and written extensively on post-operative infections in patients who have undergone cardiac by-pass surgery.

According to Dr. Grossi's affirmation, prior to the plaintiff's procedure, she was given pre- operative prophylactic antibiotics to decrease the risk of infection and that a pre-operative nose swab was negative for bacteria. Prior to the surgery, the plaintiff was shaved, showered, and scrubbed. He states that the triple coronary bypass surgery was successful and that during the surgery, steris strips were installed in all three surgical wounds to facilitate healing and minimize the risk of post- operative infection. After the surgery, the plaintiff was brought to the cardio-thoracic intensive care unit where she remained until her transfer on November 13, 2002 to the Telemetry Unit. While in the ICU, the plaintiff received post-operative antibiotics and the incision's wounds were inspected by physicians and nurses. According to Dr. Grossi, no evidence of infection was found.

While in the ICU on November 12, 2002, the plaintiff was extubated and the heavy gauze dressings were removed, leaving the steris strips and all incision wounds open to the air and without dressings for the duration of her time in the ICU. The plaintiff's ICU record shows that at the time all incision wounds were open to the air, clean, dry, and intact. From November 13 to November 16, 2002, the plaintiff's condition was stable with no signs of infection. On November 15, 2002 it is noted that the plaintiff's temperature and white blood count were normal. On November 16, 2002, the incision sites were noted by an attending physician as being clean, dry, and intact and without redness, swelling or discharge; and that the wounds were healing. The same day, Dr. Rosell authorized the patient's discharge home because of her stability and absence of any sign of infection.

Instead of leaving the hospital, the plaintiff chose to remain in the hospital under the care of Woo Suk Tak, M.D., a rehabilitation physician, on the SIUH rehabilitation floor. The first three days of the plaintiff's rehabilitation admission were uneventful, being seen by attending physicians everyday. Daily, the incision wounds were inspected and the plaintiff's white blood cell count was normal. On the evening of November 19, 2002, the plaintiff spiked a fever of 102.3° F; which was the first sign of infection. After treatment that evening, the plaintiff's temperature stabilized.

The next morning, Dr. Tak noted that the plaintiff had shortness of breath and that the plaintiff felt pain at the sternal incision site. Dr. Tak's physical examination revealed sternal wound redness, but no discharge or drainage. Dr. Tak ordered an infection disease consultation. That same day, Dr. Mubaraki, an infectious disease doctor, noted a productive cough, dyspnea, and absence of abdominal pain. He did note chest pain but also noted that the sternal wound showed no erythema or purulence. With the plaintiff's white blood cell elevated, Dr. Mubaraki's

impression was that the plaintiff had pneumonia with sepsis and ordered a urinalysis, blood culture, and introduction of antibiotics.

Dr. Tak transferred the plaintiff to the cardiothoracic services and telemetry unit because of an abnormal EKG and shortness of breath to rule out myocardial infarction. On November 20, 2002, the plaintiff was transferred to the cardiothoracic unit under the care of Joseph McGinn, M.D. At this point, the plaintiff's wound began to show evidence of infection and the plaintiff underwent daily infectious disease care. The application of gauze dressings were resumed and the plaintiff's blood cultures were positive for gram positive cocci and oxacillin resistant staph aureus. Antibiotics were commenced at this point however, seven days later, on November 27, 2002 the infection had not arrested and the sternal incision site had dehisced and had drainage at its lower end. The infectious disease specialist concluded that the plaintiff probably had osteomylitis in the sternum and a surgical consult was ordered.

On November 28, 2002 Dr. Rosell saw the plaintiff. The plaintiff had an unstable sternum with purulent drainage. Dr. Rosell recommended a sternal wound debridement and sternectomy. Dr. Rosell also ordered a plastic surgery consult with Dr. Kasabian to address the hole in the plaintiff's chest that was anticipated after the sternectomy and sternum debridement. On November 29, 2002, Dr. Rosell performed a sternectomy and sternal wound debridement. According to Dr. Grossi, Dr. Rosell debrided only necrotic tissue until he reached healthy tissue in the rib cage. Dr. Rosell then confirmed that the situs of the infection was in the sternum rather than at the incision wound, and that the plaintiff had developed osteomyelitis in the sternum and the infection had spread from there. The removal of the plaintiff's sternum was necessary.

Dr. Grossi, the defendant's expert, states that the care and treatment of the plaintiff by defendant, Dr. Rosell, conformed at all times to good and accepted medical practice. Dr. Grossi, in his affirmation, observes that from November 11, 2002 through November 16, 2002 the SIUH hospital chart documents that there was no infection, the surgical wounds were open to the air, clean, dry and intact without drainage or other evidence of infection, and that the patient's temperature and white blood cell counts were normal. Dr. Grossi states that between November 12 and November 15, 2002, Dr. Rosell had arranged for John Nabagiez, M.D., a cardio-thoracic surgeon, to cover the patient for the duration of her admission, and that the standard of care did not require Dr. Rosell to see the patient every day as long as another cardio-thoracic surgeon was following the patient.

Dr. Grossi also states that Dr. Rosell correctly authorized the plaintiff's discharge from the hospital to her home on November 16, 2002. Dr. Grossi notes that the standard of care requires that "a patient be stable before she is discharged... Ms. Spagnole was ready for discharge on November 16, 2002. There had been no complications from the surgery and plaintiff was recovering." Furthermore, "Tests showed that the repaired coronary arteries were no longer obstructed and that plaintiff's heart function was stable and normal."

In opposition to the motion for summary judgment, the plaintiffs rely upon the medical affirmation of "T.N. a physician duly licensed to practice in the State of New York."[1] Dr. T.N. states that the hospital caregivers (physicians, physician assistants, and nurses) delayed in making the correct diagnosis of a sternal wound infection, as well as "post operative

Mediastinitis" [hereinafter "POM"]. Dr. T.N. states that POM is an inflamation of the mediastinum inside of the chest and is associated with infection complicating open heart surgery. Dr. T.N. states that "with a reasonable degree of medical certainty that Mrs. Spagnole's POM is directly and proximately resultant from infection that in turn came as a result of her open-heart surgery performed by the defendant Dr. Frank Rosell on November 11, 2002." Furthermore, Dr. T.N. states that "Looking at the chart herein, there were sufficient signs and symptoms of POM in Ms. Spagnole that an average doctor of average skill working in the community of physicians in 2002 would have used to make the correct diagnosis in a timely manner."

Dr. T.N. states that although the SIUH caregivers ultimately made the correct diagnosis, it came too late. That at the time the CT Scan was performed on November 29, 2002, the plaintiff already developed osteomyelitis of her sternum which necessitated the sternectomy leaving the hole in her chest. Furthermore, Dr. T.N. states that the delay in the diagnosis delayed the antibiotic treatment as well as the sternum debridement and that if the proper diagnosis was made in a timely fashion, it would of afforded the plaintiff earlier intravenous antibiotics and a less radical surgical debridement. Moreover, Dr. T.N. states that the sternectomy would have been avoided.

The court's role upon a motion for summary judgment is one of issue finding rather than issue determination (*McKinney v. Setteducatti*, 183 AD2d 879 [2d Dept 1992]). Summary judgment should not be granted where there is any doubt as to the existence of a triable issue or where the existence of an issue is arguable (*American Home Assurance Co., v. Amerford International Corp*, 200 AD2d 472 [1st Dept 1994]). "In a medical malpractice action, a plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact. " (*Alvarez v. Prospect Hospital*, 68 NY2d 320 [1986]). In this action, there is a triable issue of fact regarding the post-operative care of the plaintiff following the triple coronary bypass surgery on November 11, 2002 by defendant, Dr. Rosell, at the defendant, Staten Island University Hospital, as evident by the differing of expert opinions. Therefore, summary judgment is not appropriate in this action.

Accordingly, it is hereby:

ORDERED, that the defendant's motion for summary judgment is denied; and it is further

ORDERED, that this action is transferred to the Jury Coordinating Part 8 (JCP 8) of the Supreme Court of Richmond County; and it is further

ORDERED, that all parties are to appear in JCP 8 on Monday, **April 23, 2007** without further notice from the court.

ENTER,

DATED: March 26, 2007

Joseph J. Maltese
Justice of the Supreme Court

[1]In medical malpractice actions, CPLR § 3101(d) allows for a party to withhold the actual name of their medical experts.