

Mondesire v Israelski
2009 NY Slip Op 30633(U)
February 18, 2009
Supreme Court, Queens County
Docket Number: 14870/2007
Judge: Janice A. Taylor
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Short Form Order

NEW YORK SUPREME COURT - QUEENS COUNTY

Present: HONORABLE JANICE A. TAYLOR
Justice

IA Part 15

EDMOND MONDESIRE, x

Plaintiff,

- against -

RONALD H. ISRAELSKI, M.D., BRADLEY
D. WIENER, M.D. and CATSKILL ORANGE
ORTHOPEDICS, P.C.,

Defendants.

x

Index
Number 14870 2007

Motion
Date September 9, 2008

Motion
Cal. Number 31

Motion Seq. No. 3

The following papers numbered 1 to 9 read on this motion by the plaintiff, pursuant to CPLR 4404(a), to set aside the verdict rendered by the jury in favor of the defendants on the issue of causation.

	<u>Papers Numbered</u>
Notice of Motion - Affidavits - Exhibits.....	1-4
Answering Affidavits - Exhibits.....	5-7
Reply Affidavits.....	8-9

Upon the foregoing papers it is ordered that the motion is denied.

This is an action to recover damages for medical malpractice. The plaintiff alleges that the malpractice occurred on January 9, 2002, when defendant Ronald Israeliski, M.D. gave him a corticosteroid injection in the knee and infected his knee with the streptococcus pneumoniae bacteria due to a lack of proper sterilization. The plaintiff also alleges medical malpractice arising from the failure of the defendants to timely diagnose and treat the alleged streptococcus pneumoniae infection in his knee, which caused him to develop sepsis and endocarditis and require heart valve replacement surgery.

After a trial a jury determined, inter alia, that defendant Ronald H. Israelski, M.D. departed from accepted standards of medical practice by not ordering blood cultures as part of certain laboratory work that was ordered for the plaintiff on January 14, 2002, but found that Dr. Israelski's departures were not a substantial factor in causing injury to the plaintiff. The plaintiff seeks an order, pursuant to CPLR 4404(a), setting aside the jury's verdict on the issue of causation and directing judgment in favor of the plaintiff on the issue or granting a new trial on the issue of causation. The plaintiff contends that causation must be considered for the relevant continuous period of January 14, 2002 to January 23, 2002, the date that the plaintiff was admitted to the hospital for sepsis, on the grounds that a timely blood culture during that period would have detected sepsis, the plaintiff could have been treated with antibiotics much sooner, and the heart valve damage that he sustained would have been prevented. In opposition to the motion, the defendant argues that the plaintiff's theory as to the origin and progression of his infection was rejected by the jury which, in turn, was fatal to his experts' testimony as to when the plaintiff first became septic.

The Trial Testimony

The Plaintiff's Case

Dr. Alexander McMeeking, an infectious disease specialist, testified on behalf of the plaintiff. Dr. McMeeking indicated that he became board certified in infectious diseases in 1985. He is also an associate professor at NYU, has been affiliated with NYU Bellevue hospital for 21 years, and maintains a private office practice. Dr. McMeeking explained that streptococcus pneumoniae is a very common organism that classically resides in a person's respiratory tract. The organism can reside on a person's skin as well. In such case, the bacteria could be transferred from someone who coughed into their hands and touched a place on the skin, causing the organism to set up there. Dr. McMeeking also explained that sepsis is a syndrome that occurs when bacteria gets into a person's blood stream from another infection, including the streptococcus pneumoniae bacteria. The plaintiff was diagnosed with sepsis on January 23, 2002, upon his admission to the hospital. According to Dr. McMeeking, the only possible source of the plaintiff's streptococcus pneumoniae infection is that it was introduced through the plaintiff's skin by way of a knee infection that occurred when Dr. Israelski gave the plaintiff a steroid injection in the knee during an office visit on January 9, 2002. When asked why he believes that the only possible source of the infection leading to the plaintiff's sepsis was the knee injection

administered by defendant Dr. Israelski, Dr. McMeeking opined as follows:

"Well, the first thing I thought about was the possibility because the name implies streptococcus pneumoniae, it classically presents as pneumonia. It is the commonest cause of bacteria pneumonia. However, the [plaintiff] had a normal lung exam with no respiratory complaints in the doctor's office or when he first got to the hospital, coughing up phlegm, blood. His physical examination was normal. His chest x-rays for the first three days in the hospital were also totally normal and because he had such a severe infection in my experience and I think it is born out my years of practice, if streptococcus pneumoniae was giving you a blood stream infection enough to cause this gentleman's heart valve to start to be destroyed to make him as sick as [he was], the pneumonia would be very obvious, he would have an abnormal x-ray, he would have symptoms. It would be easy to hear findings on his lung exam and the patient had none of these findings, and so after reviewing and thinking about this, this was the only explanation I was able to come up with as a source of how this gentleman got bacteria in his blood stream that then involved his heart valve. I could think of no other explanation."

In sum, Dr. McMeeking opined that knee the injection administered by Dr. Israelski on the January 9, 2002 caused an infection in the plaintiff's knee which caused sepsis, endocarditis, and the destruction of the plaintiff's heart valves.

Upon cross-examination, Dr. McMeeking admitted that the plaintiff was directed by Dr. Israelski to go for blood work on January 14, 2002 because he complained of fever for three days between January 9 and January 14, 2002, but did not go to the to have his blood drawn until January 17, 2002. He also conceded that the plaintiff was again directed to go for blood work on the January 18, 2002 but that he did not go. Instead, the plaintiff went to the hospital on January 23, 2002 on that date either. Dr. McMeeking further conceded that there was nothing confirming the presence of infection in the plaintiff's knee. However, it was his contention that intravenous antibiotics administered to the

plaintiff in the hospital cured the knee infection. In addition, Dr. McMeeking concurred that there was evidence of pneumonia in the plaintiff's lung as of about January 26, 2002. Dr. McMeeking insisted that the bacteria would have been in the plaintiff's bloodstream at least one to two weeks prior to January 23, 2002, but closer to two weeks, to cause the kind of damage that it caused to the plaintiff's heart.

Dr. Ronald Krasnick, an orthopedic surgeon, also testified at trial on behalf of the plaintiff. Dr. Krasnick opined that Dr. Israelski departed from accepted medical practices when he administered the corticosteroid injection into the plaintiff's knee by failing to wear gloves or wash his hands, which does not fulfill the obligation of a surgeon to maximize prevention against infection. Before giving an injection it is mandatory to engage in septic technique to prevent infection. However, Dr. Israelski's quick and light swab of the injected area was not an acceptable attempt to sterilize the skin from organisms. The plaintiff's recorded complaints of extreme pain in the thigh on January 14, 2002 may mean that there was a spread of infection. The symptoms complained of by the plaintiff on the January 14, January 18 and January 23, 2002 were consistent with a septic knee.

The Defendants' Case

Dr. Bruce Farber, an infectious disease specialist, offered testimony on behalf of the defendants. Dr. Farber became board certified in infectious disease in 1984. He is an associate professor at NYU School of Medicine, is a member of numerous professional medical societies, has written two books, published 60 articles, 25 reviews and probably 40 abstracts. He also maintains an active clinical practice. In contrast to the testimony offered by the plaintiff's witnesses, Dr. Farber stated that the plaintiff's strep pneumoniae did not result as a consequence of the knee injection. He also stated that there is no doubt that the plaintiff's knee did not become infected with strep pneumoniae, which was the devastating organism that caused the plaintiff's endocarditis, and indicated further that he does not believe that the plaintiff's knee was ever infected. Specifically, Dr. Farber gave the following reasons for his opinion:

"Getting an infection from a knee injection, steroids, or tapping the knee or lidocaine, or what have you, is a very rare thing, has a rough incidence, one-in-between-one in 500,000 is the number that sort of sticks in mind as the incidence. Most orthopedic surgeons don't

see one in their lifetimes. It can happen. There's no question that there's literature out there that it can happen, but it's very rare, but of those cases that do develop from injections and, for that matter, from arthroscopy, from knee surgery, the organism isn't strep pneumoniae. The organism is staphylococci and streptococci, which far and away account for the largest contingency of organisms that sit on the skin and you could puncture, and strep pneumoniae is a very common organism. There's not two weeks that go by in my practice where I don't see somebody infected with strep pneumoniae. It's called pneumoniae so they don't confuse it with streptococcus from your throat, streptococcus, Group A strep, which can cause an infection in the knee and in the skin.

This organism is a respiratory organism. It lives in the sinuses, it lives in the throat, it lives it can live in the inner ears. It's a common cause of pediatric otitis media, middle ear infection. It's the most common cause of pneumonia in people over the age of 50 years old. It's the most common cause of spontaneous meningitis in adults. It's a very rare cause of endocarditis, as occurred here. Two percent of all infections of the heart valve are caused by this organism, but the bottom line is, this organism lives in the respiratory tract, does not live and set up shop on the skin and does not cause infection through puncture needles, and the reasons for that are so many, but let me give you some of the most basis ones

First of all, the organism doesn't live for prolonged periods of time on the anatomy area The organism just does not like to live on the skin. It doesn't like to live on the environment. It spreads by droplet nuclei, meaning, I cough, if it has it in my throat and the cough is suspended, the organism is suspended in small particles of air, saliva, can travel up to three feet. After that, they drop and they die, so it doesn't like to live on the skin.

That's why you don't see strep pneumoniae as a cause of cellulitis or skin infection. You don't see this organism as a cause of septic arthritis very often. Yeah, there's probably 150, 200 reports of it happening, but all of the reports indicate that it happens in the same way that meningitis happens and that endocarditis happens, and that's that it travels in the bloodstream to the joint, to the heart, to the meninges, or to wherever it's causing infection. It doesn't enter through the skin. It enters through the respiratory tract and then enters the blood and travels around ...

Strep pneumonia ... lives in the respiratory tract, all over the respiratory tract. It is not a skin organism. If you're talking about transmission of a common cold, then, yes, I could touch my nose, which has the common cold in it, touch your hand and shake hands, then you touch your nose and, bingo, transmission occurs, and that's a more efficient way of transmission of a rhinovirus, the cause of the common cold, than is, say, coughing or sneezing, believe it or not, but when it comes to strep pneumoniae, strep pneumoniae is not transmitted that way. That's the reason we don't see it as a cause of wound infection following trauma, we don't see it following—as a cause of wound infection following surgery, we don't see it as a cause of infection following injection, we don't see it as a cause of infection following evasive procedures, be them cardiac catheterizations, blood draws, any other thing. Injections into the knee are only a teeny [sic] piece of this. We see injection and strep pneumoniae is not an organism that causes those infections."

Further, Dr. Farber emphatically stated that the evidence that the plaintiff's knee was not infected at any time is overwhelming. This is his explanation as to why he concluded that there was no infection:

"What's the evidence for it? Well, first of all, in order to make a diagnosis of a knee infection, which is called septic arthritis,

the first thing you have to do, the gold standard of making that diagnosis is to tap the knee and grow the organism from the fluid. It's done routinely. Anybody who has septic arthritis or you're even remotely thinking about septic arthritis, that's the first thing you do is tap that knee because, number one, that's how you make the diagnosis, and number two, it's somewhat of an emergency in that time is of the essence in the setting of a septic arthritis

The treatment of a septic arthritis is two things; draining the knee repeatedly, usually it's done after the knee is tapped and you think there's septic arthritis, 90 percent of orthopedic surgeons wash out the knee with arthroscope, but be that as it may, it's antibiotics and draining the knee. You don't treat a knee that's infected without draining it, and I don't mean draining it once, I mean draining it multiple times or washing it out.

Number, two, the reason you drain it is because the organisms that cause this infection and the inflammation it brings in, the white cells usually go up to 50,000 in number per cc of synovial fluid, destroy the knee, so if you don't evacuate the joint and keep it clean, you're going to destroy the knee cartilage, absolutely destroy it, so number two is-is, you know, you have to do that.

Number three is it doesn't get better unless you drain it. The knee gets swollen and red and hot and painful and gets bigger and bigger and bigger, and eventually, your knee has to be drained, particularly with an organism like strep pneumoniae that's so virulent.

So how do we know that he didn't have it? Well, number one, the knee was never even tapped, not only when he was at the orthopedic offices as an outpatient, it wasn't tapped when he got to Horton Hospital and it wasn't tapped when he got to Westchester because none

of the doctors obviously seriously thought the knee was infected.

Number two, it got better without being tapped with just antibiotics.

Number three, he has a bone scan done. Bone scans are not terribly specific, meaning they're often positive when there is no infection, but one thing is very sensitive and the difference is, you know, a specific test means that it's accurate in eliminating false positives. A bone scan is extremely sensitive meaning it will pick up a lot of other things, but one thing it always does is pick up a septic joint. Sometimes it picks up gout. If you traumatize your knee and hurt it playing basketball, a bone scan will be abnormal. In this particular case, the bone scan was normal. It did not suggest septic arthritis when he got up to Horton or Westchester Hospital, I think it was Westchester, so that's another reason why we know that the decision by the physicians taking care of him in Westchester and in Horton was correct, that they were right, that the knee did not-was not infected.

Next is the MRI scan. He had an MRI scan done at Westchester Hospital. Again, it showed no destruction of the cartilage. That's another fine test that you would do if were even remotely concerned with an infection in the joint, and that did not demonstrate it.

And lastly, the knee never appeared to be infected ... a bone scan, an MRI scan would definitely show something and, you know, it wouldn't get better with just antibiotics. The first basic thing is to drain the knee. You cannot make-I mean, even the plaintiff's orthopedic surgeon said he's never seen a septic knee, I believe, that hasn't been drained

Because the knee is a closed space. That's the difference. The knee is a closed space.

Now, if you have strep pneumonia in the lung, you cough up and drain through coughing. If you have seen an infection in the urinary tract, which we see all the time, you never drain that. People urinate, it goes out in the urine, but a knee, like a brain, is in a closed space. There is absolutely no way to communicate with that knee other than through the bloodstream, and you cannot- it won't drain spontaneously because it's locked in a synovial capsule, and so the only way you can get rid of the pus and the inflammatory debris that is accumulating and destroying the knee and causing the swelling and the pain and the redness is to drain it and the drainage has to occur either surgically or by multiple taps."

Dr. Farber was then asked whether he has an opinion within a reasonable degree of medical certainty as to how the strep pneumonia entered the plaintiff's blood stream and what its source was. He responded as follows:

"Yes ... I read Dr. McMeeking's testimony and his basic argument to you was that well, he didn't have pneumonia so it had to get there somehow, therefore, it must have come from the injection- to sort of summarize what I read- and that's 100% wrong and I'll tell you why it's wrong. It's wrong because, yes, it definitely got out of the lung. It caused endocarditis, it can cause meningitis, it can cause septic arthritis. But it doesn't get there by accident. It gets there through the blood stream and if you look at the group of people who have endocarditis or who have extrapulmonary, meaning pneumococcal disease outside of the lung, you find that only a majority of them actually have pneumonia ... The majority of people with endocarditis don't have pneumonia ... It gets there in the case that's been reported through the respiratory tract and you don't have to have pulmonary infection or pneumonia or anything else."

He continued:

"The organism gets into the blood stream very simply through a host of mechanisms, but the

most common is through the lungs. The organism gets into the blood stream very simply through a host of mechanisms, but the most common is through the lungs. The lungs are full of blood vessels; that's their purpose. These capillaries, every time you breathe ... you're going to get those substance [which you inhaled] into your blood stream."

Finally, Dr. Farber thoroughly disagreed with Dr. McMeeking's testimony that the plaintiff's knee was septic and rejected the theory that the steroid injection received by the plaintiff masked the inflammation and other symptoms of a septic knee. Rather, Dr. Farber explained that if one injected a steroid into a knee joint that was simultaneously infected through that same injection, "the knee would be red, hot, swollen, tender, and would develop so much fluid that it would be very, very abnormal." In addition, Dr. Farber added that another indication that the knee plaintiff's knee was not infected was the fact that the plaintiff's aortic valve was replaced. He explained that before a heart valve is replaced, the doctors must ensure that there is not infection occurring anywhere else in the body because if there is, the valve is going to become reinfected and, in such a case, a whole new valve replacement must be performed.

Dr. Farber did agree with Dr. Horowitz, the infectious disease specialist who evaluated the plaintiff and admitted him to Westchester Medical Center, that it is doubtful that the knee injection was the reason for the plaintiff's endocarditis. Dr. Farber also agreed with Dr. Weiner, who examined the plaintiff on January 23, 2002, after he was sent to Horton Hospital, that the plaintiff's knee was not septic.

Dr. Elton Strauss, an orthopedic surgeon, also testified at trial on behalf of the defendants. According to Dr. Straus: "Septic knees are like cancer. They don't go away unless treated ... You have to open up the joint somehow, either arthroscopically or through a regular surgical incision, and wash out the pus and then treat the patient with antibiotics, and sometimes you have to go back and back again." Dr. Straus noted that the septic knee treatments that he described were never administered in the plaintiff's case. Thus, Dr. Strauss opined that the plaintiff's systemic sickness was not related to his knee because his knee was never infected. In Dr. Strauss' view, the absence of an infection in the knee was evidenced by the MRI performed on the plaintiff's knee at Horton Hospital on January 24, 2002, and the scan studies

later performed at Westchester Medical Center on February 19 and February 20, 2002.

ANALYSIS

CPLR 4404(a) provides as follows:

"After a trial of a cause of action or issue triable of right by a jury, upon the motion of any party or on its own initiative, the court may set aside a verdict or any judgment entered thereon and direct that judgment be entered in favor of a party entitled to judgment as a matter of law or it may order a new trial of a cause of action or separable issue where the verdict is contrary to the weight of the evidence, in the interest of justice or where the jury cannot agree after being kept together for as long as is deemed reasonable by the court."

In order for the court to find that the jury verdict should be set aside, pursuant to CPLR 4404(a), on the ground that it is unsupported by legally sufficient evidence, there must be "no valid line of reasoning and permissible inferences which could possibly lead rational [persons] to the conclusion reached by the jury" (Robinson v City of New York, 300 AD2d 384 [2002], quoting Cohen v Hallmark Cards, 45 NY2d 493, 499 [1978]). Moreover, a jury verdict will not be set aside as against the weight of the evidence unless it could not have been reached on any fair interpretation of the evidence (see Novick v Godec, ___ AD2d ___ [2009]; Salmeri v Beth Israel Medical Center-Kings Highway Div., 39 AD3d 841 [2007]; Torres v Esaian, 5 AD3d 670 [2004]; Nicastro v Park, 113 AD2d 129 [1985]). "Where the verdict can be reconciled with a reasonable view of the evidence, the successful party is entitled to the presumption that the jury adopted that view" (Torres v Esaian, 5 AD3d 620 [2004], supra).

In this case, the verdict was supported by legally sufficient evidence and was not against the weight of the evidence. The plaintiff's medical experts testified that the only possible source of the strep pneumoniae bacteria existing in the plaintiff's bloodstream and leading to the plaintiff's endocarditis was the knee injection administered by Dr. Israelski. The defendants' medical experts countered that the plaintiff's knee was never septic and that the organism that caused the plaintiff's sepsis and resulting endocarditis entered the plaintiff's blood stream through his respiratory system. Moreover, the plaintiff's theory that the

endocarditis could have been avoided had the defendants ordered the plaintiff's blood cultures in the days before the plaintiff was admitted into the hospital, because the plaintiff would have received antibiotic treatment several days earlier than he did, was countered by the defendants' evidence that the plaintiff delayed having his blood drawn for several days after he was directed to do so. Since the trial record is not "replete with evidence of negligence" (Nicastro v Park, 113 AD2d 129, supra), and the jury could have reached its verdict in this case based upon a fair interpretation of the evidence, the plaintiff's motion to set aside the verdict rendered in favor of the defendants as against the weight of the evidence must be denied.

Further, the sharply conflicting testimony of the parties' medical witnesses presented a classic battle of the experts. As such, the testimony with respect to causation presented a credibility issue for the jury to resolve (see Covett v Interfaith Medical Center, 52 AD3d 578 [2008]; Velez v Policastro, 1 AD3d 429 [2003]; Cavlin v New York Med. Group, 286 AD2d 469 [2001]; Ibrahim v Lombardo, 229 AD2d 423 [1996]). It is well-settled that great deference must be given to the determination of a jury which heard the testimony and observed the witnesses and their demeanor. To find that the jury's verdict was against the weight of the evidence, this court would have to find that the defendants' witnesses were not worthy of belief. After due consideration, the court finds that there is no basis upon which such a determination should be made (see Loughman v A.W. Flint Co., Inc., 132 AD2d 507 [1987]).

Accordingly, the motion is in all respects denied.

Dated: February 18, 2009

J.S.C.