Bell v Bronx Lebanon Hosp.
2015 NY Slip Op 32485(U)
December 7, 2015
Supreme Court, Bronx County
Docket Number: 14778/06
Judge: Stanley Green

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M

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MIA BELL,

Plaintiff(s),

- against-

BRONX LEBANON HOSPITAL, HEIDI DUPRET, M.D., PITUCK UNGSUNAH, M.D., VISITING NURSE SERVICE OF NEW YORK, VISITING NURSE SERVICE OF NEW YORK HOME CARE and VISITING NURSE SERVICE OF NEW YORK HOME CARE II,

Defendant(s)

INDEX No. 14778/06

DECISION

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HON. STANLEY GREEN:

The motion by Bronx Lebanon Hospital for an order pursuant to CPLR §3212 granting summary judgment dismissing the complaint is hereby consolidated for decision with: (1) the motion for summary judgment by Visiting Nurse Service of New York, Visiting Nurse Service of New York Home Care and Visiting Nurse Service of New York Home Care II (hereinafter VNS); (2) the motion for summary judgment by Heidi Dupret, M.D.; and (3) the cross-motion by plaintiff for an order pursuant to CPLR §3126 precluding and sanctioning Dr. Dupret and Bronx Lebanon for spoliation of evidence. Upon consolidation, the motion by Dr. Dupret is granted. The motions by Bronx Lebanon Hospital, VNS and the cross-motion by plaintiff are denied.

Plaintiff claims that defendants failed to provide proper post-operative wound care following abdominal surgery and as a result, a gauze was retained in the surgical wound that was not discovered until nearly a year later, when she suffered abdominal pain and discharge and a piece of gauze was protruding from the scar, necessitating further surgery to remove it.

On 12/22/03, plaintiff presented to the emergency room at BLH with complaints of severe bilateral quadrant pain. She was evaluated in the ER by Dr. Dupret, the attending OB/GYN on call. That night, Dr. Dupret performed an exploratory laparotomy and left salpingo-oophorectomy, but the surgery was complicated by dense adhesions in the abdomen which blocked access to the pelvis. Dr. Dupret called for a consultation by Dr. Ungsunah, a general surgeon. Dr. Ungsunah performed a lysis of adhesions, appendectomy and placement of Jackson Pratt drains. A large amount of exudative infected fluid in the peritoneal cavity was drained and the fluid collections were irrigated with sterile water. Dr. Dupret sutured closed the fascia encircling the peritoneum, but the skin and subcutaneous tissue was left open (except for the placement of two retention sutures at the distal ends of the wound) in order to foster healing of the subcutaneous tissue and skin by secondary intention (the body's natural healing process) to decrease the risk of infection.

Dr. Dupret placed Xeroform packing (the brand name for Iodoform packing, which is a long ribbon of 1/4 to ½ inch wide tightly wound gauze pre-soaked in Iodine or Betadine) in the surgical wound to keep it moist, clean and antiseptic. An Ob/Gyn resident entered an order on the chart to begin wet-to-dry dressings (typically, a 4x4 gauze that is soaked in sterile saline and placed inside the wound which becomes dry over the course of 24 hours and is then removed and replaced with a new wet-to-dry dressing). From 12/24 until plaintiff was discharged on 12/31, resident physicians at BLH performed wound dressing changes. At the time she was discharged, plaintiff was given instructions to return to the hospital for wound care on Monday (1/5/04) and for a GYN follow-up in one week. However, plaintiff did not return to BLH until 1/21/04, when she presented to the Women's Health Center.

From 1/2/04 through 1/16/04 (except for 1/5/04) VNS made home visits and performed daily wound care, which consisted of cleansing the wound with a solution of normal saline and hydrogen peroxide in equal parts, applying wet to dry dressings once a day and placing a dry gauze over the packed wound at the surface and taping it to the surface of plaintiff's body.

On 1/21/04, plaintiff presented to the Womens Health Center at BLH. At that time, it was noted that the wound was dry, clean and intact with retention sutures in place.

On 12/9/04, plaintiff presented to the BLH emergency department with complaints of "oozing from the op wound since last September and getting worse." The attending Ob/Gyn on duty noted that plaintiff presented with abdominal pain, foul smelling discharge and gauze protruding at the incision site. Plaintiff was admitted to Dr. Dupret's service and was seen by her on 12/10/04. Dr. Dupret noted a wound dehiscence at the distal tip of the prior abdominal wound. It included two small defects in the layers of skin where gauze was protruding through the holes. Dr. Dupret performed a wound exploration through a 4 cm (1.5") incision through which she removed old sterile gauze material and necrotic and fibrotic tissue. The exploration and debridement went to a depth of 4cm (1.5") until only normal, healthy subcutaneous tissue remained.

Dr. Dupret seeks dismissal of the complaint as against her on the ground that the care and treatment she provided was within good and accepted standards of medical practice and did not cause the claimed injuries. In support of the motion, Dr. Dupret submits the affirmation of Dr. Ellison, a board certified OB/GYN.

Dr. Ellison opines that the care and treatment rendered by Dr. Dupret was at all times in accordance with good and accepted standards of medical care and that the gauze that was

removed on 12/10/04 was not placed by Dr. Dupret or anyone at BLH, but originated from one of the wound care dressing changes performed after plaintiff's discharge from the hospital.

Dr. Ellison's opinion is based on the fact that the CT scan of plaintiff's abdomen and the operative report show that the gauze was superficially located above the fascia in the subcutaneous tissue directly under the plaintiff's keloid scar. Dr. Ellison explains that if the gauze had originated from one of the earlier dressing changes at BLH and packed deep into plaintiff's wound, there would have been extensive necrotic tissue, likely extending to the level of the fascia or close to it. However, this was not the case as the operative report describes the necrotic tissue as debrided until healthy tissue appeared at a depth of 4 cm (1.5") which [Dr. Ellison opines] is a shallow depth for a patient of plaintiff's size.

Dr. Ellison also explains that when wound care and dressing changes are performed on a daily basis (as was the case from 12/25/03-1/16/04), the presence of the wet to dry gauze pads that were placed on a prior day are easily discernible by the physician or nurses cleaning the wound and are not easily susceptible to being overlooked and left behind. However, if a saline soaked dressing is placed in or on an open and wet wound, and covered with another piece of gauze, as was done by VNS in January, if it isn't removed after several days, the wound will heal over the piece of saline soaked gauze.

Dr. Ellison notes that on 1/16/04, the VNS nurse who performed the final VNS wound care and dressing change noted that the wound was still wet and that it was 95% granulated and in the healing process. She explains that had the wound not been open at that time, there would have been no need for wound care and a dressing change with a piece of wet to damp gauze and the wound would have been left uncovered to allow it to continue to heal. However, on that date,

Nurse Woolery noted that she cleaned the surgical wound, then placed a wet to damp piece of gauze in the wound, and then covered the wound with a piece of dry gauze. Dr. Ellison opines that this created a moist and humid environment for the wound, which if left alone for several days, can result in the wound healing over the wet to damp piece of gauze with granulation and epithelial tissue.

Dr. Ellison also notes that: (1) the gauze that was recovered on 12/10/04 was not the Iodoform (Xeroform) packing that Dr. Dupret placed in the open wound on 12/22; (2) none of the wet to dry dressings were placed personally by Dr. Dupret into the plaintiff's surgical wound; (3) there is no evidence that Dr. Dupret was ever the on-call physician during any of the dressing changes performed at BLH; and (4) Dr. Dupret had no responsibility to oversee outpatient and at home dressing changes by VNS nurses, who are fully trained in and capable of performing wound care and dressing changes independent of any physician oversight. Thus, she opines that Dr. Dupret did not depart from the standard of care in her treatment of plaintiff and did not proximately cause the claimed injuries.

Dr. Ellison opines that plaintiff's cross-claim against Dr. Dupret for spoliation lacks merit because Dr. Dupret was an Ob/Gyn physician, was not responsible for the maintenance of BLH pathology specimens and had no notice that it was necessary to retain the gauze that she removed.

BLH seeks dismissal of the complaint against it on the ground that the decision to care and treatment that it rendered to plaintiff was at all times within good and accepted medical standards and did not proximately cause the claimed injuries. In support of the motion, BLH submits the affidavit of Dr. Anthony Quatrell, who is board certified in obstetrics and

gynecology.

Dr. Quatrell opines that the decision to allow that portion of the surgical wound to heal by secondary intention was properly made by qualified attending physicians who were not employed by BLH, that it was an appropriate exercise of medical judgment and that the gauze that was removed on 12/10/04 had not been accidentally or negligently placed in the wound or accidentally or negligently left there by BLH because the Ob/Gyn physicians and general surgeons performed the packing changes and described their observations inside the wound and the operative report of 12/10/04 shows that the entire depth of the procedure, including the removal of all gauze material and debridement of all affected, necrotic tissue, extended down only to about 4 cms (1.5") from the surface.

Dr. Quatrell explains that the original, subcutaneous tissue wound in a patient of plaintiff's size (measuring from the skin down to the level of the fascia) would have been at least four or five inches deep and because all of the gauze and necrotic tissue was located much closer to the surface, a wet to dry pad, which is made of gauze, or a dry gauze pad either had not been removed from the wound, or was incompletely removed from the wound by one of the nurses during the final days of the at-home nursing care in January or it had not been removed by plaintiff's mother after she was instructed by VNS Nurse Parry on how to continue dressing changes. Dr. Quatrell also notes that plaintiff was not compliant in returning to the hospital and that by the time she returned on 1/21/04, the wound had closed.

BLH contends that plaintiff's cross-motion for spoliation must be denied because she has failed to make a prima facie showing of entitlement to either preclusion or sanctions, her expert affirmation is conclusory and the affirmation of Dr. Niazi shows that the specimen was disposed

of after two weeks in accordance with hospital protocol and there was no legal action in existence that would have provided notice and a duty to preserve the gauze. BLH also notes that plaintiff and VNS have not shown that they have been hindered in prosecuting or defending this action or presented evidence of willful, intentional acts that would warrant striking its answer or any other type of sanctions.

VNS seeks dismissal of the complaint and all claims against it on the ground that its nurses did not depart from good and accepted nursing practice in their treatment of plaintiff and no alleged departure caused or contributed to plaintiff's claimed injuries.

In support of the motion, VNS submits the affidavit of Nurse Nuzzo, who opines that the care and treatment rendered by VNS was appropriate and consistent with accepted standards of care and physician's orders and did not cause or contribute to any claimed injury.

Nurse Nuzzo notes that at the time VNS first treated plaintiff, Nurse Parry indicated that the wound was .5cm (approx. ½") in depth. She opines that this was too shallow to be packed to the point where packing could be retained and that it would be impossible to miss seeing its existence. She also opines that the gauze would have fallen off on its own and would not have been retained in the wound. Nurse Nuzzo also notes that the operative report and pathology reports show that the gauze was removed from an area that was closed and covered with Steri-strips as of plaintiff's discharge from BLH and that it was at a level 3 to5 times deeper than the wound depth at the time VNS first treated it. She opines that retained dressings cannot and do not burrow deeper into a body cavity, but work their way out and, because the wound at its deepest point was .5cm upon presentation to VNS, the retained dressing cannot be the result of retained dressing placed by VNS and must have been retained during in-patient dressing changes

when the wound was deeper. Nurse Nuzzo adds that the fact that the retained gauze took almost a year to work its way to the surface is "a clear indication" that it was retained at a depth considerably deeper than .5cm.

Plaintiff does not oppose VNS' motion. BLH contends that VNS' motion must be denied because it not supported by a medical expert's affirmation and is not probative as to the healing time or manner or degree to which a retained piece of gauze might be expected to move or travel within the tissue. BLH also contends that Nurse Nuzzo makes medical judgments as to what is "possible," such as, "that it would be impossible to miss the existence of a retained dressing" but fails to discuss why or how VNS would not be responsible for the fact of the gauze being retained when VNS received the patient for home nursing care and documented that the wound was open when it received the patient and noted that VNS nurses packed and re-packed the wound with saline-soaked gauze, through 1/16/04, as recorded in their own notes.

BLH also contends that Nurse Nuzzo fails to explain how the changes of saline soaked gauze in the open wound, as described in the VNS nearly daily nursing notes, followed by the placement of dry gauze over the wound, could have been conducted over steri-strips supposedly located over the wound, holding it closed, or how VNS nurses, in that event, could have been describing the wound bed on each occasion.

Plaintiff contends that defendants have failed to meet their prima facie burden on the motions and cross-moves for an order precluding BLH and Dr. Dupret from offering evidence regarding the type of gauze found in plaintiff's abdomen, whose gauze it was, which defendant was responsible for leaving the gauze based on the type of gauze found in the wound.

In opposition to the motions by BLH and Dr. Dupret, plaintiff submits the affirmation of

an expert who is a board certified surgeon with a sub-specialty in vascular surgery and wound care. The expert opines that the failure to remove all gauze materials or otherwise allowing gauze materials to remain in plaintiff's surgical wound from her December 2003 surgery was a departure from good and accepted standards of medical and nursing care and practice and that this departure was a substantial factor in causing plaintiff to develop an infection which required an additional surgery in December 2004 in which gauze was removed from the wound. The expert notes that nowhere in the BLH record is the depth or size of the surgical wound described by Dr. Dupret or the Ob/Gyn residents, although it is known that plaintiff was morbidly obese and there are numerous notes which state that wound packing was done by surgical and Ob/Gyn residents. The expert also notes that the VNS notes indicate that on 1/2/04, the wound was 3.5 x 1.5 x 0.5 cm, "meaning that the depth of the wound that VNS initially treated was less than .2 of an inch" and "By January 7, 2004 the depth of the wound is 0.0; in other words it was flush with the surrounding skin so that the dressing and/or gauze would be on the outside." He opines that given these "facts," the gauze that was discovered in December 2004 was not left in place by VNS. He explains that:"Presumptively, the surgical wound was much deeper during the 2003 hospital stay and was healing by secondary intention meaning from the bottom up" and "the wound was observed by visiting nurse to be at 100% granulation within 4 days of their arrival meaning that there was no packing that could have been inserted into the wound." He also notes that "there were Steri-Strips on the lower part of the wound and that the nurses from VNS were not touching them." Thus, he opines that "given the size of the wound opening and its shallow depth it is highly unlikely, with a reasonable degree of medical probability, that the VNS nurses would have missed a gauze in the wound." He also notes that plaintiff and her mother deny that

either of them cleaned the wound and/or put packing gauze in the wound.

Plaintiff's expert also notes that the removal of dead and/or infected tissue was required until approximately 4cm or 1.5 inches of the fascia layer which was "...presumptively the depth in December 2003 when the wound was first packed with iodoform gauze" and then with wet to dry gauze pads. Thus, the expert opines that it is "more probable than not with in a reasonable degree of medical certainty" that the gauze material retrieved in December 2004 was left behind in December 2003 by BLH residents who "were charged with packing the wound under the direction and supervision of the attending physicians, including Dr. Dupret during the 2003 admission."

Plaintiff also contends that because the gauze was a "foreign object," BLH and Dr. Dupret were on notice that it might be necessary to be preserved for future litigation and had an obligation to preserve it. However, plaintiff acknowledges that her claim can be prosecuted without the gauze.

Initially, it is noted that although Dr. Dupret and Dr. Ungsunah were attending physicians at BLH at the time they treated plaintiff that does not preclude BLH from being held vicariously liable for their malpractice, if any, because plaintiff sought treatment at BLH via the emergency room and did not seek treatment from a particular physician (Mduba v. Benedictine Hospital, 52 AD2d 450).

Here, Dr. Dupret has established prima facie entitlement to summary judgment by showing that she never dressed the wound after initially packing it, that there is no evidence that she was the on call attending during the times when the wound was dressed by residents at BLH and that she had no duty to supervise VNS nurses. Thus, the burden shifted to plaintiff to present

competent evidence sufficient to raise a material issue of fact (Zuckerman v. City of New York, 49 NY2d 557). She has failed to meet this burden. Although the affirmation of plaintiff's expert is sufficient to raise a question of fact as to whether the gauze was left in the wound by resident physicians at BLH or by VNS nurses, in the absence of evidence that Dr. Dupret was ever involved in changing the dressing or supervising the resident physicians who changed the dressings, she cannot be held liable for failing to remove all or part of the gauze that was recovered in December 2004. Accordingly, Dr. Dupret is entitled to summary judgment dismissing the claims against her.

As to BLH, while Dr. Quatrell opines that, based on the depth at which the gauze was retrieved, the fact that the original subcutaneous tissue wound in a patient of plaintiff's size would have been at least four or fine inches deep from the skin down to the level of the fascia, the fact that VNS nurses continued to change the dressing daily until 1/16/04 and the fact that plaintiff had been having oozing from her surgical wound for three months before she returned to BLH on 12/9/04, evidencing an infection that would have grown larger over the three months that followed, and the fact that the surgery on 12/10/04 went only to a depth of 4cms (1.5") to remove all infected tissue, the gauze that was retained was one of the last gauze pads placed in the wound, the opinion of plaintiff's expert, based on the depth of the wound at the time VNS first treated it and on 1/7/04 (0.0cm depth) and the operative report of 12/10/04, creates material issues of fact as to whether BLH staff or VNS staff failed to remove all or part of a gauze pad during a dressing change and caused the claimed injuries.

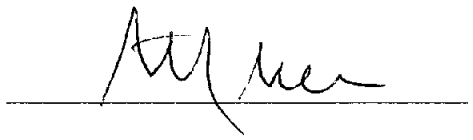
As to VNS, while Nurse Nuzzo is not qualified to render a medical opinion in this case, she is competent to render a nursing opinion as to the wound care. Therefore, her opinion that

due to the shallowness of the wound at the time VNS changed the dressings, the wound was such that it would be impossible to miss the existence of a retained dressing and that if a dressing had, in fact, been left in a wound with a depth of .5 cm, the dressing itself would have fallen off on its own and would not have been retained in the wound, is admissible. Nevertheless, the opinion of BLH's expert to the contrary is sufficient to raise material issues of fact which preclude a grant of summary judgment.

As to plaintiff's cross-motion, in the absence of pending litigation or notice of a specific claim, a defendant should not be sanctioned for discarding items in good faith and pursuant to its normal business practices (Stuhl v. Home Therapy Equip., Inc., 23 AD3d 825); Dobson v. Gioia, 39 AD3d 995). Notice is also a prerequisite to sanctions for inadvertent or negligent destruction (Diaz v. Rose, 40 AD3d 429). In this case, the evidence shows that the gauze was discarded after two weeks pursuant to BLH's usual practice, there was no notice of claim or litigation pending and neither plaintiff nor VNS has shown that the specimen was necessary to the prosecution or defense of the case. Accordingly, plaintiff's cross-motion for spoliation is denied.

This constitutes the decision and order of the court.

Dated: December 7, 2015



STANLEY GREEN, J.S.C.