Circuit Court for Baltimore City
Case No. 24-C-16-000240

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 2057

September Term, 2017

JEFFREY CRADDOCK, *et ux.*

v.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORP. *et al.*

Nazarian,
Leahy,
Wilner, Alan M.
(Senior Judge, Specially Assigned)

JJ.

Opinion by Wilner, J.

Filed: January 18, 2019

*This is an unreported opinion, and it may not be cited in any paper, brief, motion, or other document filed in this Court or any other Maryland Court as either precedent within the rule of *stare decisis* or as persuasive authority. Md. Rule 1-104.

This is a medical malpractice action by Jeffrey and Isabel Craddock against the University of Maryland Medical System Corp. and the University of Maryland Medical Center (collectively UMMC). The gravamen of the action is the alleged failure of UMMC to properly treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection in July 2010, when Mr. Craddock (hereafter Craddock) was a patient at UMMC.

The action was preceded by a claim filed with the Maryland Health Care Alternative Dispute Resolution Office (HCADRO) on June 13, 2013, pursuant to Md. Code, Courts Article, § 3-2A-02, which, apparently on a waiver of ADR proceedings in that Office, was transferred to the U.S. District Court for the District of Maryland on November 19, 2013.[1]

Upon a voluntary dismissal by stipulation of that action on June 25, 2015, the claim was refiled in the HCADRO and, upon another waiver of ADR proceedings, was transferred to the Circuit Court for Baltimore City. The filing in Circuit Court was on January 15, 2016. After several unfavorable interlocutory rulings whittled away at the actions pled, summary judgment was entered in favor of UMMC based on limitations; hence, this appeal.

FACTUAL BACKGROUND

[1] We presume that Federal jurisdiction was based on the fact that Craddock was a resident of Virginia.

On July 3, 2010, Craddock suffered significant injuries to his left leg in a jet ski accident at Deep Creek Lake. After being stabilized at a local hospital, he was transferred the next day to UMMC, where he came under the care of Dr. Theodore Manson, a board certified orthopedic surgeon and a UMMC employee. Craddock was diagnosed with a serious fragmented break of his left femur and a substantial open wound on his left thigh. On July 5, Dr. Manson treated the break by installing an external fixator (which we are advised is a cage-like structure) on the left leg secured by bolts screwed into the bones, and by insertion of an intramedullary rod into the interior of the femur, also secured by internal bolts.

Upon his arrival at UMMC on July 3 and subsequently on July 8, following the surgery, Craddock was tested for MRSA; both tests were negative. Thereafter, evidence of infection became manifest, and, on July 12, Craddock was put in isolation after he tested positive for MRSA. He remained in isolation until July 19, when, on orders from Dr. Manson, he was discharged to Mount Vernon Inova Hospital, an acute rehabilitation center in Virginia (Inova).

Craddock testified that, upon his arrival at Inova, the staff intended to put him in a regular room, but, before they could wheel the bed in, "a nurse came running in [saying] that no, he's got MRSA," and they put a gown, mask, and gloves on him and took him to an isolation room. Craddock acknowledged that when he arrived at Inova, he had an elevated temperature. Later that evening, the medical staff opened his wound and noticed a "gray, red, greenish ugly mess coming out around the bolt that was in [his] bone." It

appears that a CT scan was done while he was at Inova that showed "fluid around the femur, everywhere from the knee, sort of ascending up to the thigh to the hip rather." The fluid was not tested to determine whether it was infected.

Craddock remained at Inova until July 27, when he was transferred back to UMMC for treatment of the infection. When asked why he was sent back, he acknowledged that "there was concern about an infection in [his] leg" on the part of three doctors – two infectious disease doctors and an orthopedic doctor. Upon his return, Dr. Manson seemed puzzled, telling him "I don't know why you're here. I don't deal with infections."[2] Later that day, however, in a procedure that Craddock said was extremely painful, the external fixator was removed.

Craddock was discharged from UMMC on July 29. He returned to Inova, where he was treated for infection and remained until August 18. He made regular visits to Dr. Manson thereafter, but on October 1, 2010, he was readmitted for "left knee manipulation." He was readmitted again in May 2011 for a three-day stay, when Dr. Manson reopened the incision and removed ossification from the leg and adjacent area. He made periodic visits to UMMC until August 2011.

That appeared to be the end of his treatment at UMMC. In June 2012, Craddock was admitted to Fairfax Hospital in Virginia with fever, left leg swelling, septic arthritis of the knee, and staphylococcus. Tests showed a heavy growth of MRSA infection,

[2] In his complaint, Craddock construes that statement, contrary to its plain meaning, as an assertion by Dr. Manson that Craddock did not have an infection. *See* Complaint, ¶ 16.

which, in his Complaint, Craddock claims was the same organism that existed in 2010. *See* Complaint, ¶ 5. He was operated on for site irrigation, debridement, and removal of some of the hardware. Further surgery occurred on July 9 and September 12, 2012 when the internal hardware was removed from his femur. In November 2012, he returned to have scarring removed and to lengthen tendons. Near the end of 2013, he had a total knee replacement.

PROCEDURAL HISTORY

As noted, Craddock's claim was filed initially with HCADRO in June 2013 and was transferred to the U.S. District Court. That claim was accompanied by a Certificate of Qualified Expert from Dr. William Petri, who was not an orthopedic surgeon but a specialist in infectious diseases. Dr. Petri was prepared to testify that Dr. Manson deviated from the pertinent standard of care in two respects: first, by discharging Craddock on July 19, 2010 rather than ordering that he remain hospitalized for "definitive therapy of [his] infection," and second, on July 27-29, 2010, by "failing to remove all of the hardware to achieve definitive therapy of the infection."

UMMC moved to dismiss the action for lack of jurisdiction under Federal Rule12(b)(1) on the ground that Dr. Petri was not qualified to express an opinion on either issue. Md. Code, Courts Article, § 3-2A-02(c)(2)(ii) requires the filer of a certificate (1) to have clinical or academic experience in the same field of health as the defendant, and (2) if the defendant is board certified in a specialty, to be board certified in

the same or related specialty, and Dr. Petri met neither condition. The court concluded that the first issue, dealing with the discharge on July 19, was one on which Dr. Petri, as an infectious disease expert, could testify, but that the issue of whether the hardware should have been removed on July 27-29 was one about which only an orthopedic surgeon could testify. Upon that conclusion, the court granted the motion to dismiss that claim, but granted leave to Craddock to file a motion for reconsideration based on a new Certificate within 60 days. Craddock declined that offer and, with UMMC's consent, voluntarily dismissed the Federal action on June 15, 2015. The actual Order dismissing the case was filed June 25, 2015.

Pursuant to 28 U.S.C. § 1367(d), Md. Rule 2-101(b) provides that, when an action filed in U.S. District Court within the period of limitations applicable under Maryland law is dismissed for lack of jurisdiction or because the court declines to exercise jurisdiction, an action filed in a Circuit Court within 30 days after entry of the order of dismissal shall be treated as timely filed in this State. This action was filed on the Circuit Court for Baltimore City on January 15, 2016. That was, of course, more than 30 days after dismissal of the Federal action. The ultimate question is whether it was within the period of limitations afforded by Maryland law.

The Maryland Complaint contained six counts, three against the Center and three against the Corporation. The first 38 paragraphs alleged much of the history recited above. The gravamen of the Complaint, applicable to all six counts, was that UMMC failed to institute and practice proper measures to prevent the onset and spread of

infection at its facility during the summer of 2010 and to remove the hardware from Craddock's leg at that time.

Counts One and Two were identical, charging the Center and the Corporation, respectively, with deviating from the acceptable standard of care. Counts Three and Four, also identical, charged the Center and the Corporation, respectively, with violating State law intended to prevent and control infection in a hospital environment. Counts Five and Six, identical, charged the Center and the Corporation with violating Federal law intended to prevent and control infection in a hospital environment.

Attached to the Complaint as exhibits were (1) a Certificate of Dr. Petri, who, as in his earlier Certificate, asserted that Dr. Manson departed from the standard of care on July 19, 2005 by not ordering that Craddock remain in the hospital for definitive treatment of his infection, and (2) a Certificate from Dr. Charles Lefebure, an orthopedic surgeon in West Virginia from 1977 to 2009, who opined that UMMC deviated from the standard of care for orthopedic surgery from July 19, 2010 to May 2011 by failing to remove the internal hardware from Craddock when he had a manifest MRSA wound infection.

UMMC's first response, filed on March 17, included a motion to dismiss the Complaint as being time-barred, a motion *in limine* to preclude Dr. Petri from testifying, another motion *in limine* to preclude Dr. Timothy Wyant, a biostatistician who was not a physician, from testifying, and a motion for partial summary judgment.

The motion to dismiss on limitations grounds asserted that Md. Code, § 5-109 of the Courts Article requires that an action against a health care provider be filed within three years after the injury was discovered, that the alleged injury occurred and was discovered in July 2010, and that this action was not filed until January 2016. That motion was initially denied by Judge Nance on April 20, 2017 on the grounds that (1) MRSA is the kind of infection that can become dormant for a period of time and did become dormant in this case, and (2) Craddock was told by Dr. Manson when he returned to UMMC in July 2010 that there was no infection. As we have indicated, Craddock's actual testimony does not support that second finding.

The separate motion sought dismissal on the ground of collateral estoppel and to preclude Dr. Petri from testifying that the hardware inserted into Craddock's femur in July 2010 should have been removed during his readmission in July 27-29, 2010. That motion was based, in part, on the defense of collateral estoppel, to preclude Craddock from relitigating the issue that was decided in the Federal case. On April 24, 2017, Judge Williams denied the motion to the extent it was based on collateral estoppel, concluding that the voluntary dismissal of the Federal case was not a final judgment to which collateral estoppel would apply. He did, however, follow the Federal ruling and granted the *in limine* request to preclude Dr. Petri from opining that Dr. Manson breached the

standard of care by not removing the internal hardware during the July 27-29 stay at UMMC.[3]

The third motion was directed at Dr. Wyant, who was slated to give statistical evidence. He had prepared a report regarding the number of preventable hospital-acquired complications at UMMC from 2009 to 2014, showing that potentially preventable infection rates at UMMC declined by 66 percent from FY 2010 to FY 2014. From that, he concluded that more than half of the hospital-acquired infections occurring at UMMC when Craddock was first admitted were preventable. He made no assertion that Craddock's infection, in particular, could have been prevented or that it was caused by any negligence on the part of UMMC.

The dispute over Dr. Wyant's credentials focused on Counts Three through Six. Neither Dr. Petri nor Dr. Lefebure asserted that Craddock had *acquired* MRSA as a result of UMMC negligence, although there was evidence that he did not have the infection when he arrived there. As noted, their view was that the negligence consisted of not treating the infection properly once it was discovered. Through his statistical analysis, Dr. Wyant maintained that, had UMMC kept certain infection logs required by Federal and State law, the spread of MRSA could have been prevented and that UMMC's failure

[3] Subsequently, the court held that Dr. Lefebure was not qualified to render an expert opinion on the case. That ruling, which is not challenged in this appeal, left Craddock without an expert witness who could testify to any departure from the applicable standard of care by Dr. Manson or UMMC based on the failure to remove all of the hardware in July 2010.

to keep those logs constituted a departure from the standard of care and provided an independent source of negligence.

UMMC argued that Dr. Wyant was not an orthopedic surgeon, or even a physician, and he therefore was not competent to offer an opinion as to whether UMMC was negligent, which was the only relevant issue. Judge Williams made several rulings. As noted, he (1) granted the motion to preclude Dr. Petri from opining that Dr. Manson breached the standard of care by not removing the internal hardware during Craddock's July 27-29 readmission; (2) he deferred the motion *in limine* to preclude Dr. Wyant from testifying to the trial judge; (3) he denied the request for partial summary judgment; and (4) he converted the motion to dismiss Counts Three through Six to a motion for summary judgment and granted that motion. In that last regard, Judge Williams concluded that, although the failure to comply with statutory requirements – keeping the infection logs – may be evidence of negligence and therefore relevant to Counts One and Two, it was not negligence *per se*, and that Counts Three through Six therefore did not state a cause of action.

As a result of those rulings, only Counts One and Two remained in play[4]. They were disposed of by Judge White in November 2017. After recounting the evidence, she concluded that Craddock was aware in July-August 2010 that he had MRSA and that it

[4] Judge Williams' ruling striking Counts Three through Six was revisited in the hearing before Judge White, who confirmed that ruling and precluded any reference to those Counts.

was connected with the hardware that had been inserted on and in his leg and that, under the applicable statute of limitations, the action had to be filed within three years thereafter. On that basis, summary judgment was entered for UMMC.

THE ISSUES

Craddock attacks the three major rulings that led to the adverse judgment. He argues:

(1) That UMMC's continuing treatment of him until August 2011 permitted him to rely on UMMC's diagnosis of no "concerning" infection and that no injury associated with the hardware infection was identified prior to the June 2012 reinfection episode;

(2) The court erred in granting summary judgment on Counts Four through Six based on the violation of applicable statutes and regulations by refusing to take judicial notice of the rules applicable to infection logs and to acknowledge Craddock as an intended beneficiary of those rules; and

(3) The court erred in precluding the testimony of Dr. Wyant.

We need address only the first of those issues.

STATUTE OF LIMITATIONS

The trial court's ruling that Craddock's claim was barred by limitations was in the form of a summary judgment. Summary judgment may be granted when the court finds

that there is no genuine dispute as to any material fact and that the moving party is entitled to judgment as a matter of law. Md. Rule 2-501(f). Our review of such a judgment is *de novo*; we determine whether the trial court was legally correct. In determining whether a genuine dispute of material fact exists, we must view the evidence in a light most favorable to the non-moving party, in this instance Craddock. *Young Electrical v. Dustin Construction*, 459 Md. 356, 389 (2018). Even where the basic facts are undisputed, if they are susceptible to more than one permissible factual inference, summary judgment is inappropriate. *Id.*

The statute of limitations applicable in this case is set forth in Md. Code, § 5-109 of the Courts Article. An action for damages for an injury arising out of the rendering or failure to render professional services by a health care provider must be filed within the earlier of five years from the time the injury was *committed* or three years from the date the injury was *discovered*. An injury is *committed* when legally compensable tort damages first occur, regardless of whether those damages are discoverable or undiscoverable. *Supik v. Bodie*, 152 Md. App. 698, 716 (2003). An action is *discovered*, and thus accrues under that prong of the statute, when the plaintiff knew, or, with due diligence, reasonably should have known of the wrong. *Id.* at 713-14; *Frederick Road v. Brown & Sturm*, 360 Md. 76, 95-96 (2000).[5]

[5] Craddock asserts in his brief that Maryland has recognized a corollary to the discovery rule that has been termed the "continuation of events" doctrine under which, as explained in *Frederick Road*, 360 Md. at 97:

As discussed in *Windesheim v. Larocca*, 443 Md. 312, 327 (2015), "[n]otice is critical to the discovery rule." Before an action can accrue, the plaintiff must have notice of the nature and cause of his or her injury. Notice can be actual or constructive. Actual notice can be express or implied. Actual notice is established by direct evidence and includes not only knowledge but also that which is communicated by direct information from those who are cognizant of the fact communicated. *Id.* Implied notice, or inquiry notice, is notice implied from "knowledge of circumstances which ought to have put a person of ordinary prudence on inquiry (thus, charging the individual) with notice of all facts which such an investigation, in all probability, would have disclosed if it had been properly pursued." *Id*, quoting from *Poffenberger v. Riser*, 290 Md. 631, 637 (1981).

It is undisputed that Craddock had both actual and implied notice that he had an MRSA infection during the period from July 12, 2010 through July 29 of that year. He was told that; he was put in isolation as a result of it, both at UMMC and Inova; and he was treated for it. His response to that, drawn mostly from Dr. Petri's deposition

> "[i]f the facts show *continuing medical or surgical treatment* for a particular illness or condition in the course of which there is malpractice producing or aggravating harm, the cause of action of the patient accrues at the end of the treatment for that particular illness, injury or condition, unless the patient sooner knew or reasonably should have known of the injury or harm."

Had counsel read footnote 13 in *Frederick Road*, also at 97, he would know that that common law doctrine had been repealed by the enactment of § 5-109 in 1973. *See Hill v. Fitzgerald*, 304 Md. 689, 700 (1985).

testimony, is that MRSA – the bacteria – can attach to a part of the body, which Dr. Petri referred to as a "colonization" that is not a true infection, that can be treated, and that is relatively harmless, or it can attach to hardware inserted into the body, become an infection, and be more difficult to treat because it has to be removed from that hardware.

Dr. Petri's view was that the MRSA at issue here had attached to the internal hardware and was not effectively treated until the hardware was removed in September 2012 and that Craddock was unaware that the MRSA was of that nature until then.[6] Coupling that with Craddock's erroneous view that the continuing course of treatment rule tolled limitations until 2012, he urges that the initial filing in Federal Court in November 2013 was timely, and that, upon dismissal of that action in June 2015, his refiling in January 2016 also was timely under Md. Code, § 5-119 of the Courts Article.

Sorting through all of this, the trial court concluded that Craddock was at least on inquiry notice by August 2010 that he had a MRSA infection that was not being properly treated and that, had he pursued an investigation, he would have discovered the problem – that the recurring MRSA infection was due to its untreated attachment to the internal hardware –within three years thereafter. The court determined that "[h]e had enough facts about his infections and the reasons for the infections, including his infection by

[6] Although Dr. Petri was not permitted to testify as to a deviation from the standard of care, a critical part of his *de bene esse* deposition was recounted at the motions hearing before Judge White, without objection. In that testimony, Dr. Petri said that the MRSA infection recognized in July 2010 "continue[d] until the hardware is eventually removed at Fairfax Hospital" – that "the *same bug* remained in him from 2010 to 2012." (emphasis added).

name as MRSA." In drawing that conclusion, the court properly did not apply the continuing course of treatment rule.

In determining a limitations issue, two dates are critical – when did the period begin to run and when did it end? We agree with the trial court's analysis and conclusion that the limitations period began to run no later than August 2010. Dr. Petri may be right that treating MRSA attached to internal hardware is more difficult and requires a longer course of treatment than what he refers to as "colonization" of the MRSA bacteria. The critical and undisputed fact, however, is that Craddock clearly was aware by August 2010 that he had a MRSA infection in his left leg, that the infection was connected with at least some of the hardware that was bolted into his bone, and that there were obvious symptoms from that infection. In light of Dr. Petri's conclusion that the MRSA infection evident in 2010 remained in him – the same bug – until 2012, that put him at least on inquiry notice then that he had suffered an injury and was not being effectively treated.

As to when it ended, that would be three years later. Because the Federal action was not dismissed because of any jurisdictional defect but voluntarily by Craddock, he gets no benefit from Rule 2-101(b).

JUDGMENT AFFIRMED; APPELLANT TO PAY THE COSTS.