SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2743-22

JAMES SPILLE and LORRAINE SPILLE, his wife,

Plaintiffs-Appellants,

v.

VIRTUA HEALTH, INC., d/b/a VIRTUA VOORHEES HOSPITAL, ANN MAHADEVIAH, M.D., EDWARD AMANAKWAAH, C.R.N.A., LAURIE SPENCER, R.N., LADESA ADAMS, O.R.T., EDWARD SHIELDS, R.N., RUTH SINIBALDI, C.R.N.A., NOEMI RODRIGUEZ, C.R.N.A., KERRY RONAN, P.A., and BECTON DICKINSON & COMPANY,

Defendants-Respondents.

Argued November 7, 2024 – Decided January 3, 2025

Before Judges Currier, Paganelli, and Torregrossa-O'Connor.

On appeal from the Superior Court of New Jersey, Law Division, Middlesex County, Docket No. L-0170-21.

Christina Vassiliou Harvey argued the cause for appellants (Lomurro Munson, LLC, attorneys; Jonathan Lomurro and Christina Vassiliou Harvey, of counsel and on the briefs; Jeffrey Niesz, on the briefs).

Robert E. Spitzer argued the cause for respondent Ann S. Mahadeviah, M.D. (MacNeill, O'Neill, Riveles & Spitzer, LLC, attorneys; Lauren K. O'Neill, of counsel; Robert E. Spitzer and Danyelle H. Golland, on the brief).

Matthew E. Blackman argued the cause for respondents Edward Amankwaah, C.R.N.A., Ruth Sinibaldi, C.R.N.A., and Noemi Rodriguez, C.R.N.A. (Ruprecht Hart Ricciardulli & Sherman, LLP, attorneys; Renee J. Sherman, of counsel; Matthew E. Blackman, on the brief).

Mary Kay Wysocki argued the cause for respondents Virtua-West Jersey Health System, Inc. (improperly pled as Virtua Health, Inc. d/b/a Virtua Voorhees Hospital), Laurie Spencer, R.N., LaDesa Adams, O.R.T., and Edward Shields, R.N. (Law Offices of Parker McCay, PA, attorneys; Mary Kay Wysocki and Kevin B. Maginnis, on the brief).

Samuel A. James argued the cause for respondent Becton Dickinson and Company (McCarter & English, LLP, attorneys; Edward J. Fanning, Jr., and Natalie H. Mantell, of counsel and on the brief; Samuel A. James and Michael D. Fasciale, on the brief).

Nicholas J. Repici argued the cause for respondent Kerry Ronan, P.A. (Lenox, Socey, Formidoni,

Giordano, Lang, Carrigg & Casey, LLC, attorneys; Casey P. Acker, on the brief).

PER CURIAM

In this medical malpractice case, plaintiff James Spille[1] contends he contracted Methicillin Resistant Staphylococcus Aureus (MRSA)—a type of staph infection—about three weeks after undergoing knee replacement surgery at defendant Virtua Voorhees Hospital. He alleged defendants, except for Becton, Dickinson & Co. (BD), were negligent in their care of him, resulting in the development of the infection. He asserted BD "negligently manufactured, produced, developed, sanitized, and/or oversaw their product" used in the procedure, specifically a needle used to inject anesthesia, causing him damages.

Plaintiff sought to shift the burden of proving negligence to defendants under the doctrines of res ipsa loquitor, the principles of Anderson v. Somberg, 67 N.J. 291 (1975), and the common knowledge exception. Plaintiff contends N.J.S.A. 26:2H-12.35 (the statute) establishes a standard of care, eliminating the need for expert testimony. The trial court granted defendants summary judgment. Because the statute did not create a per se cause of action for

[1] Plaintiff Lorraine Spille asserts a per quod claim against defendants. We refer to James by his name or as plaintiff.

negligence, a MRSA infection is not the type of case that falls under the narrow parameters of Anderson, and the common knowledge exception is inapplicable, we affirm.

I.

On January 10, 2019, James was admitted to Virtua and underwent a total left knee replacement necessitated by osteoarthritis of the knee. James tested negative for MRSA on December 3, 2018, prior to the procedure. The hospital records reflect "all of the inherent risks and benefits associated with knee replacement were reviewed[, including infection,] and the patient elected to proceed."

Defendant Dr. Ann Mahadeviah—an anesthesiologist—staffed with defendant certified registered nurse anesthetist (CRNA) Edward Amankwaah, gave James a single spinal anesthesia block injection at the L3-L4 level of the spine using a 25-gauge, 3.5-inch Whitacre needle manufactured by BD. Defendants Laurie Spencer, RN; Physician Assistant Kerry Ronan; Operating Room Technician LaDesa A. Adams and Edward Shields, RN were present in the operating room during the surgical procedure.

Plaintiff was discharged from Virtua on January 11. The Discharge Summary stated, in pertinent part:

> Hospital Course: The patient was admitted to the hospital and underwent uncomplicated knee replacement. . . . The patient was mobilized and was discharged after clearing PT. They were neurovascularly intact with no signs of drainage or infection while in the hospital.

Plaintiff began physical therapy at a rehabilitation facility on January 14. The physical therapist noted James had stiffness and pain in his left knee, which he described as an eight out of ten at worst in severity of pain, as well as difficulty walking.

On January 28, plaintiff was readmitted to Virtua with "back pain, knee pain[,] and fever." He had an elevated white blood cell count, and the admitting notes indicated: "Most likely [James] is having a discitis versus spinal epidural abscess as eviden[ced] by his relatively acute onset of low back pain and abnormal imaging suggestive of a fluid collection." Blood cultures taken on January 28 through 30 were all positive for MRSA. Blood cultures taken on January 31 and thereafter were negative for the infection. Plaintiff was treated for "MRSA bacteremia, L4-L5 discitis, and an epidural abscess."

James was discharged on February 11, 2019. The Discharge Summary stated, "Disci[]tis/Bacteremia/ with history of left [total knee replacement] . . . [;] Blood cultures with MRSA. . . . Patient to continue [antibiotic]" for six weeks. The x-ray report of the lower back revealed "L4-5 and L5-S1

degenerative disc disease with posterior facet arthropathy at L3-4 through L5-S1."

In April 2019, plaintiff returned to Virtua with knee pain and was diagnosed with a knee infection. On April 25, he underwent "an incision, drainage, and exchange of plastic" in the knee replacement.

II.

Plaintiffs served an affidavit of merit (AOM) authored by board-certified anesthesiologist Sheldon Deluty, M.D., against all defendants. Dr. Deluty stated he had experience supervising CRNAs in administering "neuraxial block procedures" and with sterilization techniques for such procedures. He opined:

> Based upon my understanding of the facts involved in the treatment rendered here, I state there exists a reasonable probability that the care, skill and/or knowledge exercised and/or exhibited by the Virtua . . . medical personnel, [and] hospital employees involved in the administration of the neuraxial block procedure performed on January 10, 2019 in the course of the surgical care rendered to James . . . fell outside acceptable professional or treatment standards.
>
> . . . Based upon my review of the medical records, the patient's contraction of a . . . [MRSA] infection appears to have been causally related to the neuraxial block procedure, secondary to improper sterile technique, faulty equipment, improper oversight or a combination of any, or all of these factors.

> . . . The medical personnel involved in the neuraxial block administered to James . . . on January 10, 2019 include . . . Virtua . . ., . . . Mahadeviah . . . Amankwaah, . . . Spencer, . . . Adams, . . . Shields, . . . Ronan, . . . Sinibaldi, . . . Rodriguez, . . . and any other staff named or unnamed at this time, who may be determined during the course of [d]iscovery to have been involved in the performance of the neuraxial block procedure.

The court held a Ferreira[2] conference in March 2021. There are no issues raised on appeal regarding the sufficiency of the AOM.

A.

Plaintiffs moved for a declaration that the common knowledge doctrine applied, obviating the need for an AOM, and for an order shifting the burden of proof to defendants. Plaintiffs contended that under Anderson, the burden of proof should shift to defendants because they have all the information. Plaintiffs further asserted they could rely on the statute to establish the requisite standard of care. In the alternative, plaintiffs sought a declaration that Dr. Deluty's AOM was sufficient against all defendants.

Defendants opposed the motion, arguing generally that burden shifting under Anderson is rarely applied, and there is no strict liability for developing a

[2] Ferreira v. Rancocas Orthopedic Assocs., 178 N.J. 144 (2003).

MRSA infection after a surgical procedure because it can develop without negligence. They argued a MRSA infection cannot be equated to leaving a foreign instrument in a patient's body.

Defendants also asserted since James's last bloodwork was five weeks prior to the surgery, it was unknown whether the infection developed just before, during, or after the procedure when he began physical therapy on January 14 before being readmitted to Virtua on January 28.

In addition, defendants contended an average lay juror could not understand the respective roles of the medical professionals and, therefore, plaintiffs needed to proffer expert testimony addressing the standard of care required of each medical practitioner.

In issuing an oral decision, Judge J. Randall Corman analyzed the statute and disagreed with plaintiffs' construction of it. Judge Corman preliminarily noted a statute's statement is not part of the statute, and if there is a discrepancy, the statute's language prevails. The judge found the statute

> requires that hospitals create an infection prevention program and it also requires them to report MRSA cases to the Department of Health and it authorizes the Department of Health to promulgate administrative penalties for hospitals that violate it, that don't have a proper infection prevention program[,] and who don't report MRSA cases to the State.

> That's all it does. There is no language in there about burden shifting or strict liability. It requires hospitals to set up a program.

Judge Corman concluded the AOM was not sufficient under Meehan v. Antonellis, 226 N.J. 216 (2016), to assert the standard of care required of the physician's assistants, CRNAs, and other medical personnel defendants. The court entered an order denying plaintiffs' motion on June 11, 2021.

B.

Following discovery, Dr. Mahadeviah moved for summary judgment and to dismiss plaintiffs' complaint with prejudice, arguing that plaintiffs had not provided an expert report by the ordered deadline and, therefore, could not support their medical negligence action. BD cross-moved for summary judgment, also premised on the lack of expert testimony.

Thereafter, plaintiffs submitted an expert report from infectious disease physician Julie Joseph, M.D., MPH, MBA. Dr. Joseph stated: "The purpose of my review was to evaluate the causation of the development of MRSA bacteremia and epidural abscess in . . . James . . . on January 10, 2019, leading to the dissemination of MRSA infection to his left knee" on April 25, 2019.

After reviewing James's medical records and the hospital records, Dr. Joseph concluded:

> To a reasonable degree of medical certainty, . . . James . . . obtained the MRSA epidural abscess and bacteremia from the epidural anesthesia he received for his left knee replacement surgery on January 10, 2019, which also led to the dissemination of the MRSA infection to his left knee. MRSA infection is a serious and potentially deadly infection that can rapidly progress and spread throughout the body, such as the knee, as in the case of [James]. The use of aseptic technique in the administration of epidural anesthesia is critical in the prevention of the development of infection. In addition, timely diagnosis and treatment of infection is critical in preventing the progression of infection and the development of infectious complications such as sepsis and death.

The remaining defendants cross-moved for summary judgment and to dismiss plaintiffs' complaint with prejudice, asserting Dr. Joseph's report did not establish the applicable standard of care to them respectively, nor the deviation from the standard of care and did not allege the individual defendant's actions was the proximate cause of plaintiffs' injuries.

Plaintiffs opposed defendants' motions for summary judgment and cross-moved to shift the burden of proof to defendants. In support of their motion, plaintiffs attached an August 2, 2007 news release from the Governor's office regarding the signing of the statute. It stated:

> [The statute] requires hospitals to implement an infection prevention program to eliminate antimicrobial-resistant infections and requires hospitals

> to report cases of [MRSA] to the New Jersey Department of Health and Senior Services.
>
> "Each year, two million patients in this country become infected with MRSA after entering the hospital," said Governor Corzine. "Staph infections are highly avoidable and having this prevention program in place to protect patients is a matter of good public health policy for New Jersey."
>
> Under the legislation, it will be mandatory for all general hospitals to implement an infection prevention program in their intensive care units. If a hospital has no intensive care unit, the program should then be implemented in another high-risk unit where there is significant risk of facility-acquired infections.
>
> "According to the Centers for Disease Control, MRSA has become the dominant cause of hospital staph infections over the past three decades, rising from 2% of all reported cases in 1974 to more than 63% of all cases in the United States," said Senator Buono, D-Middlesex. "Fortunately, there are simple, proven ways to reduce the prevalence of this infection, saving countless lives. . . ."

Plaintiffs also attached the legislative statement, which expressed, in relevant part:

> This bill requires hospitals in this State to eliminate antimicrobial-resistant infections by interrupting the chain of transmission within their facilities.
>
> The Department of Veterans Affairs (VA) Pittsburgh Healthcare System undertook an MRSA control program that reduced infections in one of its

surgical care units by 70%. Because it was so successful, the Veterans Health Administration issued a directive for all VA health care facilities to test similar plans tailored to their own facility's circumstances, to prevent the spread of MRSA. The initial focus was one high-risk unit in the facility with the eventual plan to apply successful strategies throughout the facility. This bill is based on the VA directive in that it allows each facility the flexibility to address infection prevention based on its own circumstances.

Under the bill, all general hospitals are to implement an infection prevention program in their intensive care units. If a hospital has no intensive care units, then the program is to be implemented in other high-risk units such as a surgical unit or other unit where there is significant risk of facility-acquired infections. . . .

In addition to any other best practices and effective strategies, the following elements are to be incorporated into the infection prevention program:

identification and isolation of both colonized and infected patients in order to break the chain of transmission;

contact precautions for patients found to be MRSA positive, as "contact precautions" is defined by the Centers for Disease Control and Prevention;

patient cultures for MRSA upon discharge or transfer from the unit where the infection prevention program has been implemented, and flagging of patients who are readmitted to the facility;

strict adherence to hygiene guidelines;

> a written infections prevention and control policy with input from frontline caregivers; and
>
> a worker education requirement regarding modes of MRSA transmission, use of protective equipment, disinfection policies and procedures, and other preventive measures.
>
> A facility that violates this bill would be subject to such penalties as the commissioner of Health and Senior Services may determine pursuant to N.J.S.A. 26:2H-13 and 26:2H-14.
>
> The bill also provides that the commissioner is to report to the Governor and standing reference committees on health on the effect of this bill in reducing MRSA infections in hospitals.

Plaintiffs contended the statute established the standard of care that the contraction of MRSA bespoke negligence, and that Anderson applied to shift the burden of proof to defendants.

Defendants responded, in addition to arguments previously made, that plaintiffs' cross-motion was really a motion for reconsideration because the issues of burden shifting and common knowledge exception were previously decided. BD added that Dr. Joseph did not address plaintiffs' allegations against it.

Plaintiffs replied that Dr. Joseph's report was the new information before the court to warrant reconsideration. During oral argument on the motions,

plaintiffs' counsel conceded that if their burden shifting and common knowledge arguments were unsuccessful, they did not have an appropriate expert report addressing the standard of care to support their claims.

Judge Bina K. Desai presided over the second set of motions and noted in her oral opinion that plaintiffs' cross-motion was a motion for reconsideration and not a renewed motion to shift the burden of proof under Anderson. She found that Dr. Joseph's report did not

> pertain to any issues regarding the burden shifting[,] for example discussing the statute, discussing MRSA, discussing the . . . types of arguments that counsel relies on to argue burden shifting; but rather it simply states that infectious disease doctor[']s opinion that the MRSA [infection] was caused during . . . the anesthesia prior to the surgery.

Judge Desai found Judge Corman's decision was "appropriate and consistent with [her] own review" that there is no precedent that a case involving a MRSA infection is treated as a strict liability case that would shift the burden to defendants. The judge stated:

> [T]he statute here does not create a standard of care or otherwise create any civil remedy within the act and therefore, I do agree with Judge Corman and his decision [that] this case is readily and clearly distinguishable from cases like Anderson where some inappropriate object was left behind inside of a [patient] after being treated at a hospital.

> Here, the all[eg]ations by the plaintiff . . . [are] that the defendants['] negligence led to him contracting MRSA[,] which as Judge Corman noted also[,] is known to grow and multiply and move for a variety of reasons . . . based on a variety of factors.
>
> Even the plaintiff[s'] expert report[] does little to explain anything dealing with MRSA other than to opine when the timing of . . . the MRSA infection [was] contracted.
>
> Whether the action of any defendant or combination of defendants was in fact negligent, and has causal connection is not borne out simply by the language of the statute cited by the plaintiff or even in reading the legislative history or intent of the same.
>
> The [s]tatutes merely reflect that MRSA [is] preventable and does not create any strict liability requirement of any sense or create a standard of care otherwise binding upon the parties.
>
> Thus, the [c]ourt again agrees with and adopts and incorporates Judge Corman's reasoning for denying the motion and I do not find that it's in the interest of justice to undo the same.

In addressing defendants' summary judgment motions, Judge Desai considered whether plaintiffs needed to provide expert testimony to establish their medical malpractice claims or whether the common law knowledge exception applied permitting a jury to determine a defendant's negligence without the benefit of expert testimony. The judge found a medical condition,

such as a MRSA infection, was "beyond the ken of an average lay person jury and requires expert testimony."

Judge Desai stated:

> Here the only expert . . . plaintiff[s have] provided is an infectious disease expert, Dr. Joseph, . . . who opines that [James] obtained the MRSA infection from the epidural anesthesia administered on January 10[], 2019.
>
> The [c]ourt is satisfied in looking at all of the information before it and having heard all of the arguments . . . and having reviewed the relevant case law regarding both common knowledge exception and res ipsa loquitor, I find as a matter of law that the facts and circumstances presented in this case contain sufficiently complex issues concerning the standard of care and causation issues that common knowledge nor res ipsa would apply to allow the plaintiff to not obtain an expert . . . as it relates to the MRSA infection particular to this case.
>
> Plaintiff[s have] failed to offer any expert testimony to prove negligence by any of the defendants as it pertains to the contracting [of] MRSA or in the treatment of the same or to even establish a causal connection.
>
> And as plaintiff[s] . . . today acknowledged, . . . if I find that the common knowledge and burden shifting and res ipsa arguments don't apply . . . they do not have an expert to then withstand the burden, but I do find . . . that would be required under our case law.

On March 29, 2023, the trial court entered an order granting defendants' motion and cross-motions for summary judgment, denying plaintiffs' cross-motion and dismissing plaintiffs' complaint and crossclaims with prejudice.

III.

Plaintiffs appeal from both the June 11, 2021 and March 29, 2023 orders. They contend the trial court erred in not applying the doctrine of res ipsa loquitor and the common knowledge exception to alleviate plaintiffs' need for expert testimony and to shift the burden of proof to defendants.

We review a trial court's decision on a motion for summary judgment de novo, "the same standard used by the trial court." Samolyk v. Berthe, 251 N.J. 73, 78 (2022). A motion for summary judgment should be granted when "there is no genuine issue as to any material fact challenged and . . . the moving party is entitled to a judgment or order as a matter of law." R. 4:46-2(c). The court should "consider whether the competent evidential materials presented, when viewed in the light most favorable to the non-moving party, are sufficient to permit a rational factfinder to resolve the alleged disputed issue in favor of the non-moving party." Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 540 (1995).

"We review matters of law de novo, owing no deference to the interpretive conclusions of . . . the trial court." McDaid v. Aztec W. Condo. Ass'n, 234 N.J. 130, 141 (2018). Our review of issues of statutory interpretation is similarly de novo. Kocanowski v. Twp. of Bridgewater, 237 N.J. 3, 9 (2019).

Plaintiffs argue the trial court erred in determining that res ipsa loquitor was inapplicable under these circumstances to shift the burden of proof to defendants. They rely on Anderson and Estate of Chin v. St. Barnabas Medical Center, 160 N.J. 454 (1999) to support their argument.

Defendants assert the trial court was correct because the statute does not create liability, and plaintiffs have not established any of the Anderson elements to shift the burden of proof. BD adds that the statute does not apply to it—a medical device manufacturer. Ronan contends she was not involved in the administration of the spinal block and that plaintiffs have not presented any expert testimony on the standard of care and causation that pertains to a physician's assistant.

The doctrine of res ipsa loquitur, which means "the thing speaks for itself," is an "evidentiary rule grounded in principles of equity." Jerista v. Murray, 185 N.J. 175, 191-92 (2005) (quoting Myrlak v. Port Auth. of N.Y. & N.J., 157 N.J. 84, 95 (1999)). "Res ipsa loquitur is grounded in probability and

the sound procedural policy of placing the duty of producing evidence on the party who has superior knowledge or opportunity for explanation of the causative circumstances." Buckelew v. Grossbard, 87 N.J. 512, 526 (1981) (italicization omitted).

Ordinarily, "negligence must be proved and will never be presumed, . . . there is a presumption against it, and . . . the burden of proving negligence is on the plaintiff." Id. at 525. The res ipsa doctrine, however, "allows the factfinder to draw an inference of negligence against the party who was in exclusive control of the object or means that caused the accident." Jerista, 185 N.J. at 192. The doctrine creates "a strong incentive on the party with superior knowledge to explain the cause of an accident and to come forward with evidence in its defense." Ibid. However, "the rule does not shift the burden of persuasion; the most that is required of defendant is explanation, not exculpation." Buckelew, 87 N.J. at 526.

To establish res ipsa loquitur, a plaintiff must show "(a) the occurrence itself ordinarily bespeaks negligence; (b) the instrumentality was within the defendant's exclusive control; and (c) there is no indication in the circumstances that the injury was the result of the plaintiff's own voluntary act or neglect." Jerista, 185 N.J. at 192 (quoting Buckelew, 87 N.J. at 525).

"Courts of this state have long recognized that depending upon the probabilities, the res ipsa loquitur doctrine can apply in a medical malpractice context." Buckelew, 87 N.J. at 526 (italicization omitted). "To prove medical malpractice, ordinarily, 'a plaintiff must present expert testimony establishing (1) the applicable standard of care; (2) a deviation from that standard of care; and (3) that the deviation proximately caused the injury.'" Nicholas v. Mynster, 213 N.J. 463, 478 (2013) (quoting Gardner v. Pawliw, 150 N.J. 359, 375 (1997)).

The doctrine will apply when "as a matter of common knowledge within the ken of lay jurors, the accident in question would not have occurred had the defendant adhered to the appropriate standard of his profession. When that principle is applicable, plaintiff need not produce expert testimony to demonstrate defendant's deviation from the standard." Buckelew, 87 N.J. at 527.

In Buckelew, a physician accidently cut into the plaintiff's bladder while performing a laparotomy. Id. at 518-19. The plaintiff's expert opined as to the standard of care and that defendant physician deviated from the standard when he cut her. Id. at 520. The defendant's expert disagreed with the deviation opinion, stating that defendant's act of cutting the bladder did not by itself establish the defendant was negligent. Id. at 521. The trial court found the plaintiff's expert's testimony was "a net opinion," and the plaintiff "failed to

establish by expert testimony that [the] defendant had deviated from the requisite standard of care." Id. at 522, 524-25.

The Supreme Court reversed, finding "a sufficient basis for the application of the doctrine of res ipsa loquitur" can also be established when a plaintiff offers "expert testimony . . . that the medical community recognizes that an event does not ordinarily occur in the absence of negligence." Id. at 527 (italicization omitted). However, the Court cautioned:

> [I]t will not be sufficient for plaintiff's expert simply to follow slavishly a "common-knowledge-within-the-medical-community" formula. There must be some evidential support, experiential or the like, offered for the expert's conclusion that the medical community recognized that the mishap in question would not have occurred but for the physician's negligence. If the plaintiff's expert's direct and cross-examination provide no basis for the witness's "common knowledge" testimony other than the expert's intuitive feeling—in other words, no more than a flat-out statement designed to satisfy the "common knowledge" test—then the court should not apply the res ipsa doctrine to the proceedings.
>
> [Id. at 528-29 (italicization omitted)].

In Anderson, the plaintiff was undergoing a laminectomy when a metal piece of the tool the surgeon was using broke off and became imbedded in the plaintiff's spinal canal. 67 N.J. at 294. According to the parties' experts, the possible theories for the break were the surgeon negligently used the tool, or the

surgeon was given a defective tool—the defect could be attributed to multiple sources. Id. at 296. After the jury returned a verdict of no cause of action, we ordered a new trial, determining that based on the facts "it was clear" at least one of the defendants was liable. Id. at 297.

On review, the plurality of the Supreme Court found:

> The position adopted by the Appellate Division majority seems to us substantially correct: that is, at the close of all the evidence, it was apparent that at least one of the defendants was liable for plaintiff's injury, because no alternative theory of liability was within reasonable contemplation. Since [the] defendants had engaged in conduct which activated legal obligations by each of them to [the] plaintiff, the jury should have been instructed that the failure of any defendant to prove his nonculpability would trigger liability; and further, that since at least one of the defendants could not sustain his burden of proof, at least one would be liable. A no cause of action verdict against all primary and third-party defendants will be unacceptable and would work a miscarriage of justice sufficient to require a new trial.
>
> [Id. at 298 (citing R. 2:10-1) (citation reformatted).]

The Court established a narrow rule that it distinguished from the traditional doctrine of res ipsa loquitur, stating: "For this particular type of case, an equitable alignment of duties owed [to the] plaintiff requires that not only the burden of going forward shift to [the] defendants, but the actual burden of proof as well." Id. at 300, 302. The majority described the type of case that might fall

within the new rule's sphere as: "those instances where the injury lay outside the ambit of the surgical procedure in question;" where "no reasonable suggestion [is] offered that the occurrence could have arisen because of plaintiff's contributory negligence;" and where multiple theories, such as "negligence, strict liability in tort[,] and breach of warranty [are] all advanced as possible theories of liability." Id. at 299, 302-03.

In Chin, 160 N.J. at 460, the Court reaffirmed the Anderson principles and articulated a three-factor test for the applicability of the Anderson exception and the shifting of the burden of proof to the defendants. Chin died during a hysteroscopy after "gas was pumped into her uterus rather than fluid," causing an air embolism that killed her. Ibid. The Court found the record "clearly demonstrates that the embolism was the direct result of an incorrect hook-up of the hysteroscope" tool used in the procedure. Ibid.

The Court determined that a plaintiff must prove three elements to shift the burden of proof to the defendant(s):

> First, the plaintiff must herself be entirely blameless. The fact pattern to which the principles of Anderson most readily apply is where a plaintiff was "clearly helpless or anesthetized" when her injury occurred. Second, the injury must be one that bespeaks negligence on the part of one or more of the defendants. Third, all the potential defendants must be before the court. That is, all those defendants who participated in

> the chain of events causing plaintiff's injury must be represented.
>
> [Id. at 465 (first quoting Myrlak, 157 N.J. at 100, and then citing Shackil v. Lederle Laboratories, Div. of Am. Cyanamid Co., 116 N.J. 155, 174 (1989)).]

Burden shifting from plaintiffs to defendants will not apply "absent the 'narrow set of factual circumstances' described in Anderson and Chin." Lucia v. Monmouth Med. Ctr., 341 N.J. Super. 95, 108 (App. Div. 2001) (quoting Chin, 160 N.J. at 465).

Against this backdrop, we consider the facts presented here. The rationale underlying the res ipsa doctrine and the Supreme Court's holdings in Anderson and Chin is that the event at issue "bespeaks negligence." See McDaid, 234 N.J. at 143; see also Buckelew, 87 N.J. at 526.

For res ipsa to apply under Buckelew, a plaintiff must present "expert testimony . . . that the medical community recognizes" the particular "event does not ordinarily occur in the absence of negligence." 87 N.J. at 527. Plaintiffs rely on the statute for this proof.

Plaintiffs contend a MRSA infection "bespeaks of negligence" because in enacting the statute, the "Legislature determined as a matter of law that a hospital has the power and the duty to prevent MRSA infections." According to plaintiffs, because the statute expresses a MRSA infection is "preventable," that

establishes that a MRSA infection "does not ordinarily occur in the absence of negligence." Therefore, plaintiffs assert they do not need expert testimony to establish the standard of care but can rely on the statute to support the application of the res ipsa loquitur doctrine, and Anderson principles.

The statute provides:

> The Legislature finds and declares that:
>
> > a. Two million patients in this country become infected after entering hospitals each year and about 90,000 of those patients die as a result of those infections;
> >
> > b. [MRSA] is a common staph infection which is resistant to powerful antibiotics and which is increasingly prevalent in health care settings;
> >
> > c. MRSA can survive on cloth and plastic for up to 90 days, and is frequently transmitted by contaminated hands, clothes and non-invasive instruments, so that the number of patients who can become infected from even one carrier multiplies dramatically;
> >
> > d. The federal Centers for Disease Control and Prevention (CDC) estimates that one in 20 patients entering a hospital carries MRSA, and reported that MRSA accounted for 60% of infections in American hospitals in 2004, up from 2% in 1974;
> >
> > e. The annual nationwide cost to treat hospitalized patients infected with MRSA is estimated to be more than $4 billion;

> f. These infections are preventable, and recent data support a multi-faceted approach to successfully combat them, including routine screening, isolation of colonized and infected patients, strict compliance with hygiene guidelines, and a change in culture to ensure that infection prevention and control is everyone's job and is a natural component of care at each patient encounter each day;
>
> g. Virtually all published analyses comparing the costs of screening patients upon admission and adopting effective infection control practices with the costs of caring for infected patients have concluded that caring for infected patients is much more expensive;
>
> h. Routine screening and isolation of all patients with MRSA in hospitals in Denmark and Holland have reduced MRSA to 10% of their bacterial infections, and a pilot program undertaken by the Department of Veterans Affairs (VA) Pittsburgh Healthcare System that reduced MRSA infections in its surgical care unit by 70% was so successful that all VA health care facilities have been directed to develop and implement similar approaches to prevent the spread of MRSA in at least one unit, with the goal to apply successful strategies facility-wide.
>
> [N.J.S.A. 26:2H-12.35].

The "overriding goal" when engaging in statutory construction is "to determine the Legislature's intent." Hubbard v. Reed, 168 N.J. 387, 392 (2001) (quoting State, Dep't of L. & Pub. Safety v. Gonzalez, 142 N.J. 618, 627 (1995)).

"The first step in determining the Legislature's intent is to look at the plain language of the statute." Ibid. (citing State v. Butler, 89 N.J. 220, 226 (1982)). "We begin by giving the words of the statute 'their ordinary meaning and significance.'" Nicholas, 213 N.J. at 480 (quoting DiProspero v. Penn, 183 N.J. 477, 492 (2005)). "Words, phrases, and clauses cannot be viewed in isolation; all the parts of a statute must be read to give meaning to the whole of the statute." Ibid. "'[I]f the plain language of a statute is ambiguous or open to more than one plausible meaning,' the court may look to sources of extrinsic evidence such as legislative history for assistance in determining legislative intent." L.A. v. N.J. Div. of Youth & Fam. Servs., 217 N.J. 311, 324 (2014) (quoting State v. Marquez, 202 N.J. 485, 500 (2010)).

The statute and its statement describe the prevalence of MRSA and that it is preventable by stopping the transmission of the infection. The statute requires hospitals[3] to implement preventative protocols, including reporting the occurrence of infections. The Legislature stated the protocols are designed to "combat" MRSA, suggesting MRSA can occur despite best efforts. Moreover, the statute reflects that the precautions discussed in the studies reduced, but did

[3] We note the statute only applies to hospitals and therefore, plaintiffs could not rely on it to establish a standard of care against the various medical professional defendants here.

not completely eliminate MRSA infections. Therefore, the studies confirmed the infection can occur without any negligent action or inaction.

The statute does not impose a standard of care or even suggest that an infection can only occur as a result of a negligent action. Therefore, the language of the statute alone does not support a finding that a MRSA infection bespeaks negligence.

We have stated that to invoke res ipsa loquitor, medical testimony is necessary to establish "that the medical community recognizes that an event does not ordinarily occur in the absence of negligence." Roper v. Blumenfeld, 309 N.J. Super. 219, 230 (App. Div. 1998) (quoting Buckelew, 87 N.J. at 527).

Plaintiffs only presented Dr. DeLuty's AOM and Dr. Joseph's expert report. In his AOM, Dr. DeLuty opines only that James's infection occurred during the administration of the epidural block and that defendants' actions fell below the standard of care in general. He does not present any testimony regarding a consensus in the medical community regarding MRSA infections. Dr. Joseph also did not address the medical community's view of MRSA as related to a medical professional's negligence. Therefore, plaintiffs have not provided the requisite expert testimony that a MRSA infection would not have

occurred without negligence to invoke either the res ipsa loquitor doctrine or the Anderson burden shifting exception.

Plaintiffs similarly failed to establish these facts fall within the narrow ambit of cases in which the common knowledge exception applies to forego expert testimony. In Lucia, we explained the absence of expert testimony

> "is not invariably fatal" to a medical malpractice action if there is other testimony from which the factfinder can determine the applicable standard of care and whether it was violated. The common knowledge doctrine is appropriately applied only in those professional malpractice cases where the common knowledge and experience of ordinary lay persons would enable a jury to conclude without expert testimony that a standard of care applied and was breached--that is, where "the mistake was obviously the result of negligence."
>
> [341 N.J. Super. at 103-04 (internal citations omitted).]

As James acknowledged in executing the consent form for surgery, developing an infection is a recognized and foreseeable risk of surgery. The trial court properly concluded that a person of common knowledge could neither understand the requisite standard of care applicable to each medical professional without expert testimony nor understand defendants' specific responsibilities in caring for James. The common knowledge exception is not applicable under the presented circumstances.

Plaintiffs required expert testimony to establish the standard of care and any deviation from it. They have not done so, and conceded their expert report was not sufficient to establish a prima facie negligence case in the absence of any of the discussed exceptions. Lacking the requisite expert testimony, the trial judges did not err in granting defendants summary judgment and dismissing the complaint.

Affirmed.