SHORT FORM ORDER

INDEX No. 09-38345
CAL. No. 10-02156MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 32 - SUFFOLK COUNTY

PRESENT:

Hon. W. GERARD ASHER
Justice of the Supreme Court

MOTION DATE 5-31-11
ADJ. DATE 8-2-11
Mot. Seq.# 002 - MG; CASEDISP

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SHU YING LEE, as Administratrix of the Estate of KITMAN LEE and SHU YING LEE, Individually,

Plaintiffs,

- against -

NEW YORK ORGAN DONOR NETWORK, INC.,

Defendant.

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Upon the following papers numbered 1 to 2 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1 - 11 ; Notice of Cross Motion and supporting papers ____; Answering Affidavits and supporting papers 12 - 19 ; Replying Affidavits and supporting papers 20 - 28 ; Other joint exhibits A - WWWW ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion (002) by defendant New York Organ Donor Network, Inc. for summary judgment dismissing the complaint is granted.

In this negligence action, plaintiff Shu Ling Lee, as Administratrix of the Estate of Kitman Lee, and individually, seeks damages for injuries sustained by decedent Kitman Lee ("the recipient plaintiff") for the care and treatment the recipient plaintiff received from March 31, 2007 through July 25, 2007. The recipient plaintiff underwent a liver transplant. Plaintiff alleges, in the bill of particulars, that defendant New York Organ Donor Network, Inc. ("NYODN") was negligent in failing to properly evaluate the suitability of the donor's organs for transplantation, failing to promptly review the donor's medical records before approving transplantation of his organs, approving and facilitating the harvesting of cancerous and diseased organs for transplantation into the recipient's body, accepting organs from a

donor with reported bacterial meningitis without identifying the organism or verifying the diagnosis, and failing to learn the true cause of death before the donation occurred.

By order dated June 18, 2009 (Cohen, J.), the Court directed that this action would be tried jointly with six related actions.[1] By order dated October 26, 2010 (Cohen, J.), the Court directed the parties to submit a single set of joint exhibits for all summary judgment motions, consisting of, *inter alia*, the pleadings, bills of particulars, deposition testimonies of the parties, the donor's medical records from Southampton Hospital and Stony Brook University Medical Center ("Stony Brook"), the recipient's medical records from NYU Hospital Center ("NYUHC"), and the NYODN donor packet.

The record reveals that the recipient plaintiff received a liver transplant from a pediatric patient ("the donor"), who had died of bacterial meningitis on March 30, 2007 at Stony Brook. Thomas Diflo, M.D. performed the transplant procedure at NYUHC on March 31, 2007.[2] The donor had been ill since March 3, 2007. He was treated at Southampton Hospital intermittently. During his last admission at Southampton Hospital, a lumbar puncture revealed no bacteria in the central spinal fluid despite a clinical picture of bacterial meningitis with symptoms of severe headaches, vomiting and fainting. His doctors prescribed antibiotics and antiviral medications. His final diagnosis at Southampton Hospital was viral meningitis or encephalitis.

The donor was transferred to Stony Brook on March 13, 2007. Another spinal tap was performed, and, again revealed no bacteria in the cerebral spinal fluid. Further lab tests revealed no viral pathogens either. His attending physician, Kimberly Fenton, M.D., a pediatric intensivist, diagnosed the donor with presumed, partially treated bacterial meningitis. By March 14, 2007, the donor became unresponsive and required assisted ventilation. The donor's Stony Brook medical record revealed that, on March 29, 2007, he had lost all cerebral autoregulation despite maximal medical management and had not improved after a lumbar drain was placed to reduce intracerebral pressure. Dr. Fenton advised the donor's parents, who agreed that no resuscitation should be initiated. In addition, the parents requested organ donation. Dr. Fenton called NYODN and gave the basic demographic information, as well as her diagnosis of presumed partially treated bacterial meningitis. On March 30, 2007, the NYODN staff placed calls to multiple transplant centers to place four of the donor's organs. Later that

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[1] The six related actions are as follows:
Kelly v Fenton, Index No. 3383/08, Action #1
Kelly v New York Organ Donor Network, Index No. 12211/09, Action #2
Trueba v Diflo, Index No. 49098/09, Action #3
Lee v Fenton, Index No. 38346/09, Action #4
Shierts v New York Organ Donor Network, Index No. 12212/09, Action #6
Shierts v Fenton, Index No. 45614/08, Action #7

[2] The donor's parents authorized the donation of four organs. In addition to the donor's liver that was donated to the recipient plaintiff in the instant action, the donor's pancreas was donated to Jodie Lynn Shierts, one of the donor's kidneys was donated to James D. Kelly, and the donor's other kidney was donated to Gerardo Trueba.

evening, the NYODN organ placement coordinator offered the donor's liver to a transplant coordinator at NYU. After reviewing the donor chart provided by NYODN, Dr. Diflo accepted the donor's liver for the recipient plaintiff. The NYODN chart included Southampton Hospital medical records which revealed a diagnosis of viral meningitis.

Plaintiff testified that the recipient plaintiff was diagnosed with liver disease, cirrhosis and hepatitis B sometime in 2002. The recipient plaintiff was placed on the transplant list at NYU and during testing, it was discovered that he had a small cancer, for which chemotherapy was started in 2006. On March 30, 2007, he was notified of the donor liver and underwent transplant surgery performed by Dr. Diflo at NYU, which was uneventful. On May 3, 2007, an autopsy of the donor's brain revealed that he died of a rare form of T-cell lymphoma in his leptomeninges. There is no dispute that such a diagnosis was not known to the donor's treating physicians during the donor's lifetime. Plaintiff recalled that she and the recipient plaintiff were notified of the cancer. One week later, the recipient plaintiff began receiving chemotherapy. They also learned that the recipient plaintiff was not a candidate for another transplant. Soon after beginning chemotherapy, the recipient plaintiff developed the same signs and symptoms of lymphoma that the donor had developed. The recipient plaintiff expired on July 25, 2007.

NYODN now moves for summary judgment dismissing the complaint.

A party moving for summary judgment must make a prima facie showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact (***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]; ***Zuckerman v New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). Of course, summary judgment is a drastic remedy and should not be granted where there is any doubt as to the existence of a triable issue (***Stewart Title Ins. Co. v Equitable Land Servs.,*** 207 AD2d 880, 616 NYS2d 650 [2d Dept 1994]), but once a prima facie showing has been made, the burden shifts to the party opposing the motion to produce evidentiary proof in admissible form sufficient to establish material issues of fact which require a trial of the action (***Alvarez v Prospect Hosp.***, 68 NY2d 320, 508 NYS2d 923 [1986]).

Because an organ donor network does not provide medical services by a licensed physician, the gravamen of the complaint as asserted against it sounds in negligence, and not medical malpractice (*see* ***Rodriguez v Saal***, 43 AD3d 272, 841 NYS2d 232 [1st Dept 2007], *see also* ***Bleiler v Bodnar***, 65 NY2d 65, 489 NYS2d 885 [1985]; ***Boothe v Lawrence Hospital***, 188 AD2d 435, 591 NYS2d 412 [1st Dept 1992]).

NYODN has made a prima facie showing of its entitlement to judgment as a matter of law on the ground that it was not negligent (***Starr v Rogers***, 44 AD3d 646, 843 NYS2d 371 [2d Dept 2007]; ***Whalen v Victory Memorial Hosp.***, 187 AD2d 503, 589 NYS2d 590 [2d Dept 1992]). In support of the motion, NYODN submits the joint exhibits, a copy of the United Network of Organ Sharing ("UNOS") policies, and the affidavits of Richard D. Hasz, Jr. and Robert S. Gaston, M.D.

The record reveals that Suzanne Kontak, a clinical manager employed by NYODN, received a call from non-party Kimberly Fenton, M.D. at Stony Brook about the donor's imminent death on March

29, 2007. Kontak stated that she completed a master's degree in adult health nursing, a bachelor's degree in nursing, and training in critical care nursing. Kontak obtained the donor's general demographic information and the cause of death from Dr. Fenton, which she testified, did not screen out the donor's organs as unsuitable for transplantation. If she had been told by Dr. Fenton that the donor had lymphoma, the donor's organs would not have been considered as suitable, and Kontak would have closed the case with regard to solid organ donation. Kontak and a colleague went to Stony Brook to gather information about the donor, approach the family and obtain their consent to offer the donor's organs for transplantation. She testified that she was in contact with her administrator on-call throughout the evening, and provided her with the donor's history and routine updates. She drew blood for infectious disease tests to determine whether the donor had HIV, which would automatically rule out the donor. Kontak testified that she collected the information that the hospital had maintained on the donor and entered it into a computerized form used by NYODN employees. In addition, the information was entered into DonorNet, which the transplant centers could access. Kontak stated that she does not make decisions on behalf of the transplant centers and does not act as a diagnostician. Kontak stated that she spoke to non-party Josh Schiller, M.D. and Dr. Fenton, the donor's physicians. The record reveals that on March 30, 2007, NYODN organ placement coordinators notified potential transplant centers that the donor's organs were going to be available for transplantation. She stated that she was aware that there were questions from several of the transplant centers about the donor's diagnosis of partially treated bacterial meningitis. Kontak testified that the decision to accept an organ of a patient who may have meningitis would be based solely on the protocols of the individual transplant center. Dr. Diflo stated that he relied upon the decision of his colleague, Glyn Morgan, M.D., who accepted the donor's liver for the recipient plaintiff, and had made an extensive inquiry about the medical history. He also stated that there were no gross abnormalities in the liver when he transplanted it into the plaintiff recipient. The plaintiff recipient's surgery and recovery were unremarkable. When the donor's cause of death was relayed to him, he immediately called the plaintiff recipient to return to the hospital for tests and chemotherapy.

Eric Francisco testified that he was employed by NYODN as a transplant placement coordinator. He worked at the NYODN office in Manhattan on March 30, 2007, from 7:00 p.m. to 7:00 a.m., and worked with Sue Kontak, the on-site coordinator. He stated that his duty was to contact the transplant centers who determined whether or not they would accept a potential organ. If a recipient center rejects the organ, a code is entered into the computerized record. He stated that some of the rejections related to the recipient's condition, and some rejections related to the donor's organ. He stated that several centers rejected this donor's organs; however, this was not an unusual occurrence. He recalled speaking to Dr. Scott Ames, a transplant surgeon at Mount Sinai Hospital who requested more information about the donor's cultures. Francisco told him that there was no positive culture, and Ames declined the organs. Francisco stated that if a transplant surgeon or transplant center staff member calls with a question, he calls the on-site coordinator, Sue Kontak, and asks the question, and relays the answer back to the transplant surgeon/center.

David O'Hara testified that he was also employed by NYODN as a transplant placement coordinator, worked on March 30, 2007 and March 31, 2007, and made contact with the transplant centers to offer the donor's pancreas. He recalled speaking to Dr. Lloyd Ratner, a transplant surgeon at New York Presbyterian/Columbia Hospital, who requested further information regarding the donor's

cultures, which O'Hara provided. He stated that Dr. Ratner rejected the organ. O'Hara's testimony supported that of Kontak and Francisco. O'Hara also stated that it was not his practice to tell transplant surgeons why other surgeons declined an organ.

The UNOS guidelines reveal that the National Organ Transplant Act of 1984 called for an organ procurement and transplantation network ("OPTN") to be created and run by a private, non-profit organization under federal contract. UNOS was first awarded the national OPTN contract in 1986 by the U.S. Department of Health and Human Services, and is the only organization ever to operate the OPTN. UNOS established an organ sharing system that maximizes the efficient use of deceased organs through equitable and timely allocation, and established a system to collect, store, analyze and publish data pertaining to the patient waiting list, organ matching and transplants. UNOS has also provided information, consultation and guidance to persons and organizations concerned with human organ transplantation in order to increase the number of organs available for transplantation. UNOS relies upon federal guidelines to govern NYODN's actions.

Richard D. Hasz avers that he is the vice president of clinical services at an Organ Procurement Organization ("OPO") in the northeastern United States, and has been certified as a procurement transplant coordinator by the American Board for Transplant Certification. It is his opinion that the actions of NYODN, in connection with the donation of the donor's organs, conformed to the standard of care pursuant to UNOS guideline 4.6.2, which was in effect in 2007.[3] In addition, he states that there are strict limitations on transplant coordinators' involvement in the donation process. The coordinator is not a physician and is not qualified to render medical opinions. The coordinator's job is to gather clinical data from the donor hospital and transmit the information to the potential transplant centers. He states that NYODN did not depart from the 2007 standards of the donation community in connection with the donation of organs from the donor. NYODN was required to offer the donor's organs inasmuch as the cause of death was identified by Stony Brook physicians as bacterial meningitis and organs of such donors must be offered to the transplant centers. NYODN reported the clinical information that the donor had been diagnosed with viral meningitis at Southampton, he was diagnosed with bacterial meningitis at Stony Brook, and none of his cultures were positive. In addition, Mr. Hasz opines, that because the UNOS guidelines permitted the organ offer despite the diagnoses of bacterial meningitis and viral meningitis, NYODN did not depart from the standard of care as set by UNOS.

Dr. Gaston states that he is a physician duly licensed to practice medicine in the State of Alabama and is board certified in internal medicine and nephrology. He states that NYODN, an OPO, must initially determine whether the donor is believed by his treating physicians to have an illness that would automatically disqualify the potential donor's organs from transplantation, such as HIV. If not, then, UNOS guidelines require the OPO to offer the organs to the transplant centers. The secondary screening

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[3] UNOS guideline 4.6.2, Screening Potential Organ Donors For Transmission of Diseases or Medical Conditions, Including Malignancies, provides, in part, that known conditions that may be transmitted by the donor organ must be communicated to the transplant centers, including, in particular, unknown infection of the central nervous system (encephalitis, meningitis), suspected encephalitis, [and other diseases].

is performed by the transplant centers and their surgeons to determine ultimate suitability, since they are in a position to make the necessary clinical judgments about the ultimate suitability of the organs and are also the ones who have access to the condition of the potential recipient. The surgeons go through a risk-benefit analysis for each recipient, and, as non-party Dr. Ty Dunn, a transplant surgeon, testified in her deposition, that they consider the relative life-saving potential of the organ and how the potential recipient patient is doing. She also stated that she would not automatically reject an organ from a donor who was diagnosed with viral meningitis. Some patients' extreme need for organs can change the risk-benefit analysis. Dr. Gaston stated that in the past, donors' organs diagnosed with bacterial meningitis, without positive cultures, have been offered for transplantation. It is up to the transplant surgeons to determine whether to accept the donor hospital's diagnosis and take the organs as well as the risks. Dr. Gaston states that, in this case, the donor was misdiagnosed by Stony Brook with bacterial meningitis; however, it was still the duty of NYODN to report that diagnosis. He further states that the contract between NYODN and NYU Hospital Center reveals that the hospital has the sole discretion and responsibility to determine whether the offered organs are usable and suitable for the transplant candidates.

The burden then shifted to plaintiffs to respond with rebutting medical evidence demonstrating a departure from accepted medical practice to raise an issue of fact as to whether NYODN was negligent (***Alvarez v Prospect Hosp.***, *supra*). Plaintiffs failed to meet this burden. In opposition, plaintiffs submit the affidavits of Paul W. Nelson, M.D., and Arnold N. Weinberg, M.D. Dr. Nelson avers that he is licensed to practice medicine in the States of Missouri and Indiana. He is a transplant surgeon and is board certified in surgery. He states that NYODN breached its duty to plaintiffs. He concedes that the donor's rare cancer was not diagnosed, or apparently considered in the differential diagnosis, by the medical teams taking care of him. He states, however, that the diagnosis of bacterial meningitis was never substantiated or confirmed, and concludes that the donor had viral meningitis, which would have made the organs unsuitable for transplantation.

Dr. Nelson further states that Kontak, the NYODN transplant coordinator, should have involved her medical director in deciding whether the donor's organs were suitable for transplant in light of conversations had between the organ placement coordinators and transplant surgeons who rejected the organs. Although he states that the Southampton Hospital medical record was not uploaded to DonorNet, he concedes later in his affidavit that the records were uploaded. He also states that NYODN cannot merely sit back and shirk all responsibility for offering cancerous organs simply because a transplant surgeon ultimately accepted them.

Dr. Weinberg avers that he is a physician duly licensed to practice medicine in the State of Massachusetts. He is board certified in internal medicine. Dr. Weinberg concurs with Dr. Nelson, and also states that factors which contradicted a specific diagnosis of bacterial meningitis should have alerted NYODN to find the organs unsuitable for transplant, and that NYODN staff should have informed Dr. Darras about the discussions they had with transplant surgeons who rejected the organs. In addition, Dr. Weinberg opines that, although the diagnosis of a viral process ultimately was incorrect, it would have been a strong contraindication to transplantation given the donor's course prior to his death.

In reply, NYODN contends that Kontak did notify the medical director, Eric B. Grossman, M.D., who states in his personal affidavit that he was extensively involved in NYODN's offer of the donor's organs. After several conversations with NYODN staff while the organs were being evaluated and offered for transplantation, he directed NYODN staff to include in its records the Stony Brook physicians' justification for making the bacterial meningitis diagnosis, the facts on which they relied in making this diagnosis, and the consultation note of their infectious disease consultant. He further stated that it would have been in the transplant surgeons' discretion to exercise their clinical judgment about whether they wished to accept the donor's organs in view of the information conveyed to them by NYODN about the two diagnoses at the two hospitals where the donor was admitted during his last illness and the individual medical condition of their recipient patient.

Plaintiffs have failed to raise an issue of fact inasmuch as their experts did not address the UNOS guidelines which govern the donation of organs. In addition, plaintiffs' experts speculate that Dr. Diflo would have decided differently if he was told about the conversations between other transplant surgeons who rejected the organs and NYODN staff (***Zuckerman v New York***, *supra*). Moreover, the experts' opinions regarding the diagnosis of viral meningitis are not supported by the evidence in the record, inasmuch as all viral tests conducted at Stony Brook were negative (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 324-5, 508 NYS2d 923 [1986]).

The Court acknowledges the tragic circumstances which led to the commencement of the instant action, and extends its sympathy for everyone involved, including the donor and his parents, the medical providers, the NYODN staff, the recipient plaintiff and his family. In addition, the Court notes that the donor's parents willingly waived HIPAA[4] restrictions (*see* ***Liew v New York University Medical Center***, 55 AD3d 566, 865 NYS2d 278 [2d Dept 2008]), openly provided their son's confidential medical records, and disclosed his ultimate diagnosis in order to help the recipient plaintiff. The Court finds that all parties acted responsibly by notifying the recipient plaintiff as soon as it was known that the donor had cancer, affording the recipient plaintiff all possible care and treatment possible. Unfortunately, inasmuch as it is not the standard of care to perform a biopsy upon a donor organ prior to transplantation, it was not foreseeable that the donor could have had cancer, this Court is constrained by the law to render this determination.

Accordingly, under the circumstances presented and the prevailing law, NYODN's motion for summary judgment dismissing the complaint is granted.

Dated: March 30, 2012

W. Gerard Asher
J.S.C.

__X__ **FINAL DISPOSITION** ____ **NON-FINAL DISPOSITION**

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[4] HIPAA is the Health Insurance Portability and Accountability Act of 1996 (see Pub L 104-191, 110 U.S. Sat 1936).