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SHORT FORM ORDER

ORIGINAL WHEN BLUE

INDEX No. 08-9451
CAL. No. 13-02076MM

COPY

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 50 - SUFFOLK COUNTY

***PRESENT:***

Hon. ANDREW G. TARANTINO, JR.
Acting Justice of the Supreme Court

MOTION DATE 4-16-14 (#014)
MOTION DATE 4-29-14 (#016)
ADJ. DATE 10-14-14
Mot. Seq. # 014 - MG
# 016 - MD

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DEBORAH BELUS, as Administratrix of the Estate of BETSY BELUS, deceased,

Plaintiff,

- against -

SOUTHSIDE HOSPITAL, WILLIAM ONYEBEKE, M.D., MAAN SHIKARA, M.D., SCOTT WODICKA, M.D., and JAMES SHASHASTY, P.A.,

Defendants.

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Upon the following papers numbered 1 to 46 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (014) 1-19; (016) 20-22; Notice of Cross Motion and supporting papers ; Answering Affidavits and supporting papers 23-28; Replying Affidavits and supporting papers 29-32; 33-38; Other 39-45; (~~and after hearing counsel in support and opposed to the motion~~) it is,

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***ORDERED*** that motion (014) by defendants James Shashasty, P.A., s/h/a James Shashasty, PA., and Southside Hospital pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted; and it is further

***ORDERED*** that motion (016) by defendant William Onyebeke, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied.

Deborah Belus, as Administratrix of the Estate of Betsy Bellus, decedent, seeks damages premised upon the alleged negligent departures from good and accepted standards of medical care and treatment, negligent hiring, wrongful death, and lack of informed consent involving the care and treatment of the decedent. An action was commenced under Index No. 08-9451 against defendants Southside Hospital and William Onyebeke, M.D. A second action was commenced under Index No. 09-30337 against defendants Maan Shikara, M.D., Scott Wodicka, M.D., and James Shashasty, P.A. These actions were consolidated pursuant to an order dated April 26, 2010 (Cohalan, J.).

Decedent, Betsy Bellus, was a twenty-two year old female with a history of seizures and mental retardation. She was also a Jehovah's Witness and, based upon religious grounds, refused blood products. She came under the care of defendant Dr. Onyebeke on May 23, 2007 for problematic fibroids of the uterus with irregular periods, pelvic pain, and heavy bleeding. On August 7, 2007, the decedent was admitted to Southside Hospital by Dr. Onyebeke for "bloodless surgery" consisting of myomectomies with possible hysterectomy. Pre-operatively, Procrit was administered by injection to raise her hemoglobin and hematocrit levels. Postoperatively, the decedent experienced some bleeding, and was discharged on August 9, 2007. On August 11, 2007, the decedent returned to the emergency room at Southside Hospital with abdominal pain and vomiting, and was admitted by Dr. Maan Shikara, at the request of Dr. Murphy who was covering for Dr. Onyebeke. Dr. Wodicka, the chief of surgery, assumed decedent's care on August 12, 2007, and Dr. Onyebeke resumed decedent's care on August 13, 2007. Subsequent surgery was performed by Dr. Wodicka on August 17, 2007, and despite antibiotic therapy, the plaintiff developed progressive ARDS, bronchopneumonia, renal failure, leukocytosis, and sepsis. She died on September 19, 2007 at Southside Hospital.

In motion (014) defendants James Shashasty, P.A. and Southside Hospital seek summary judgment dismissing the complaint as asserted against them. They have also submitted a stipulation discontinuing the action with prejudice, signed by counsel for the plaintiff and counsel for Shashasty and Southside Hospital. It is noted that the stipulation of discontinuance, however, has not been signed by counsel for defendants William Onyebeke, M.D. and Maan Shikara, M.D. It is noted that defendants Onyebeke and Shikara have not asserted cross claims against co-defendants Shashasty and Southside Hospital, and have not moved to amend their answers to assert cross claims against them. At this time, defendants Onyebeke and Shikara have not submitted expert affirmations in support of any allegation of medical malpractice as against Shashasty and Southside Hospital, and have not otherwise opposed defendants' motion for summary dismissal of the complaint against them. It is further noted that defendants Shashasty and Southside Hospital have submitted the expert affirmation of Howard Nathanson, M.D. in support of their application. Dr. Nathanson set forth the decedent's history, care and treatment during her admission, the standards of care with respect to postoperative care, discharge and the care provided upon readmission. It is Dr. Nathanson's opinion within a reasonable degree of medical certainty that defendants Shashasty and Southside Hospital did not depart from the standard of care in the treatment and care provided to the decedent, and they did not proximately cause the injuries or death suffered by the decedent.

Accordingly, motion (014) is granted and the complaint as asserted against defendants James Shashasty, P.A. and Southside Hospital is dismissed.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage. To establish liability of a physician for medical malpractice, plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries (***Fink v DeAngelis***, 117 AD3d 894, 986 NYS2d 212 [2d Dept 2014], *quoting* ***DeGeronimo v Fuchs***, 101 AD3d 933, 936, 957 NYS2d 167 [2d Dept 2012], *quoting* ***Stukas v Streiter***, 83 AD3d 18, 23, 918 NYS2d 176 [2d Dept 2011].) "Accordingly, '[a] physician moving for summary judgment dismissing a complaint alleging medical malpractice must establish, prima facie, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries'" (***Fink v DeAngelis***, 117 AD3d 894, *supra*, *quoting* ***Gillespie v New York Hosp. Queens***, 96 AD3d 901, 902, 947 NYS2d 148 [2d Dept 2012]). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden" (***Matos v Khan***, 119 AD3d 909, 2014 WL 3732819 [2d Dept 2014]; *see* ***Stukas v Streiter***, 83 AD3d at 30, *supra*).

Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (***Lau v Wan***, 93 AD3d 763, 940 NYS2d 662 [2d Dept 2012]; ***Micciola v Sacchi***, 36 AD3d 869, 828 NYS2d 572 [2d Dept 2007]; ***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 690 NYS2d 762 [3d Dept 1999]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

Turning to motion (016), William Onyebeke, M.D. testified at his examination before trial that he is licensed to practice medicine in New York and Pennsylvania, and is board certified in obstetrics and gynecology. He has had admitting privileges as an attending physician at Southside Hospital since 1992. He maintains a private practice by himself and the plaintiff was referred to him by another physician. He had some recollection of the decedent, and remembered that she was a Jehovah's Witness who would not take any blood or blood products. He testified that the Jehovah's Witness Community said he was the "guy" to perform surgery because he does bloodless surgery work. By that, he stated, it was meant that he does the operation without giving blood products. He had performed bloodless surgery on other patients previously,

and had a link on his website to "Bloodless Society," an organization which performs surgery without administering blood products.

Dr. Onyebeke stated that the hospital record set forth that the decedent was a bloodless MED level 1, which meant she was an absolutionist who chooses death over blood transfusions, whole blood, plasma, platelets, or red cells. However, during her second admission, he thought that the decedent's Jehovah Witness proxy indicated that she might be willing to accept some minor blood fractions, but the details would have to be discussed with her if she is conscious, or with her health care agent in case of her incapacity. Dr. Onyebeke stated that Hemopure, is an extract of hemoglobin, and requires FDA approval for use. He continued that there was a group effort to get the Hemopure, but the FDA did not approve its use because the decedent was not sick enough. He stated that he spoke forcefully to her family, recommending that Hemopure be administered to the decedent during the second admission because she was so anemic, and not responding to treatment with Procrit, iron, and antibiotics. He continued that Hemopure is not blood, but is just pure hemoglobin and is not actually blood or formulated blood cells. He also testified that albumin or erythropoietin can also be given. Because the decedent was not a minor, they did not go to court to get an order to administer blood products as she had a right to refuse blood.

Dr. Onyebeke testified he met the decedent on May 23, 2007, upon referral by Dr. Maan Shikara, the plaintiff's family physician. She was a 26 year old, 236 pound female, with a history of seizures, fibroid uterus, pelvic pain, and irregular menstrual periods which were treated with Depo-Provera by injection to stop the bleeding. Upon review of a March 21, 2007 transabdominal pelvic ultrasound, and an examination of the decedent, he determined that she had a lower abdominal mass consistent with a large fibroid uterus. He ordered blood cell counts, slow iron three times a day, multivitamins, and Procrit 40,000 units subcutaneously weekly, to maximize her hematocrit up to super normal levels. He never considered her to be anemic. Preoperatively, he had concerns with blood loss and infection with surgery because her uterus was large, so the surgery would take longer, and increase the chances of infection and blood loss. She had a return visit on June 8, 2007. An abdominal MRI was ordered. It was his understanding prior to the surgery that the decedent did not want any blood or blood products administered to her. However, he considered the risks of death, infection, or stroke as a consequence of her refusing blood or blood products, which he communicated to her and her family. Dr. Onyebeke testified that he never spoke to the decedent alone, only with her mother present. He felt the decedent understood when he communicated with her. On July 13, 2007, his diagnosis was fibroid uterus. He felt she needed surgery as it was her best option due to the large size of the uterus. However, he continued, her other options were to continue having pain and bleeding, and continue Depo-Provera injections and other medication for the bleeding.

Dr. Onyebeke stated that, assisted by James Shashasty, P.A., he performed surgery on the decedent on August 7, 2007, consisting of a myomectomy on the uterus and excision of a lesion on the vulva. Preoperatively, he also discussed the possibility of a total abdominal hysterectomy. During surgery, he administered an antibiotic, and used a vasopressor to reduce blood loss. The decedent refused Cell Saver, an apparatus used during surgery to collect the blood that is being lost during surgery, and the blood is then purified and infused back into the patient in a closed-loop system. There were no complications however, postoperatively the decedent had some vaginal bleeding, as noted by the nursing staff, so he ordered that he was to be notified if the hematocrit fell below 30.0 or the hemoglobin below 10. He ordered a stat H & H (hemoglobin and hematocrit). She was to be observed for further bleeding. He did not examine her. Dr. Onyebeke testified that the postoperative nursing note indicated that the plaintiff was having a large amount of vaginal bleeding at 4:29 and 4:35 p.m. At 5:15 p.m., there was less bleeding. Dr. Sallusto, the

anesthesiologist was notified that the decedent's systolic pressure was 90 or below. Normal Saline was infused rapidly. Dr. Onyebeke came in to see the decedent at 6:30 p.m.

Dr. Onyebeke testified that after surgery, the plaintiff became anemic because she lost some blood during surgery, so he started her on Procrit. Blood work drawn on August 7, 2007 at 19:16 revealed a hematocrit of 32.6. On August 8, 2007, her hematocrit was 28.7, hemoglobin 9.7, white count 20.5, and platelet count 164,000. He discharged her on August 9, 2007, after having seen her at 8:00 a.m. He stated that he must have seen the blood work results prior to discharge. He was not concerned about the results and considered her to be hemodynamically stable as her vital signs were normal, and she did not have an infection.

The decedent had a second admission to Southside Hospital by Dr. Shikara on August 11, 2007, for vomiting, possible small bowel obstruction, stroke, ileus, and for surgical consult. Dr. Onyebeke testified that he first saw her on August 13, 2007, as Dr. Murphy was covering for him prior to that day. His note indicated her abdomen was slightly distended. He set forth the laboratory values from various tests, and radiology studies. He indicated that her bowels were not moving, consistent with ileus. He considered her to be mildly anemic with a hematocrit of 26.8, and ordered antibiotics, Venofer, and Procrit. He wanted all blood draws held to prevent iatrogenic anemia. He described his findings of August 14, 2007, and indicated that her hematocrit was maintaining. He continued to set forth his findings on subsequent visits. He discussed surgery with Dr. Scott Wodicka who performed an exploratory laparotomy with evacuation of a pelvic hematoma, and decompression of small bowel, on August 17, 2007. On August 21, 2007, decedent was noted to have tachycardia at 117, and appeared weak. Later that day, she was intubated for respiratory failure due to ARDS (acute respiratory distress syndrome) and sepsis (infection due to bacteria), and transferred to ICU. By August 23, 2007, decedent's hemoglobin was 7, hematocrit 20.9. Procrit was ordered daily for three days and blood work was minimized. Dr. Onyebeke did not include a diagnosis of sepsis on that date. He was unsure if he called an infectious disease consult.

Dr. Onyebeke continued to describe the care and treatment provided. On August 28, 2007, the decedent's hemoglobin was 5.8, hematocrit 16.9, platelet 193,000. On August 29, 2007, the decedent's incision was opened at the upper pole and pus was expressed, which Dr. Onyebeke testified indicated a local infection. Antibiotics were to be determined by infectious disease for gram negative rods. On September 4, 2007, he had discussions with the decedent's family about her condition, and administration of Hemapure and fractions. He believed Albumin, Venofer and Procrit were to be administered, but the decedent refused Albumin, and agreed to take erythropoietin. On September 5, 2007, the decedent's hemoglobin was 5.8, hematocrit 18, white count 22,100, and platelet 677,000. On September 6, 2007, the decedent's hemoglobin was 8.5, hematocrit 25.9, white count 29,800. She had a significant fever of 103. Renal and hematology consults were obtained. Dr. Rizvi wrote an order advising the other attending physicians not to change his orders as it has been a long, hard struggle to get the H&H up to 15 from 5, and 24 from 8. He continued Procrit and iron.

Dr. Onyebeke stated that on September 10, 2007, he had a discussion with the family about transfusing the decedent, but the decedent's mother and twin sister refused, even to the point of her death. She was still on the vent and doing poorly. Respiratory support, antibiotics, and an antifungal, were continued. On September 11, 2007, an immunity workup was ordered for HIV-AIDS or other conditions to ascertain if the decedent was immunocompromised. A discussion concerning Hemopure was had with pharmacy. The FDA resisted the use of Hemopure for the decedent, as reflected by the note of September 13, 2007. Dr. Onyebeke stated that the decedent had been critically ill since being admitted to ICU, but on September 17, 2007, he

advised the family that the decedent needed blood and could not fight the infections without it. On September 18, 2007, the decedent's H&H was 6.8 and 21.6, white count 22.8, and platelet 304,000. He noted chest tubes for bilateral pneumothorax. Her condition was grave, he stated. The decedent died on September 19, 2007 at 2:45 p.m. It was his opinion that had the decedent received blood, she would have lived. He felt that she had an infection which contributed to her not responding well to erythropoietin and other agents being used to bring her blood count up. He did not feel the decedent had a hematoma postoperatively, just an accumulation of fluid from the oozing due to removal of the fibroid. The family refused autopsy, but he later learned they had a private autopsy done. He did remember receiving a telephone call advising that Betsy Belus died. He recommended that an autopsy be performed so they could be more sure of her cause of death, but the family refused. He felt she died from complications from anemia, and that the surgery he performed did not cause the anemia. He described anemia as low hemoglobin and hematocrit insufficient to perfuse the organs or carry enough nutrients to the organs. He added that the anemia also caused a complication of inability to fight infection.

In support of his application, Dr. Onyebeke submitted, inter alia, the expert affirmation of Michael Arato, M.D., a physician licensed to practice medicine in New York and board certified in obstetrics and gynecology. Dr. Arato indicated the records and materials he reviewed. Dr. Arato opined that at all times Dr. Onyebeke comported with good and accepted medical practice and that Dr. Onyebeke's treatment was not the proximate cause of the decedent's injuries or death.

Dr. Arato set forth the decedent's history, and indicated the decedent was a Jehovah's Witness who refused blood transfusions of any type based on religious beliefs. She had a history of mental retardation and seizures. She presented on May 23, 2007 to Dr. Onyebeke with complaints related to uterine fibroid, heavy bleeding, and pelvic pain, having been diagnosed in 2000 and treated with Depo-Provera for four years to stop the bleeding. Dr. Onyebeke, he continued, examined the decedent, confirmed a large abdominal mass consistent with fibroids, and determined surgical removal of the fibroid was the only viable option since medical management became inadequate.

Dr. Arato continued to describe the decedent's subsequent office visits with Dr. Onyebeke, whose plan was to build the decedent up prior to surgery as post operative bleeding is the number one complication associated with this type of surgery, and is adversely increased by the size of the fibroids, which, in this case, were large. The increase in the hemoglobin and hematocrit is ideal for a person who refuses blood and blood products. He stated that it is a good practice to elevate the hemoglobin and hematocrit prior to surgery in anticipation of blood loss. Dr. Arato stated the decedent signed a release after a discussion of the risks and benefits, stating if any injury, including death, was caused by the physician's inability to transfuse, she would hold the physicians and hospital harmless.

Dr. Arato indicated that on August 7, 2007, the decedent was admitted to Southside Hospital, where Dr. Onyebeke performed surgery consisting of an exploratory laparotomy with myomectomies, removal of a skin lesion, and insertion of On-g for pain control. He opined that the surgery was done in accordance with good and accepted practice and good operative techniques. Because the decedent would not accept blood or blood products, Dr. Onyebeke injected the uterus with saline mixed with two ampules of vasopressin to decrease bleeding. A lineal incision was made, and one large myoma, which occupied the whole uterus, was removed. Blood loss, he stated, was minimal. Dr. Arato noted that postoperatively at 4:50 p.m., the decedent was having heavy bleeding, as reported by nursing, but less bleeding was noted thereafter. He indicated that

the bleeding is not uncommon and is somewhat expected after surgery of this type. He continued that Dr. Onyebeke anticipated the bleeding and elevated the hemoglobin and hematocrit preoperatively. The hemoglobin and hematocrit decreased to preoperative levels due to the blood loss and hemodilution. The following day, the hematocrit was 28.7, with an expected elevated white blood count as a product of stress surgery. The decedent was discharged without a fever on August 9, 2007.

Dr. Arato stated that the H&H remained stable until after the surgery performed on August 16, 2007 by Dr. Wodicka. She had been readmitted to Southside Hospital through the emergency room on August 11, 2007, by Dr. Maan Shikara, due to sudden onset vomiting, abdominal pain, and digestive system complications, including constipation due to anesthesia and pain medication. Dr. Arato stated that in the emergency room, an abdominal x-ray revealed air fluid levels and a dilated loop of bowel; significant small bowel dilatation with collapse of the distal ileum; moderate amount of gas in the transverse colon; an enlarged uterus with postoperative changes; and complex free fluid in the pelvis, likely a hematoma; and a moderate amount of free fluid in the upper abdomen, without abscess formation. Dr. Arato stated the diagnosis was early small bowel obstruction versus ileus; treatment of the ileus falls within the specialty of internal medicine. If there is a small bowel obstruction which does not respond to conservative therapy, it falls within the field of surgery. He stated that neither an ileum nor small bowel obstruction is treated by a gynecologist.

Dr. Arato stated that after surgical consultation, Dr. Wodicka provided conservative management of the decedent with a nasogastric tube to decompress the small bowel, which improved the decedent's condition. On August 12, 2007, Dr. Wodicka noted the abdominal film revealed findings more suggestive of an ileus pattern rather than a partial small bowel obstruction. Dr. Arato stated that Dr. Wodicka testified that the decedent has no signs of an infection from August 11 through August 16, 2007. Dr. Arato stated that he agreed with Dr. Wodicka's opinion that there was no infection during that time, but does not indicate the basis. However, suddenly, on the afternoon of August 16, 2007, the decedent began to experience shortness of breath and was immediately transferred to ICU under the care of a pulmonologist for possible pulmonary embolus, which was ruled out by CT angiogram. She began vomiting that night, and CT angiogram suggested formation of a small bowel obstruction, with increase in the white blood cell count, consistent with new onset small bowel obstruction.

Dr. Arato stated that on August 17, 2007, Dr. Wodicka performed an exploratory laparotomy and found an adhesion band causing the small bowel obstruction; evacuated a pelvic hematoma; decompressed the small bowel; and inserted a right internal jugular vein triple lumen catheter. Dr. Arato stated that according to Dr. Wodicka, the decedent did not have signs of an infection. Dr. Arato stated that the adhesion can form in the abdominal cavity after any type of surgery, and does not speak of malpractice as it is an unavoidable complication from abdominal or pelvic surgery. He continued that from August 17 to 20, 2007, the decedent did relatively well, however, on August 20, 2007, her condition dramatically changed. The five-day culture report of the hematoma which Dr. Wodicka removed during surgery was positive for staph. Dr. Arato stated that this staph had no impact upon the decedent subsequently developing a gram negative sepsis. On August 20, 2007, Dr. Shikara had the decedent seen by cardiology due to an elevated heart rate. On August 21, 2007, when the decedent developed fever, she was transferred to the critical care unit, where an infectious disease consult was obtained. The critical care specialist noted the decedent had ARDS, possible sepsis, and that she was shocky.

Dr. Arato stated that during this admission, the decedent had no gynecological problem. Because her hemoglobin and hematocrit were increasing, on August 16, 2007, neurology and hematology consults were

additionally called in by Dr. Shikara. On August 23, 2007, after the hematology consult by Dr. Rizvi, Dr. Onyebeke reported his findings that the decedent was in poor condition, and that the plan was to minimize blood work. The decedent was intubated, and the diagnoses of ARDS and septic shock were considered. Decedent had a guarded prognosis. With decreasing hemoglobin and hematocrit, and the refusal of blood by the decedent, she began to show early signs of renal failure. Dr. Arata stated that on August 24, 2007, the diagnosis of sepsis was made by infectious disease in that the culture organism was gram negative. Powerful antibiotics were administered. ARDS was worsening due to sepsis and blood loss. Renal function was deteriorating. Metabolic acidosis developed. Dr. Arata stated that despite this worsening condition, which would have likely resolved with early transfusion, the decedent's family and Elders from the Church steadfastly refused transfusions because of their religious beliefs.

Due to the continued refusal to transfuse the decedent by the decedent's family, despite begging, hematology continued treatment to restore blood with Procrit and other modalities, but her condition continued to spiral downward, continued Dr. Arata. In September, 2007, infectious disease consult found C. Difficile based upon large liquid bowel movements. Dr. Arata stated that despite the efforts of infectious disease, critical care, renal, hematology, pulmonology consults, and Dr. Shikara, the decedent continued on the downward spiral. On September 4, 2007, Dr. Onyebeke discussed with the decedent's family the need to transfuse, which was denied. Neurological symptoms developed on September 6, 2007. On September 9, 2007, a fungal infection was diagnosed, which Dr. Arata stated was a poor prognostic sign. Profound anemia was found on September 10, 2007 by hematology, but blood transfusions were still refused by the decedent's family, even to the point of death. The FDA refused to approve attempts to administer Hemapure to the decedent. On September 13, 2007, Dr. Onyebeke ordered testing for immune compromised conditions due to the family advising of prior healing problems. A bleak picture for inevitable death was painted by September 15, 2007, stated Dr. Arata, indicating that Dr. Rizvi wrote that there is nothing else to offer hematologically, and without a transfusion, there is no hope for recovery at this point. The decedent died on September 19, 2007.

Dr. Arata opined that Dr. Onyebeke took reasonable steps prior to surgery to elevate the hemoglobin and hematocrit due to the decedent's religious beliefs and refusal to have blood transfusions or blood products. Vasopressors and cautery were used during the August 7, 2007 surgery to minimize blood loss. Postoperatively, there was bleeding which was anticipated, and which stopped. The hemoglobin and hematocrit stabilized until August 17, 2007 when Dr. Wodicka performed surgery. Dr. Arata opined that the pelvic hematoma is a complication seen in surgeries to remove fibroids, and was easily evacuated by Dr. Wodicka. The culture of the hematoma fluid was gram positive A staph and did not cause the sepsis, which was not suspected until August 21, 2007. The elevated white blood count after the first surgery was due to the stress of surgery, he stated.

While Dr. Arata's affirmation addresses many medical issues which arose during the course of plaintiff's care and treatment, and his opinion that Dr. Onyebeke minimized the oozing or bleeding associated with surgery to remove uterine fibroids, he has omitted to set forth the standard of care to early diagnose such hematoma formation as described by Dr. Wodicka, noted by Dr. Arata, and denied by Dr. Onyebeke, raising factual issues which preclude summary judgment. Dr. Arata stated such bleeding is to be expected, but he does not address the standard of care once bleeding has occurred and a hematoma formed; the cause of the bleeding, or the relationship of the bleeding or hematoma to those adhesions; and whether the need for additional surgeries could have been avoided, or performed, had the hematoma been diagnosed prior to the decedent's discharge on August 9, 2007. Nor does Dr. Arata address the postoperative heavy vaginal bleeding

experienced by the decedent, and the standard of care involving the heavy bleeding, and how Dr. Onyebeke comported with such standard of care. These factual issues preclude summary judgment.

Plaintiff has opposed Dr. Onyebeke's application for summary dismissal of the complaint by submitting the affidavit of her expert, a physician licensed to practice medicine in New York State, who is certified, and recertified, in surgery. He set forth his education and training, and work experience as an attending surgeon in multiple hospitals, as detailed. He set forth the materials and records which he reviewed. It is plaintiff's expert's opinion to a reasonable degree of medical certainty that the care and treatment rendered by Dr. William Onyebeke departed from good and accepted practice and was a substantial factor in causing harm to Betsy Belus, the decedent, including bleeding, pelvic hematoma, small bowel obstruction, severe sepsis, septic shock, acute respiratory distress syndrome, mechanical ventilation, acute renal failure, need for exploratory laparotomy, evacuation of pelvic hematoma and release of obstructed small bowel, multiorgan failure, profound anemia, fear of impending death, autopsy confirmed death from failure to control infection.

The plaintiff's expert set forth the decedent's history, including long-standing treatment for fibroids of the uterus, irregular periods, pelvic pain, heavy bleeding, and the fact that she was a Jehovah's witness who, along with her family, refused blood products on religious grounds. Plaintiff's expert stated that bloodless surgery consisting of myomectomies with possible hysterectomy was planned, along with Procrit injections to raise the red blood count to supernormal levels. He stated that the decedent signed a release, which included in pertinent part, that if any injury, including death was caused by the physician's inability to transfuse blood products, she would hold them harmless. Plaintiff's expert noted that the release did not exculpate Dr. Onyebeke from medical malpractice and that such release is not valid as a matter of public policy.

The plaintiff's expert stated that the discharge summary indicated that Dr. Onyebeke thought the hematocrit on discharge was 32.6, which was actually the postoperative result from August 7, drawn the day before discharge on August 8, 2007. It was actually 28.7. Plaintiff's expert opined that the failure to obtain a blood count on the date of discharge was a glaring error and that the departures from good and accepted postoperative care by Dr. Onyebeke were a substantial factor in the cascade of complications and the death of the decedent which followed.

The plaintiff's expert continued that, on August 11, 2007, upon return to the emergency room at Southside Hospital due to abdominal pain, vomiting, and signs and symptoms of small bowel obstruction, air fluid levels were present on her abdominal x-ray, and CT scan showed significant small bowel dilation, collapsed distal ileum, and findings compatible with a pelvic hematoma. Conservative management was employed with a nasogastric tube decompression and hydration by Dr. Shikara at the request of Dr. Murphy who was covering for Dr. Onyebeke. The decedent was seen by surgeon Dr. Bhjaskaram on August 11, 2007, however, Dr. Wodicka, chief of surgery, assumed decedent's care on August 12, 2007. The bowel obstruction appeared to be resolving over the next few days. Dr. Onyebeke saw the decedent on August 13, 2007. On August 15, 2007, decedent's blood count was 10.1 and 29.8, but by August 16, 2007, decedent had projectile vomiting. A repeat CT scan revealed continued small bowel obstruction with collapse of the distal bowel and colon. The white blood count rose from 12.2 to 16.5, consistent with infection.

The plaintiff's expert stated that Dr. Wodicka took the decedent to surgery on August 16, 2007, removed an adhesive band of omentum, and evacuated a large hematoma within the pelvis which was contributing to the obstruction, as "some collapsed small bowel was delivered from the surrounding area of

the hematoma." Plaintiff's expert stated that, significantly, the hematoma was infected with staphylococcus, as proven by intra-operative cultures taken during the surgery by Dr. Wodicka. Despite aggressive antibiotic therapy with Vancomycin, continued plaintiff's expert, the decedent developed progressive ARDS, bronchopneumonia, renal failure, leukocytosis, sepsis with gram negative rods (later identified as Pseudomonas), and eventually, Candid (fungal) bacteremia. The plaintiff's expert stated that although the decedent received appropriate ICU care and infectious disease consults, and appropriate antibiotic therapy tailored to the changing culture results, the increasingly desperate nature of her deteriorating clinical condition, her weakened state from bowel obstruction, reoperation sepsis, and progressive anemia, rendered her unable to fight off infection, which ultimately claimed her life.

The plaintiff's expert opined that the bleeding in the decedent's pelvis following Dr. Onyebeke's August 7, 2007 surgery, which bleeding went largely ignored by him, lead to a very large hematoma which was a substantial factor in causing the postoperative bowel obstruction, infection of the hematoma, overwhelming sepsis, multiple organ failure, and progressive life-threatening anemia. Dr. Rizvi's consult confirmed that the decedent had no apparent ongoing bleeding, however, she was becoming progressively more anemic, multifactorial due to prior blood loss, sepsis and stress, bottoming out on August 30, 2007 with a hemoglobin of 5.8 and hematocrit of 17.3. The decedent's family did not consent to blood transfusions despite the possibility of death. This came as no surprise to Dr. Onyebeke who knew of decedent's religious convictions prior to the August 7, 2007 surgery. The decedent died on September 19, 2007 despite aggressive treatment with Procrit and Venofer, and an attempt to procure Hemopure which was turned down by the FDA. The plaintiff's expert stated that the autopsy report by Dr. Louis Roh on September 24, 2007, identified "failure of infection control" leading to sepsis and ARDS as the cause of death. The plaintiff's expert continued that the blood left in the decedent's pelvis after the surgery of August 7, 2007 by Dr. Onyebeke was an excellent culture medium and set the stage for infection of the hematoma, bowel obstruction, need for second surgery, and a panoply of infectious complications.

Plaintiff's expert disagrees with Dr. Arata's opinions that Dr. Onyebeke acted in accordance with good and accepted practice in the technical performance of the August 7, 2007 surgery and contends that Dr. Onyebeke's postoperative care likewise fell below the standard of care. According to plaintiff's expert, the blatant disregard of the postoperative bleeding and large pelvic hematoma, disregard of the precipitous drop in hematocrit from 48 to 28.7, nearly 20 points, indicating blood loss between 6-7 units of blood postoperatively, reckless discharge of the decedent on August 9, 2007, without rechecking the H&H, and mistaking the August 7, 2007 blood tests for the August 8, 2007 blood tests indicative of anemia upon discharge, were substantial factors in the decedent's infections and anemic complications, ARDS, multiorgan failure, and death. The sequela culminating in decedent's death could have been prevented by recognizing and treating decedent's postoperative bleeding.

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (***Fink v DeAngelis,*** 117 AD3d 894, *supra*; ***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 [2d Dept 2005]) [s]uch conflicting medical opinions... raise credibility issues, which can only be resolved by a jury" (***Fink v DeAngelis***, 117 AD3d 894, *supra; **DeGeronimo v Fuchs***, 101 AD3d at 936, 957 NYS2d 167 [2d Dept 2012]). Here, there are conflicting factual issues and credibility issues to be resolved by the jury as plaintiff's and defendant's experts have adduced conflicting expert medical opinions.

Accordingly, motion (016) by defendant William Onyebeke, M.D. for summary dismissal of the complaint as asserted against him is denied.

Dated: DEC 03 2014

A.J.S.C.

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