

Papp v NYU Langone Health Sys.

2025 NY Slip Op 33057(U)

July 25, 2025

Supreme Court, New York County

Docket Number: Index No. 805336/2018

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY**

PRESENT: HON. JOHN J. KELLEY PART 56M

Justice

-----X

ROBERT PAPP and YULIYA PYASETSKA,

Plaintiffs,

- v -

NYU LANGONE HEALTH SYSTEM, NYU LANGONE
HOSPITALS, and DR. ELIAS ZIAS,

Defendants.

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INDEX NO. 805336/2018

MOTION DATE 07/23/2024

MOTION SEQ. NO. 003

**DECISION + ORDER ON
MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 003) 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 99, 100, 101, 102, 104, 105, 106, 107, 108, 110

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, common-law negligence, negligent hiring, training, supervision, and retention of health-care personnel, and loss of spousal consortium, the defendants NYU Langone Hospitals and Dr. Elias Zias (the NYU defendants) move pursuant to CPLR 3212 for summary judgment dismissing the amended complaint insofar as asserted against them.¹ The plaintiffs oppose the motion. The motion is granted to the extent that summary judgment is awarded to NYU Langone Hospitals dismissing the amended complaint insofar as asserted against it, and to Zias dismissing the common-law negligence and negligent hiring, training, supervision, and retention causes of action insofar as asserted against him. The motion is otherwise denied.

The crux of the plaintiffs' claim is that, on August 30, 2017, the defendant cardiac surgeon Zias, who then was employed by nonparty New York University School of Medicine,

¹ In a stipulation dated December 18, 2018, the plaintiff discontinued the action insofar as asserted against the defendant NYU Langone Health System.

negligently performed a multiple cardiac bypass procedure on the plaintiff Robert Papp (the patient) because he failed completely to bypass the patient's left anterior descending artery (LAD), leaving the patient later to rely on the placement of a less-effective stent to maintain that artery in a non-occluded condition.

In their amended complaint, in addition to the allegation that Zias improperly performed the surgery by engaging in "unskillful conduct," the plaintiffs alleged that Zias failed to act in accordance with generally accepted medical standards, failed to perform necessary and proper tests and diagnostic procedures, failed promptly, properly, and adequately to diagnose and treat the patient's true condition, and failed to employ necessary, adequate, and professional techniques that would have been proper under the circumstances. They further alleged that Zias failed to recognize various signs, symptoms, indications, and manifestations that the patient presented to him, and failed to heed warning signs that required further procedures. The plaintiffs further alleged that they would also be relying on the doctrine of *res ipsa loquitur*.

In their bills of particulars, they reiterated the allegations set forth in their complaint, and further alleged that Zias committed malpractice by failing to anastomose the LAD bypass to the left internal mammary artery (LIMA), that is, he failed to create a structural connection between those arteries. Specifically, they faulted him for employing a saphenous vein graft to the first diagonal, with a tubular 50% stenosis extending from the proximal to mid segment that was not amenable to percutaneous intervention, and for employing a saphenous vein graft to the first obtuse marginal that was totally occluded and not amenable to percutaneous intervention. They also alleged that Zias anastomosed the LAD to the patient's diagonal artery in contravention of the surgical plan to anastomose the LAD to the LIMA, causing the patient to require further cardiac intervention, including surgery. As in their amended complaint, the plaintiffs alleged in their bill of particulars that they were also relying on the doctrine of *res ipsa loquitur*.

The plaintiffs alleged that, as a consequence of Zias's negligent anastomosis of

the LAD to the diagonal artery, Zias failed to accomplish the goals of the coronary artery surgery, and that the patient was caused to suffer heart malfunction, necessitating the placement of a stent, which presented the patient with a lower likelihood of survival than a proper bypass. They further asserted that the patient's LIMA that was supposed to have been bypassed to the LAD "was not so bypassed, producing an anterior wall defect." With respect to the left internal mammary graft, the plaintiffs alleged that, although that bypass graft appeared patent, the distal vessel did not anastomose to the LAD, in other words, the failure of the bypass graft to anastomose to the LAD rendered it nonfunctional. In addition, they averred that the patient was later compelled to undergo percutaneous coronary intervention of the proximal to mid LAD, while his second obtuse marginal vessel in the mid segment evinced a 70% stenosis just prior to the bifurcation of a lateral branch. The plaintiffs alleged that there was competitive flow in the bypass graft in the circumflex, and that the right coronary artery was totally occluded in its proximal segment, which had been known from pre-bypass angiography. In addition, they contended that the saphenous vein graft to the first obtuse marginal was totally occluded. The plaintiffs further averred that, as a consequence of Zias's tortious conduct, the patient suffered from weakness, shortness of breath, and permanent and daily increased risk of cardiac arrest, and that he temporarily lost his livelihood as a pilot due to the loss of his Federal Aviation Administration (FAA) approval on health grounds.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see CPLR* 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Flanders v Goodfellow*, _____ NY3d _____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *Vega v*

Restani Constr. Corp., 18 NY3d 499, 503 [2012]). In other words, “[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility” (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; see *Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (see *Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant’s failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]). “The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even ‘arguable’” (*De Paris v Women’s Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; see *Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff’s case, but must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

“To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff’s injury” (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Foster-Sturup v Long*, 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Such a cause of action may be premised upon a claim that those departures allowed a patient’s condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (see

Mortensen v Memorial Hosp., 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]).

In support of their motion, the NYU defendants submitted, among other things, the pleadings, the plaintiffs' bills of particulars, relevant medical and hospital records, medical reports, the patient's employment records, the transcripts of the parties' deposition testimony, the note of issue, an attorney's affirmation, and the expert affirmation of board-certified thoracic surgeon Michael Argenziano, M.D.

Dr. Argenziano opined that Zias did not depart from good and accepted medical practice in performing the multiple bypass procedure, that the medical records from the plaintiff's subsequent treating cardiologist, Robert J. Kayser, Jr., M.D., did not establish that the patient's distal LIMA failed to anastomose to the LAD, and that nothing that the defendants did or did not do caused or contributed to patient's alleged injuries.

Dr. Argenziano first recounted the patient's medical history, noting that the patient, who was then 53 years old, presented to Zias's office on August 18, 2017, with a chief complaint of coronary artery disease. He noted that the patient smoked one pack of cigarettes per day, and that the patient previously had been diagnosed with elevated blood pressure on a routine physical examination, for which he was prescribed Valsartan. According to Dr. Argenziano, the patient, who was a licensed commercial airline pilot, had previously undergone cardiac catheterization that had been performed by an FAA cardiologist. As he interpreted it, that study revealed a 70% to 95% occlusion of the LAD, minimal disease in the left circumflex, 70% stenosis of the second obtuse marginal artery, and a completely occluded right coronary artery, although the patient had a normal ejection fraction of 65% to 70%. Dr. Argenziano asserted that a July 11, 2017 stress test revealed a moderate fixed defect in the inferior wall, with a reversible defect in the inferior wall and a normal ejection fraction, as seen on an echocardiogram, of 55%, albeit with mild left ventricular hypertrophy, a mildly dilated left atrium, but no significant valvular disease. He further asserted that carotid studies revealed less than 50% stenosis bilaterally.

Dr. Argenziano explained that, at the patient's first appointment with Zias, the patient complained of dyspnea on exertion when walking uphill or for extended distances, but denied any chest pain, palpitations, dizziness, or peripheral edema. According to Dr. Argenziano, the patient's blood pressure on August 18, 2017 was 169/94, which he characterized as elevated. He noted that the patient was 5'11" in height, and weighed 205 pounds, and was on a regimen of baby aspirin, Valsartan, and Varenicline. As Dr. Argenziano interpreted the patient's chart, Zias formulated a plan at that initial visit to perform coronary artery bypass graft surgery for revascularization and that, as part of the preoperative workup, the patient would undergo a computed tomography (CT) scan of the chest, without contrast, and would be administered the beta blocker Lopressor, at a dosage 12.5 milligrams (mg) twice daily to moderate his heart rate.

Dr. Argenziano recounted that an August 23, 2017 CT scan of the patient's chest revealed multi-vessel coronary atherosclerosis, moderate emphysema with mild diffuse airway inflammation, and a nonspecific right middle lobe nodule measuring 3 millimeters. He stated that, on August 30, 2017, the patient presented to NYU Langone Hospitals for the planned coronary artery bypass surgery. Zias commenced the surgical procedure at 9:46 a.m. on that date, and concluded it at 2:25 p.m., with the patient leaving the operating room for the post-anesthesia care unit at 2:38 p.m.

As Dr. Argenziano interpreted the operative report, the subject surgery included coronary artery bypass grafting at five sites, "utilizing" the LIMA to the LAD. He asserted that Zias employed saphenous vein grafts from the aorta to the first and second obtuse marginal arteries, "diagonal," and a reverse saphenous vein graft from the aorta to the posterior descending artery. In his report, Zias had characterized as "good" the quality and size of the internal mammary artery, as well as the quality and size of the veins that he harvested from the bilateral lower extremities for the saphenous vein grafts. Dr. Argenziano noted that the operative report stated that the LIMA was, in fact, anastomosed to the LAD with 8-0 prolene suture, purportedly "with excellent flow." Specifically, Zias, in the report, had written that a

“separate vein segment was used to create anastomosis to diagonal with 8-0 Prolene suture with excellent flow. Then a separate vein segment was used to create anastomosis to the posterior descending artery with 8-0 Prolene suture with excellent flow. Lastly, the left internal mammary artery was anastomosed to the left anterior descending coronary artery with 8-0 Prolene suture and excellent flow.”

Dr. Argenziano referred to Zias’s deposition testimony, in which the latter testified that he could conclude that postoperative blood flow was “excellent” because, “[i]n every operation, not only this one, 'cause I do not specifically remember this one, but in every operation we test the anastomosis by injecting manually blood into the veins and seeing where that blood goes into the heart.” Dr. Argenziano reiterated the conclusions set forth in the operative report that the patient tolerated the procedure well and was transferred to the recovery room in stable condition. He further noted that the patient remained at NYU Langone until September 3, 2017, and that his stay was “uneventful, apart from some tachycardia postoperatively.”

As Dr. Argenziano summarized the relevant chart, on September 7, 2017, the patient contacted Zias’s office to report that he had lost five pounds since the surgery, despite the fact that he was not taking diuretics, in response to which Zias advised the patient that fluid retention often causes patients first to gain weight and then lose it after surgery. The patient returned to see Zias at the latter’s office on September 11, 2017, purportedly with no postoperative complications, other than some pain around the sternal incision site, upper back, and neck area. According to Dr. Argenziano, the patient reported nonproblematic sleep, normal bowel movements, and an appetite that was “ok but improving.” The chart indicated that the patient was experiencing no chest pressure or pain, no shortness of breath, no lower extremity swelling, and no fever, chills, dizziness, syncope, or palpitations. He stated that the patient

“had about a two to five block exercise tolerance. The cardiac exam was normal with a normal rate and rhythm, S1 S2, no murmurs appreciated. It is documented that he looked good and was recovering well after surgery. He was to continue Aspirin, Plavix, Cardizem, and Lipitor daily. Lopressor was changed to Toprol daily as his blood pressure readings were still in the high 160s systolic from his home logbook. He was also using a Nicotine patch and Chantix for smoking cessation. The plan was to follow-up with cardiology in a week and cardiothoracic surgery in two weeks.”

Hence, on September 18, 2017, the patient telephoned Zias, and reported that his weight was stable at 199 pounds and that he was walking one to two miles daily. The patient returned to Zias's office on September 25, 2017 and complained neither of dyspnea nor of shortness of breath, and reported that he was walking two to three miles every day. According to Zias's chart, the patient denied palpitations or dizziness, his blood pressure was well controlled on Toprol, and he was scheduled to commence cardiac rehabilitation on September 26, 2017. On October 4, 2017, the patient reported by telephone to Zias's office that he was walking three miles daily, and attending outpatient cardiac rehabilitation therapy session three times per week.

On March 2, 2018, what Dr. Argenziano characterized as an "abnormal stress test" that had been ordered by the patient's treating cardiologist, Dr. Kayser, "revealed anterior/apical ischemia." On March 14, 2018, Dr. Kayser performed a left heart catheterization of the patient at Jersey Shore Medical Center in Neptune City, New Jersey. He reported that the LIMA did not "appear" on the images to have been anastomosed to the LAD despite Zias's surgery, and that the patient was suffering from severe stenosis of the proximal and mid portions of the LAD "in what appears to be an un-bypassed vessel," while the other grafts made by Zias, other than what Dr. Argenziano characterized as an "irrelevant occluded saphenous vein graft to the first obtuse marginal," appeared to be patent. According to Dr. Argenziano's interpretation of Dr. Kayser's chart, during the catheterization procedure, Dr. Kayser performed a percutaneous coronary intervention of the native LAD stenosis, employing a drug-coated stent. Dr. Argenziano asserted that, based upon his review of the records, the patient was asymptomatic from a cardiovascular standpoint both before and after the revascularization by Dr. Kayser. According to Dr. Argenziano's interpretation of the relevant chart, on June 18, 2018, Dr. Kayser concluded that the patient's prognosis was excellent, that he had normal functional cardiac capacity with no physical restrictions, and that repeat stress testing showed apparent resolution

of his anterior wall ischemia. On June 22, 2018, Dr. Kayser performed another cardiac catheterization which showed a patent LAD stent.

On November 20, 2018, the patient was evaluated by cardiologist Ravi N. Nair, M.D., at the Cleveland Clinic in Cleveland, Ohio. As Dr. Argenziano read Dr. Nair's chart, the latter reviewed the records of the March 14, 2018 cardiac catheterization that Dr. Kayser had performed, but did not specify whether he reviewed only the report or the images as well. According to Dr. Argenziano, Dr. Nair reiterated Dr. Kayser's statement that the distal LIMA did not appear to anastomose to the LAD on that study, and concluded that the stenting performed by Dr. Kayser was "due to LIMA graft failure." Dr. Argenziano averred that, while Dr. Nair also stated that the patient had residual moderate disease in the mid segment and a small calibre distal vessel, these conditions were not causing any ischemia and did not need to be addressed with revascularization. As Dr. Argenziano recounted it, subsequent cardiac evaluations in 2019 by cardiologist Marc A. Tecce, M.D., at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania, "indicate that Mr. Papp was exhibiting excellent exercise tolerance and had no signs of coronary insufficiency" and that Dr. Tecce "documented a completely normal cardiac examination." Dr. Argenziano asserted that his review of the patient's employment records led to the conclusion that, in September 2019, the patient received medical clearance to return to work without restrictions, and that the patient himself testified at his deposition that, by October 2019, he had resumed working as a pilot.

Dr. Argenziano explicitly rejected the plaintiffs' claims that, during the August 30, 2017 coronary artery bypass graft procedure, Zias failed to anastomose the patient's LIMA to the LAD because Zias's operative report "specifically and unequivocally documents that the LIMA was, in fact, anastomosed to the LAD" and had recited that there was "excellent flow" within each bypass, including the bypass of LIMA to the LAD. In connection with this opinion, he also relied upon Zias's deposition testimony that the anastomosis for each bypass was tested intraoperatively to ensure that there was good blood flow through them. Dr. Argenziano

speculated that the plaintiffs' claims were based "entirely on Dr. Kayser's cardiac catheterization report," in which Dr. Kayser did not expressly assert that Zias actually failed to anastomose the graft to the LIMA, but only that, at the time of the catheterization, it did not "appear" that the LIMA graft was anastomosed to the LAD. In this respect, Dr. Argenziano explained that images taken during a cardiac catheterization are two dimensional, which makes it "inherently more difficult to appreciate the three-dimensional relationships of cardiac structures." Dr. Argenziano asserted that, based on his independent review of the subsequent imaging, including those relied upon by Dr. Kayser, it "cannot be concluded that the graft was not anastomosed to the LAD by Dr. Zias," despite the adequacy of the imaging for the purpose of supporting Dr. Kayser's determination to perform a percutaneous coronary procedure.

Dr. Argenziano opined that it is a known and accepted risk that an anastomosis of any bypass can fail both during and after bypass surgery. Although he reiterated that Dr. Nair had concluded that the LIMA graft here "failed," he noted that Dr. Nair did not opine why or when it failed, nor did Dr. Nair assert that Zias failed to anastomose the LIMA graft to the LAD in the first instance. As Dr. Argenziano explained it, graft failure can and does happen in the best of hands and despite the use of proper techniques in full accord with proper surgical practice. With respect to the saphenous vein graft to the first obtuse marginal, although Dr. Argenziano noted that Dr. Kayser had concluded that it was "totally occluded," he asserted that there was no stenosis noted in the native obtuse marginal vessel on angiography and, that, in any event, any occlusion of the saphenous vein graft "had no impact on the patient as there was blood flow in that native vessel."

Dr. Argenziano additionally concluded that the clinical outcome with respect to stenting is "substantially the same" as the outcome to be expected with successful bypass surgery. He thus characterized as "meritless" the plaintiffs' claim that stenting subjected the patient to a lower likelihood of survival. In this respect, he noted that the patient did not have symptoms secondary to graft failure, and the ischemia that had been present was reversed. Hence, Dr.

Argenziano concluded that the patient had an excellent outcome and will continue to have good heart function with the stent.

In her affirmation submitted in support of the motion, the NYU defendants' attorney, among other things, argued that Zias was not an employee of NYU Langone Hospitals when he performed the subject surgery, but was instead an employee only of New York University School of Medicine, which was a completely separate entity. She thus argued that NYU Langone Hospitals could not be held vicariously liable for any malpractice that Zias might have committed and that, in any event, the plaintiffs made no allegations either in their amended complaint or bills of particulars that any other hospital employee committed any tortious act. Hence, she contended that summary judgment should be awarded to NYU Langone Hospitals regardless of whether there were triable issues of facts as to whether Zias committed malpractice.

In opposition to the NYU defendants' motion, the plaintiffs relied on many of the same documents that the NYU defendants had submitted in support of their motion. The plaintiffs also submitted additional medical records and reports, an annotated angiogram image, a peer-reviewed article from *The Lancet*, an attorney's affirmation, an affirmation from Dr. Kayser, and an expert affirmation from a board-certified cardiac surgeon. The plaintiffs' attorney argued that the NYU defendants failed to meet their burden of establishing their prima facie entitlement to judgment as a matter of law because Dr. Argenziano only speculated that Dr. Kayser could not ascertain from the post-surgical imaging taken during the catheterization process whether the LIMA had been anastomosed to the LAD.

In his affirmation, Dr. Kayser first described his initial encounter with the patient on July 31, 2017, his finding, upon that date's catheterization, that the patient was then suffering from a 70% stenosis of the LAD, and his recommendation that the patient undergo coronary bypass surgery because "the scientific data showed that with multi-vessel coronary artery disease, one

achieves a mortality benefit with bypass surgery.” Dr. Kayser described the techniques that are employed in such surgery, explaining that the LIMA is:

“used to bypass the blockages of the left anterior descending artery. In bypassing the LAD, the surgeon removes the LIMA attachments to the inside of the chest wall, leaving the beginning part attached to [its] native origin from the subclavian artery (the artery that feeds the left arm) and then attaches the new free end to the LAD beyond the blockages. . . . The other arteries of the heart are usually bypassed using a vein harvested from the leg called the saphenous vein. They saphenous vein grafts (SVG) are transplanted to the chest where one end is attached to the aorta and the other end to the coronary artery beyond the blockage. . . . All of these bypasses have known rates of failure and many factors affect the longevity of bypasses such as surgical technique, and patient factors such as the quality of the coronary artery it is attached too and how well the person complies with preventive health measures following the surgery. But it is known that the SVGs have an average lifespan before becoming diseased themselves of approximately 10-15 years, while the LIMA graft is colloquially thought of as immortal in that it is expected to remain open for the remainder of the person’s life if properly anastomosed to the left anterior descending artery, this ‘immortality’ is usually independent of any other factor unlike the SVG’s.”

He asserted that, several months after Zias performed the subject coronary artery bypass graft procedure, he met with the patient on March 2, 2018 and conducted a stress test to ascertain if any part of his heart muscle was not getting a sufficient blood flow. Dr. Kayser concluded that the stress test revealed a large area of ischemia in the anterior part of the heart, which, because that portion of the heart is supplied with blood by the LAD, it should have been perfused via the LIMA graft. He characterized this finding as abnormal and worrying and, thus, recommended a second cardiac catheterization, which he performed on March 14, 2018.

After performing the second cardiac catheterization, Dr. Kayser concluded that there was a tubular 70% stenosis in the proximal segment of the LAD, and a 90% stenosis in the mid segment of the LAD at the bifurcation of the second diagonal branch. He asserted that those lesions were “unchanged from his pre-bypass angiography.” He explained that the left circumflex artery, which is a large size, nondominant vessel, evinced luminal irregularities, while the first obtuse marginal vessel, which is moderate in size, had no significant disease. Nonetheless, he asserted that the second obtuse marginal vessel in the mid-segment reflected a 70% stenosis just prior to the bifurcation of a lateral branch, while there was “competitive flow”

noted in the bypass graft in the circumflex. While Dr. Kayser asserted that the bypass graft of the LIMA appeared patent, and that surgical clips and cardiac motion were seen on angiography, “the vessel does not appear to be anastomosed to left anterior descending artery. There is no native left anterior descending artery flow noted in this graft.” Similarly, Dr. Kayser concluded that, “on injection of the native vessel, there is no competitive flow noted in the vessel.” Consequently, he wrote in his report that it “does not appear that the internal mammary graft has been anastomosed to left anterior descending artery.”

In response to Dr. Argenziano’s parsing of the phrase “does not *appear* to be anastomosed” (emphasis), Dr. Kayser explained that this was merely a matter of phrasing, in that the direct injection of X-ray dye directly into the LIMA graft showed that the dye never left the graft, clearly demonstrating that the graft did not provide blood flow into any coronary artery. He reiterated that, when he injected dye directly into the LAD, he observed no “competitive” flow, that is, backflow into the LIMA graft, which, to him, confirmed the lack of flow via the LIMA graft into the LAD. As he analyzed it, the NYU defendants’ contention that these words left any doubt in the matter was “mistaken.” Dr. Kayser further averred that, despite Dr. Argenziano’s interpretation of the angiography report, the remainder of the angiography, plus Dr. Kayser’s further treatment of the patient when the latter was still on the angiography table, “left no doubt: the LAD had no flow into it via the LIMA graft.”

Consequently, Dr. Kayser asserted that the conclusion in his report that “[t]here is no native left anterior descending artery flow noted in the graft . . . No injection of the native vessel . . . no competitive flow in the vessel,” which proved that the “supposed” LAD bypass was nonfunctional, resulting in a reduced blood flow to the anterior wall of the patient’s heart arising from the original stenosis, “which the LIMA graft was supposed to bypass.” He concluded that this created the ischemia noted on the March 2, 2018 stress test, and placed the patient in danger of suffering a myocardial infarction and jeopardizing his flying status. As Dr. Kayser explained it, he had no choice during the angiography but to place a stent in the patient’s LAD to

open up the original blockage of that artery and, that, because he had to perform that procedure, the patient, in accordance with FAA guidelines, had to wait an additional three months before he could submit to another stress test and further cardiac catheterization as part of the FAA's clearance process.

Dr. Kayser explained that, on June 22, 2018, the patient returned to see him for another cardiac catheterization, after which he again noted that the LIMA graft did not provide blood flow into the LAD. He thus concluded that it either had never been anastomosed to the LAD, or was occluded by a surgical clip that was seen "running across" the end of the graft, but that, whatever the structural cause, the LIMA graft did not provide blood flow into the LAD. Dr. Kayser explicitly concluded that there was, at the time, "no doubt the LAD had *never* been effectively anastomosed to the LIMA (emphasis added)," and submitted one of the June 22, 2018 cardiac catheterization images, which he contended established that the "LIMA graft had *never* provided blood flow into the LAD" (emphasis added). He thus averred that he was

"100% certain, based upon the cardiac catheterizations I performed on Mr. Papp at that time, that after the cardiac bypass surgery Dr. Zias performed on Mr. Papp, the LIMA did not flow into any native heart vessel as it should have been just 6 months after surgery. The defense expert's claim that one cannot tell this because the diagnostic films taken during the cardiac catheterization are 'two dimensional,' is of no relevance. Cardiac catheterization, as are all radiologic images, are of course 2D images. It is understood that the heart is a complex three-dimensional structure, however, the technique of taking cardiac images at multiple angulations of the X-ray machine allows us to visualize and understand this three-dimensional structure. Two dimensionality does not affect the diagnosis."

Dr. Kayser thus opined that Zias's failure properly to anastomose the LIMA to the LAD caused the patient to sustain "serious" injuries. He noted that he was himself a senior FAA medical examiner, and thus was familiar with the standards that the patient had to meet in order to obtain clearance to fly an airplane, which included the complete absence of ischemia. Dr. Kayser asserted that the patient would have been back to work in six months after the bypass procedure and a stress test, but instead was delayed due to the "faulty bypass." In addition, contrary to Dr. Argenziano's conclusion, he opined that the unattached LIMA increased the

patient's cardiac health risks for life, since a LIMA attached to an LAD gives a healthy blood flow for life, while a stent in the artery has a real possibility of re-narrowing, clogging, or closing. Moreover, while Dr. Kayser asserted that leg, or saphenous, vein bypasses have a known failure risk, the failure of a LIMA graft, especially so early after surgery, is "virtually unheard of," thus implying that Zias's negligence was the only plausible cause of the absence of the anastomosis between the patient's LIMA and LAD.

The plaintiffs' retained expert cardiologist opined that Zias departed from good and accepted practice because he, in fact, failed to anastomose the patient's LIMA to the LAD, and that this caused the patient to undergo otherwise unnecessary and less-effective stenting. The expert agreed with Dr. Kayser's factual description of a LIMA to LAD bypass, as well as with his opinion that there was never any anastomosis of the LIMA and LAD, and that, consequently, Zias simply failed to perform the bypass surgery in a fashion that met the standard of care.

The plaintiff's expert asserted that Dr. Argenziano made certain fundamentally erroneous conclusions, including that the use of a stent is just as good as a LIMA-to-LAD bypass. As the expert explained it, a LIMA-to-LAD bypass is always better for long term survival than a stent. The expert expressly asserted that Zias did not bypass the LIMA, as "proven separately by both Dr. Kayser and Cleveland Clinic," and that Zias never recorded in the operative report the manner in which he tested the integrity of any such bypass for a proper anastomosis. The plaintiff's expert noted that, although Zias testified that he generally tested a bypass by injecting blood into the veins, "he did not say, nor did the record show that he tested the left interior mammary artery (LIMA)." According to the expert, an arterial graft, as opposed to a saphenous vein graft, "is not tested by having the perfusionist flow blood through it," since that is only an appropriate test for veins, and that, to test an artery, like the LAD, the surgeon must use a "flow probe." The expert explained that this device involves placing a hook on the artery, that an attached digital readout measures blood flow, and that, based on the record and the deposition testimony, this test was not performed. The plaintiff's expert also concluded that

that there was no proof that Zias tested the LAD blood flow at the end of the surgery, and that such a failure was a departure from good and accepted medical practice.

The plaintiff's expert cardiologist rejected Dr. Argenziano's opinion that the absence of post-operative symptoms could be the basis for any material conclusions as to whether the LAD was in fact anastomosed to the LIMA. As the expert framed the issue, "[h]is heart was not being stressed, and in the absence of that, it means nothing." The cardiologist opined that the abnormal March 2, 2018 stress test was a "smoking gun" that the anastomosis had not been effectuated because the LAD "blockade" generated no symptoms until it was stress-tested. The expert faulted Zias for telling the patient to walk two miles per day in order purposefully to stress his heart, inasmuch as doing so with an un-bypassed LAD was "ill-advised." The expert further criticized, as "absurd," Dr. Argenziano's suggestion that a "first-rate institution such as Cleveland Clinic would agree" with an angiogram reading "without studying the films themselves." The expert asserted that, contrary to Dr. Argenziano's speculation, the Cleveland Clinic's records clearly established that its cardiologist, Haitham Ahmed, M.D., read the angiogram films.

The plaintiff's expert explicitly agreed with Dr. Kayser's opinion that it was virtually impossible for a proper LIMA-to-LAD anastomosis to just "fail." As the expert phrased it, "Dr. Argenziano misleadingly states that it is a known and acceptable risk that a heart bypass graft can 'fail'. Here, the LIMA/LAD graft did not fail, it was never anastomosed. Also, unlike a saphenous vein graft, LIMA to LAD grafts never fail — they are, per Dr. Kayser's Affirmation 'immortal.'" The expert asserted that Dr. Nair's use of the word "failed" was just a "loose way to say it was not anastomosed." The expert cardiologist further explained that

"[o]ne does not bypass arteries which, as Defendants' expert states, have no blockage. Here, Dr. Argenziano says the vein graft was occluded, but that was acceptable because the native artery had normal blood flow. This makes no sense. Why, then, bypass it? If this argument were true, heart bypasses would not be done."

In reply, the NYU defendants submitted an attorney's affirmation, in which counsel essentially asserted that the opinions of both Dr. Kayser and the plaintiff's retained expert cardiologist were conclusory, speculative, and not supported by the medical records.

The court concludes that, contrary to the plaintiffs' contention, the NYU defendants made a prima facie showing of their entitlement to judgment as a matter of law in connection with the medical malpractice cause of action. With respect to Zias's alleged malpractice, Dr. Argenziano's affirmation was sufficiently detailed and, although it sometimes verged on the speculative, it did not cross that line. Nonetheless, the plaintiffs raised triable issues of fact, with Dr. Kayser's and their retained expert's affirmations, as to whether Zias committed malpractice by failing ever to anastomose the patient's LIMA to his LAD, and by failing properly to test the integrity of the purported LIMA-to-LAD anastomosis, as well as whether Zias's failure to anastomose those arteries to each other constituted a departure from good and accepted medical practice, and whether that failure caused the patient to undergo additional procedures, lose time from work, and lose the opportunity for a better outcome. Hence, that branch of the NYU defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Zias must be denied to the extent that that cause of action was premised upon Zias's alleged departures from good and accepted practice.

There also are triable issues of fact as to whether the plaintiffs may avail themselves of the doctrine of *res ipsa loquitur* to establish Zias's liability. As explained above, "[t]o sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Although a plaintiff asserting a medical malpractice claim usually must demonstrate that the defendant physician or hospital deviated from acceptable medical practice, and that such

deviation was a proximate cause of the plaintiff's injury (*see Rivera v Kleinman*, 16 NY3d 757, 759, [2011]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24; *Terranova v Finklea*, 45 AD3d at 572; *Zellar v Tompkins Community Hosp.*, 124 AD2d 287, 288-289 [3d Dept 1986]), the theory of res ipsa loquitur may be applied to occurrences “[w]here the actual or specific cause of an accident is unknown” (*Kambat v St. Francis Hosp.*, 89 NY2d 489, 494 [1997]). Under such circumstances, “a jury may . . . infer negligence merely from the happening of an event and the defendant’s relation to it” (*id.*; *see States v Lourdes Hosp.*, 100 NY2d 208, 211-212 [2003]; Restatement [Second] of Torts § 328D). To establish a prima facie case of negligence in support of a res ipsa loquitur charge, plaintiff must establish three elements:

“[1.] the event must be of a kind that ordinarily does not occur in the absence of someone’s negligence;

“[2.] it must be caused by an agency or instrumentality within the exclusive control of the defendant; and

“[3.] it must not have been due to any voluntary action or contribution on the part of the plaintiff”

(*Kambat v St. Francis Hosp.*, 89 NY2d at 494; *see James v Wormuth*, 21 NY3d 540, 545-546 [2013]; *Ebanks v New York City Tr. Auth.*, 70 NY2d 621, 623 [1987]; Prosser and Keeton, Torts § 39 at 244 [5th ed]). Res ipsa loquitur, a doctrine of ancient origin (*see Byrne v Boadle*, 2 H & C 722, 159 Eng Rep 299 [1863]), derives from the understanding that some events ordinarily do not occur in the absence of negligence (*see id.*; *see also Dermatossian v New York City Tr. Auth.*, 67 NY2d 219, 226 [1986]). Once a plaintiff satisfies the burden of proof on these three elements, the res ipsa loquitur doctrine permits the jury to infer negligence from the mere fact of the occurrence (*see States v Lourdes Hosp.*, 100 NY2d at 211-212; *Kambat v St. Francis Hosp.*, 89 NY2d at 495). Thus, for example, where “a foreign object is left in the body of the patient, or the patient, while anesthetized, experiences an unexplained injury in an area which is remote from the treatment site” (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 827 [2d Dept 2016] [citation omitted]), the invocation of the doctrine of res ipsa loquitur may be

warranted (*see id.*; *see also Mattison v OrthopedicsNY, LLP*, 189 AD3d 2025, 2027 [3d Dept 2020]; *Swoboda v Fontanetta*, 131 AD3d 1042, 1045 [2d Dept 2015]; *DiGiacomo v Cabrini Med. Ctr.*, 21 AD3d 1052, 1054 [2d Dept 2005]; *Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]; *Leone v United Health Servs.*, 282 AD2d 860, 860-861 [3d Dept 2001]; *Hill v Highland Hospital*, 142 AD2d 955, 956 [4th Dept 1988]).

The plaintiffs established that the patient was under anesthesia when the bypass surgery was performed, that Zias and his assistants were in sole control of the instruments employed in that procedure, and that the patient himself did not contribute to his own injuries. Crucially, there is a sharp factual dispute as to whether Zias's allegedly negligent surgery was the only possible cause of the patient's LAD occlusion or the absence of an LIMA-to-LAD anastomosis, specifically whether a properly created anastomosis could simply fail, or whether the only explanation for the absence of such an anastomosis was that it was never created in the first instance (*see Sklarova v Coopersmith*, 180 AD3d 510, 511-512 [1st Dept 2020] [res ipsa loquitur may apply because there were triable issues of fact as to whether there could be non-negligent explanation for injury; defendant must demonstrate some other potential cause]). In other words, the parties' experts disagreed as to whether patient's injuries ordinarily occurred in the absence of negligence, raising an issue of fact on that point (*see States v Lourdes Hosp.*, 100 NY2d at 211 [2003]; *Bradley v Soundview Healthcenter*, 4 AD3d 194, 194 [1st Dept 2004]).

Summary judgment, however, must be awarded to NYU Langone Hospitals. "In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself" (*Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2d Dept 2018]). Zias testified that he was not employed by NYU Langone

Hospitals when he performed the subject surgery, but by New York University School of Medicine. The patient testified that Dr. Kayser first referred him to a physician named Dr. Johnson, but because that physician was not in the patient's insurance network, Dr. Kayser's practice referred him to NYU Langone Hospitals. As the patient described it, a representative of NYU Langone Hospitals *referred* him to Zias. In other words, the hospital did not just simply designate Zias as the patient's surgeon or hold him out to be a hospital employee. Thus, the NYU defendants made a prima facie showing of entitlement to judgment as a matter of law in connection with the medical malpractice cause of action insofar as asserted against NYU Langone Hospitals, and the plaintiffs failed to raise a triable issue of fact as to whether that entity could be held vicariously liable under a theory of ostensible agency (*see generally Sklarova v Coopersmith*, 180 AD3d at 512).

Summary judgment also must be awarded to both Zias and NYU Langone Hospitals dismissing the causes of action that purport to seek recovery for common-law negligence. "Conduct may be deemed malpractice, rather than negligence, when it 'constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician'" (*Scott v Uljanov*, 74 NY2d 673, 674, 675 [1989], quoting *Bleiler v Bodnar*, 65 NY2d 65, 72 [1985]). "When the duty arises from the physician-patient relationship or is substantially related to medical treatment, the breach gives rise to an action sounding in medical malpractice, not simple negligence" (*Mendelson v Clarkstown Med. Assoc.*, 271 AD2d 584, 584, [2d Dept 2000]; *see Bleiler v Bodnar*, 65 NY2d at 72; *Morales v Carcione*, 48 AD3d 648, 649 [2d Dept 2008]; *Levinson v Health S. Manhattan*, 17 AD3d 247, 247 [1st Dept 2005]). Here, the NYU defendants established that the plaintiffs alleged no facts giving rise to an independent claim sounding in common-law negligence, and that all their claims of breach of duty sound only in medical malpractice. In fact, the allegations constituting the purportedly common-law negligence causes of action, as set forth in the amended complaint, all couch the defendants' alleged liability in terms of the defendants' failure to "exercise the degree of care and skill

exercised by physicians in the community and consistent with the expertise which defendant publicized to the community,” the very definition of medical malpractice. The plaintiffs failed to raise a triable issue of fact in opposition to the NYU defendants’ showing in this respect. Hence, that branch of the NYU defendants’ motion seeking summary judgment dismissing the common-law negligence causes of action as duplicative of the medical malpractice cause of actions must be granted (*see Marin v Northwell Health, Inc.*, 2025 NY Slip Op 30736[U], *26, 2025 NY Misc LEXIS 1242, *47 [Sup Ct, N.Y. County, Mar. 4, 2025] [Kelley, J.]; *Cebularz v Samadi*, 2019 NY Slip Op 31260[U], *5, 2019 NY Misc LEXIS 2242, *5 [Sup Ct, Kings County, Apr. 24, 2019]).

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either “knew, or should have known,” of their employees’ “propensity for the sort of conduct which caused the [patient’s] injury” (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). The NYU defendants established, prima facie, that Zias and all other health-care personnel were properly trained. Since the plaintiffs, in their opposition papers, adduced no facts with respect to whether the NYU defendants knew or should have known of the propensity of the medical providers treating the patient to commit acts of malpractice, that branch of their motion seeking summary judgment dismissing that cause of action must be granted.

Accordingly, it is,

ORDERED that the motion of the defendants Dr. Elias Zias and NYU Langone Hospitals is granted to the extent that summary judgment is awarded to NYU Langone Hospitals dismissing the amended complaint insofar as asserted against it, and to Zias dismissing the common-law negligence and the negligent hiring, training, supervision, and retention causes of action insofar as asserted against him, the amended complaint is dismissed insofar as asserted against NYU Langone Hospitals, the common-law negligence and the negligent hiring, training,

supervision, and retention causes of action are dismissed insofar as asserted against Dr. Elias Zias, and the motion is otherwise denied; and it is further,

ORDERED that, on the court’s own motion, the action is severed against NYU Langone Hospitals; and it is further,

ORDERED that the Clerk of the court shall enter judgment in favor of NYU Langone Hospitals and against the plaintiffs dismissing the amended complaint insofar as asserted against NYU Langone Hospitals; and it is further,

ORDERED that that, on the court’s own motion, the attorneys for all of the remaining parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on August 21, 2025, at 11:00 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

7/25/2025
DATE



JOHN J. KELLEY, J.S.C.

CHECK ONE:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION	
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/>
			<input type="checkbox"/>	DENIED	
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER	<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN	<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/>
					<input type="checkbox"/>
					REFERENCE