Williams v Oliveira
2025 NY Slip Op 33085(U)
August 13, 2025
Supreme Court, New York County
Docket Number: Index No. 805237/2018
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

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SCOTT V. WILLIAMS,

Plaintiff,

- v -

CRISTIANO OLIVEIRA, M.D., WEILL CORNELL MEDICINE, WEILL CORNELL EYE ASSOCIATES, ABC CORPS. 1-10, and JOHN DOES 1-10,

Defendants.

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INDEX NO. 805237/2018

MOTION DATE 07/23/2025

MOTION SEQ. NO. 003

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 003) 54, 55, 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, 98, 99, 100, 101, 102

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, the defendants Cristiano Oliveira, M.D., Weill Cornell Medicine, and Weill Cornell Eye Associates (collectively the Weill defendant) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is denied, on condition that, on or before September 12, 2025, the plaintiff submits the contents of the expert report of Kaushal M. Kulkarni, M.D., in the form of an affirmation or affidavit.

The crux of the plaintiff's claim is that, on January 20, 2016 and May 9, 2016, the defendant neuro-ophthalmologist Oliveira, while working for the defendant Weill Cornell Eye Associates, a division of Weill Cornell Medicine, departed from good and accepted practice by failing to diagnose him with a detached retina, thus delaying appropriate treatment, causing him to undergo six surgical procedures, and leaving him blind in his right eye.

In his complaint, the plaintiff alleged that, at the January 20, 2016 appointment, he complained to Oliveira of blurry vision in his right eye that had worsened over time. He asserted

that Oliveira performed a field vision test, and then dilated and examined his eyes. According to the plaintiff, Oliveira informed him that his retina "was in proper form and that there were no issues with" it, and ultimately diagnosed him with "drooping eyelid," that could be corrected with plastic surgery. The plaintiff further averred in his complaint that, when he returned to see Oliveira on May 9, 2016, Oliveira, without examining the retina in his right eye, diagnosed him both with drooping eyelid and "lazy eye" syndrome, and recommended that his deteriorating vision could be addressed with contact lenses. The plaintiff asserted that, shortly thereafter, when he saw his regular optician on June 2, 2016 to be fitted for a new pair of contact lenses, the optician noticed an irregularity, and referred him to another ophthalmologist, who diagnosed a retinal detachment, and, in turn, referred him to a surgeon who performed reattachment surgery upon him later that month, after which he underwent five additional surgeries, but nonetheless completely lost his eyesight in his right eye. In both his complaint and bill of particulars, the plaintiff alleged that Oliveira departed from good and accepted practice in failing to diagnose the detached retina at the January 20, 2016 appointment, and failed to test for that condition at the May 9, 2016 appointment, thus further delaying the diagnosis. He reiterated, in his bill of particulars, that these departures caused or contributed to the necessity of the six surgical procedures, and ultimately resulted in his loss of eyesight.

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-Sturrup 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]). Moreover, where a

physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

In support of their motion, the Weill defendants submitted the pleadings, the plaintiff's bill of particulars, relevant hospital, medical, and opticians' records, transcripts of the parties' deposition testimony, a statement of allegedly undisputed material facts, a memorandum of law, an attorney's affirmation, and the expert affirmations of ophthalmologist/neuro-ophthalmologist Floyd Warren, M.D., and board-certified ophthalmologist Daniel Kiernan, M.D., both of whom opined that Oliveira did not depart from good and accepted practice, and that nothing that Oliveira did or did not do caused or contributed to the plaintiff's claimed injuries.

In their statement of material facts, the Weill defendants explained that, on January 8, 2015, when the plaintiff was 16 years old, he presented to ophthalmologist Peter Schwartz, M.D., complaining that he had experienced tension headaches and migraine headaches for the two previous years. Although the Weill defendants asserted that the plaintiff made no complaints about his vision at that time, he did inform Dr. Schwartz that he had difficulty reading for more than 15 to 20 minutes because that would exacerbate his headaches. They asserted that Dr. Schwartz dilated his eyes, but found no evidence of retinal tears, concluding that both retinas were flat. The Weill defendants asserted that the plaintiff evinced no papilledema or any apparent ocular cause for his headaches. Dr. Schwartz formed an impression that the plaintiff

merely suffered from myopia, and thus wrote a new prescription for eyeglasses, while directing the plaintiff to return in one year for observation. On October 30, 2015, personnel at Cayuga Medical Center in Ithaca, New York, performed a magnetic resonance imaging (MRI) scan of the plaintiff's brain to investigate the etiology of plaintiff's chronic headaches, which revealed a right petrous apex lesion that was described as most consistent with a cholesterol granuloma or proteinaceous cyst. On November 30, 2015, Weill Cornell pediatric neurosurgeon Mark Souweidane, M.D., upon referral from otolaryngologist Robert Strominger, M.D., evaluated the lesion that had been observed on the October 30, 2015 MRI scan. At that visit, the plaintiff informed Dr. Souweidane that his headaches were occurring daily, but denied any vision changes, diplopia, tinnitus, vertigo, or tremor. According to the Weill defendants, Dr. Souweidane's examination revealed that the plaintiff's visual acuity was grossly intact, concluded that the plaintiff likely had a right petrous apex cholesterol granuloma, a type of benign lesion, and recommended repeat audiometry and a consultation by a neuro-ophthalmologist due to the frequency of the headaches. On November 25, 2015, personnel at Cayuga Medical Center performed a second MRI of the plaintiff's brain, which reflected no change from the October 30, 2015 scan. Physicians at that hospital concluded that the scan was most consistent with a cholesterol granuloma or proteinaceous cyst.

On December 24, 2015, Weill Cornell otolaryngologist and head and neck surgeon Samuel H. Selesnick, M.D., evaluated the lesion, upon which he concluded that the plaintiff demonstrated normal ocular motility and no evidence of a gaze nystagmus, while the plaintiff himself denied that he experienced double vision or had ever been diagnosed with glaucoma. Dr. Selesnick concluded that audiograms from both February 6, 2013 and December 9, 2015 were normal. He thus formulated an impression that the granuloma was stable, small, and not threatening any structures, and recommended a follow-up MRI in one year.

On January 20, 2016, the plaintiff first met with Weill Cornell neurologist/headache

specialist Dara Jamieson, M.D., who memorialized that the plaintiff had been experiencing frequent headaches since he was 8 years old, and that they began to worsen when he turned 15. Dr. Jamieson reported that he described the severity of his headaches as 0 to 4 on a scale of 10, and that he asserted that the headaches lasted for an entire day. According to Dr. Jamieson's records, the plaintiff evinced no focal neurological symptoms, including any change in vision, and noted that he did experience rare nausea and occasional dizziness. The plaintiff further reported that the headaches were triggered by lights, visual movement, stress, change in weather, change in sleep, and ingestion of caffeine, monosodium glutamate, and chocolate. Dr. Jamieson performed an eye examination, and reported that the plaintiff's extra-ocular muscles and visual acuity were grossly intact, while the plaintiff's chronic headaches had decreased in severity. She diagnosed the plaintiff with intractable migraines, without aura and without status migrainosus, that is, a migraine lasting more than 72 hours, and vestibular migraine.

In his affirmation, Dr. Warren explained that the plaintiff was referred to Oliveira on January 20, 2016, as part of an ongoing neurological work-up for his chronic daily migraine headaches, to determine whether there was a potential neuro-ophthalmological explanation therefor. He opined that Oliveira appropriately performed various diagnostic tests, including a Humphrey's Visual Field test as part of this work-up, and that all of the tests were performed in accordance with the applicable standard of care. Dr. Warren asserted that the visual field test revealed a superior visual field defect in the right eye, and that Oliveira's interpretation of the test was appropriate, while external and slit-lamp examinations revealed a "subtle" ptosis of the right eye, that is, a "droopy eyelid," that also was clinically visible, in which the eyelid is lower than normal and can affect an individual's vision. Dr. Warren explained that it was Oliveira's impression that the eyelid position was the potential cause of the visual field defect in the plaintiff's right eye, and opined that this was an entirely appropriate conclusion.

Dr. Warren further concluded that Oliveira appropriately performed a dilated fundal examination of the plaintiff's eyes. As he described it, this test involves dilating the pupils with

medicated eye drops and using an ophthalmoscope to obtain a more complete view of the fundus, that is, the back surface of the eye, consisting of the retina, optic disc, macula, fovea, and blood vessels. According to Dr. Warren, the fundus examination revealed that the macula and periphery of the retina were normal, while the dilated fundus examination revealed no evidence of a retinal detachment or signs of an impending retinal detachment. After noting Oliveira's impression that there was no retinal or optic nerve pathology to explain the plaintiff's condition, Dr. Warren concluded that it was entirely reasonable for Oliveira to believe that the visual field defect was not caused by an actual or impending retinal detachment, but instead was caused by ptosis, and that Oliveira appropriately instructed plaintiff to return for follow-up testing. In this respect, Dr. Warren asserted that Oliveira also requested the plaintiff to bring photographs of himself as a child to his next visit so that he could ascertain whether the ptosis was a long-standing issue. Dr. Warren stated that, since the plaintiff did not complain of flashers, floaters, or other clinical signs of a potential retinal detachment during the January 20, 2016 visit, and the dilated fundal examination revealed no evidence of a retinal detachment, there was no indication for Oliveira to refer the plaintiff to a retinal specialist at that juncture.

In connection with the plaintiff's May 9, 2016 appointment with Oliveira, Dr. Warren asserted that the medical records and deposition testimony confirmed that the plaintiff did not complain to Oliveira of any vision changes or new conditions since the January 20, 2016 visit. Hence, Dr. Warren opined that there was no indication for Oliveira to perform a repeat dilated fundal examination on that date, since serial dilated fundal examinations are not standard for neuro-ophthalmologists, particularly without any indication for conducting them. In addition, Dr. Warren noted, however, that visual acuity testing performed on the plaintiff that day revealed a "very minimal change" in visual acuity in the right eye. He concluded that this change was not an indication for conducting a second dilated fundal examination, and that it was entirely appropriate for Oliveira to attribute the change to the need for a new prescription for

the plaintiff's contact lenses and glasses. As he phrased it, "[m]ore importantly, the very minimal change in visual acuity was not a sign of a retinal detachment."

Dr. Warren recounted that, as instructed, the plaintiff and his parents thereafter furnished Oliveira with photographs of the plaintiff when he was a child, correctly confirmed that the plaintiff's ptosis was evident since childhood, and, therefore, presented a chronic issue. Dr. Warren additionally asserted that Oliveira appropriately ordered a repeat visual field test to further evaluate the ptosis and right eye visual field defect. He averred that the test was performed both "taped and untaped," which was consistent with the applicable standard of care. According to Dr. Warren, there was mild improvement in the visual field testing of the right eye when compared to the January 20, 2016 visual field test. He concluded that the results of this test showed minimal improvement in the taped versus untaped examination, but were in no way indicative or suggestive of a retinal detachment. In this respect, he explained that it was common for a neuro-ophthalmologist to observe visual field defects "without a clear explanation and without new vision changes or complaints by the patient," and that the standard of care requires the physician to direct the patient to follow up for further testing and to monitor visual acuity. Dr. Warren opined that Oliveira appropriately instructed the plaintiff to return seven to eight months later, "which was an appropriate interval given the lack of vision complaints or changes." He also concluded that no further or different testing, such as an MRI, was required in light of the totality of the findings that Oliveira made at the May 9, 2016 visit.

Although the plaintiff's optician expressed concern about a retinal detachment at the plaintiff's June 2, 2016 appointment, and Dr. Warren conceded that the plaintiff ultimately was diagnosed with a right eye retinal detachment in mid-June 2016, he noted that this was well over a month since his final visit with Oliveira. He also noted that the plaintiff had reported blurry vision in his right eye for three months to ophthalmologist Anton Orlin, M.D., and that the vision had gradually worsened during the final month of that three-month period, but asserted that, contrary to the allegations set forth in the complaint, "it is clear that plaintiff never

complained of blurry vision to Dr. Oliveira during the May 9, 2016 visit," but, instead, specifically denied at his deposition having reported any visual changes or complaints to Oliveira.

Dr. Warren ultimately opined that there was nothing to indicate to Oliveira that the plaintiff had sustained a retinal detachment or an impending retinal detachment at either the January 20, 2016 or May 9, 2016 visits, and that Oliveira did not miss an earlier opportunity to diagnose a right eye retinal detachment. In addition, he characterized it as "speculative" for the plaintiff to argue that a second dilated fundal examination would have revealed a retinal detachment, "given that plaintiff did not have any vision complaints or any other signs or symptoms consistent with a retinal detachment or impending retinal detachment." Dr. Warren asserted that, since the plaintiff was referred to Oliveira specifically for the evaluation of any possible neuro-ophthalmological explanations for his chronic headaches, and the testing that was performed revealed no evidence of any pathology to explain the headaches, Oliveira did not depart from accepted practice in determining which tests were necessary to undertake. He further asserted that the headaches themselves were unrelated to the subsequently diagnosed retinal detachment. As he framed the issue, the "plaintiff's case is based upon the assumption that non-indicated testing would have revealed an incidental retinal detachment, for which there were absolutely no clinical signs."

Dr. Kiernan essentially concurred with Dr. Warren's opinions, and expressly asserted that the plaintiff did not present with any signs or symptoms of a retinal detachment on January 20, 2016 or May 9, 2016, that, consequently, Oliveira did not miss an opportunity to make an earlier diagnosis of a retinal detachment, and that no act or omission on the part of Oliveira or of any employee of the Weill defendants caused or contributed to the plaintiff's alleged injuries. He rejected the plaintiff's contention that Oliveira should have consulted with other physicians at Weill Cornell, as well as the plaintiff's contentions that Oliveira misdiagnosed him with a drooping eyelid and lazy eye at the May 9, 2016 appointment, and committed malpractice by failing to examine the retina in his right eye at that visit.

As Dr. Kiernan explained it, at the plaintiff's January 20, 2016 visit with Oliveira, the plaintiff did not complain of or demonstrate the presence of any signs or symptoms of a right eye retinal detachment, including, not limited to, changes in vision such as blurred vision, a sudden increase in new floaters, experiencing flashes of light, or experiencing a dark "curtain" or shadow affecting the field of vision of the eye. He expressly opined that Oliveira's suspicion that the plaintiff's ptosis was causing the right eye visual field defect was reasonable, based on the plaintiff's history, clinical examination, and testing. Dr. Kiernan further noted that, at that initial visit, Oliveira did in fact perform a dilated fundus examination, which Dr. Kiernan characterized as "the gold standard for evaluating a patient's retina," and that Oliveira "found no evidence of a retinal detachment or impending detachment." Based on his review of results of the dilated fundus examination, and the lack of vision complaints reported by the plaintiff, Dr. Kiernan expressly concluded that that the plaintiff was not suffering from a retinal detachment or an impending detachment on January 20, 2016, and that here was no indication to refer plaintiff to a retinal specialist at that time as well.

Dr. Kiernan further asserted that, when the plaintiff returned to see Olivera on May 9, 2016, he did not report any visual changes or disturbances, and concluded that there was nothing to suggest that the plaintiff was suffering from a retinal detachment at that time, since there were no subjective changes or complaints related to his vision. Moreover, Dr. Kiernan explained that the visual field testing performed on May 9, 2016, when compared to the January 20, 2016 testing, did not demonstrate any evidence of a retinal detachment. In this regard, he alleged that, had the plaintiff been experiencing a retinal detachment on May 9, 2016, the visual field testing results would have been markedly worse than the results from January 20, 2016, which did not occur. Dr. Kiernan explained that, had the plaintiff been experiencing a retinal attachment on May 9, 2016 visit, it would have affected his visual field, particularly the middle of his field of vision. Although he conceded that the visual acuity in the plaintiff's right eye had decreased "slightly" from 20/25 on January 20, 2016 to 20/40 on May 9, 2016, he opined that

these changes were not evidence of a retinal detachment, when considered in conjunction with the lack of reported visual changes or complaints from the plaintiff, the visual field testing results, and other testing on May 9, 2016. As Dr. Kiernan described it, changes in visual acuity can have many causes, including typical examination fluctuations, the need for a new eyewear prescription, eye dryness, or the fact plaintiff had an amblyopic eye, also known as lazy eye.

In any event, Dr. Kiernan explained that the reason for the plaintiff's follow-up examination with Oliveira on May 9, 2016 was only to confirm the plaintiff history of ptosis, and to ensure that that condition was stable, which Dr. Kiernan concluded it was. He opined that further testing regarding the plaintiff's visual acuity was not indicated, particularly in light of the fact that the plaintiff was being followed by his optometrist, who was managing his contact lens and eyeglass prescriptions. He also approved of Oliveira's recommendation that the plaintiff follow up with Oliveira in seven to eight months, which Dr. Kiernan characterized as an appropriate interval in light of all findings during this visit. Dr. Kiernan concurred with Dr. Warren that it was appropriate for Olivera forego a dilated fundus examination during the plaintiff's May 9, 2016 visit in the absence of new symptoms or complaints during a routine follow-up visit. He concluded that Oliveira did not miss a retinal detachment on May 9, 2016, and that there was no indication for Oliveira to perform the test.

In addition, Dr. Kiernan concluded that there was no merit to the plaintiff's contention that a delayed diagnosis of his retinal detachment caused his current right eye vision deficits. He stated that the timing of the diagnosis of retinal detachment did not cause plaintiff's current right-eye deficits because, "for the sake of argument, even if plaintiff had a retinal detachment on May 9, 2016 and had it been diagnosed on that date, his outcome would not have been different because he still would have required surgery to repair the detachment and these surgeries were not successful at repairing the detachment." Dr. Kiernan stated that lack of surgical success was unrelated to the timing of the diagnosis, but, instead, was a "known complication[ ]" of retinal detachment, particularly in a patient as young as the plaintiff was.

In opposition to the Weill defendants' motion, the plaintiff relied on many of the documents that they submitted, and he also submitted, among other things, a counter statement of material facts, an attorney's affirmation, additional medical records, and an unsworn and unaffirmed report of board-certified neuro-ophthalmologist Kaushal M. Kulkarni, M.D.

After recounting the plaintiff's medical history, Dr. Kulkarni opined that Oliveira departed from good and accepted practice by failing further to investigate the cause of the plaintiff's superior visual field defect that Oliveira noted on January 20, 2016 and May 9, 2016. He asserted that this visual field defect could not be explained by ptosis of the plaintiff's right upper eyelid if, as was the case here, the visual field defect was still present and unchanged on the taped visual field examinations. Rather, he concluded that an inferior retinal defect would explain the superior visual field defect. While he conceded that it would be "certainly unusual" for a patient to be harboring a retinal detachment with no visual changes or symptoms at all, it was possible that the plaintiff was experiencing a shallow peripheral retinal detachment that was present on January 20, 2016, and he concluded that the delay in diagnosis led to progression of the detachment into the macula, contributing to the poor outcome of the retinal surgeries.

Dr. Kulkarni also faulted Oliveira for failing properly to investigate and diagnose the cause of the plaintiff's decreased central visual acuity between the January 2016 and May 2016 visits. He opined that the plaintiff's vision clearly declined between January 2016 and May 2016, and that anisometropic amblyopia would not explain such a decline. Furthermore, Dr. Kulkarni asserted that it would be unusual for the small extent of anisometropia in the plaintiff's case to cause amblyopia in the first instance. Moreover, he asserted that, even if the plaintiff did suffer from amblyopia, it should "by definition be apparent and relatively stable since childhood and would have been apparent" at the January 20, 2016 appointment. Dr. Kulkarni thus characterized the plaintiff's presentation to Oliveira as a case of unexplained vision loss, and asserted that the standard of care for unexplained vision loss would typically include optical coherence tomography of the macula, "which may have led to earlier discovery of the retinal

detachment, since it is likely that the cause of the reduced central visual acuity in the right eye at the May 2016 visit was a macula-involving retinal detachment."

Dr. Kulkarni averred that a reasonably trained neuro-ophthalmologist would have examined the inferior retina more carefully during the January 20, 2016 visit to ascertain the cause of the plaintiff's superior visual field defect, or would have referred the patient to a retina specialist or general eye-care provider for further examination. He further asserted that a reasonably trained neuro-ophthalmologist would have performed an optical coherence tomography examination of the macula in the right eye during the May 9, 2016 visit to ascertain the cause of the vision loss in plaintiff's the right eye during the interval between the two visits, or would have referred the patient to a general eye-care provider for a more comprehensive examination. Dr. Kulkarni asserted that these failures constituted deviations from good and accepted medical practice that were a substantial factor in ultimately causing the plaintiff's permanent vision loss in his right eye, since earlier diagnosis of the retinal detachment could have led to earlier treatment and a potentially better visual outcome.

In reply, the Weill defendants submitted an attorney's affirmation, in which counsel argued that Dr. Kulkarni's opinions should not be considered because his report was unsworn and unaffirmed and, thus, was not submitted in proper evidentiary form. Counsel further argued that, even were the court to consider the report, Dr. Kulkarni's opinions were speculative and conclusory, and ignored the findings and results set forth in the plaintiff's chart with respect to the testing that was performed.

Although the Weill defendants correctly contend that a medical report that is neither sworn to nor affirmed is without probative value because it is not in proper evidentiary form (*see Ghosio v Weiser*, 224 AD3d 664, 667 [2d Dept 2024]; *Quinones v Ksieniewicz*, 80 AD3d 506, 506 [1st Dept 2011]; *Niles v Lam Pakie Ho*, 61 AD3d 657, 658 [2d Dept 2009]; *see also Grasso v Angerami,* 79 NY2d 813, 814-815 [1991]; *cf. Cinelli v Greyhound Lines, Inc*., 211 AD3d 571, 572 [1st Dept 2022] [unsworn and unaffirmed physician's reports contained in medical records

that were not relied upon by the defendants' experts are inadmissible]), law office failure in submitting medical proof in evidentiary form may warrant a renewal motion, pursuant to which the underlying motion for summary judgment may be decided on the basis of the record, where there is no showing of prejudice to the defendants (*see Campbell v Cloverleaf Transp., Inc*., 5 AD3d 169, 170 [1st Dept 2004]; *Cespedes v. McNamee*, 308 AD2d 409, 410 [1st Dept 2003]; *Rady v Santana*, 2022 NY Misc LEXIS 41729, *14-15 [Sup Ct, Bronx County, Apr. 5, 2022]). Inasmuch as the court concludes that Dr. Kulkarni's opinions, had they been submitted in proper evidentiary form, would raise triable issues of fact with respect to both liability and proximate cause, in the interest of judicial economy, the court will consider the substance of his opinions and deny the motion, on condition that the plaintiff submit the contents of Dr. Kulkarni's report in the form of an affirmation or affidavit. If the court were to grant the Weill defendants' motion on the ground that the report was not in evidentiary form, the plaintiff would simply move for leave to renew, submit an affirmation or affidavit Dr. Kulkarni, and the court would be constrained to grant renewal and thereupon deny the summary judgment motion. This would clearly be a waste of the court's time, as well as a waste of the parties' time and resources.

With respect to the merits of the motion, the court concludes that, although the Weill defendants established their prima facie entitlement to judgment as a matter of law, the plaintiff raised triable issues of fact with respect to both liability and proximate cause with his submissions, including Dr. Kulkarni's opinion, which was neither conclusory nor speculative. Rather, it identified what conduct was required of Oliveira during the two examinations, based on the plaintiff's presentations and the change in his visual acuity, and it explained why Oliveira's impressions of ptosis and lazy eye syndrome did not account for the quick deterioration of the plaintiff's central visual acuity. Moreover, contrary to Dr. Warren's contention, this is not a case in which Oliveira failed to investigate a condition that would have led to an incidental discovery of an unindicated condition, which the court agrees would not constitute malpractice (*see* C*lifford v White Plains Hosp. Med. Ctr.*, 217 AD3d 405, 405 [1st

Dept 2023]; *Rotante v New York Presbyt. Hosp.-N.Y. Weill Cornell Med. Ctr.,* 175 AD3d 1142, 1144 [1st Dept 2019]; *David v Hutchinson*, 114 AD3d 412, 413 [1st Dept 2014]; *Curry v Dr. Elena Vezza Physician, P.C.*, 106 AD3d 413, 413 [1st Dept 2013]; *Rivera v Greenstein*, 79 AD3d 564, 568 [1st Dept 2010]). Rather, Dr. Kulkarni expressly asserted that the finding of a retinal detachment would not have been an incidental finding, but that Oliveira should have noticed a small detachment on the January 20, 2016 dilated fundal examination, should have included retinal detachment in his differential diagnosis at the May 9, 2016 examination due to the plaintiff's rapidly deteriorating visual acuity, and should have performed a second dilated fundal examination on May 9, 2016 to rule in or out a retinal detachment.

Hence, the Weill defendants' motion is denied, on condition that the plaintiff submit the contents of Dr. Kulkarni's report in the form of an affirmation or affidavit.

"'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]). Oliveira was an employee of Weill Cornell Eye Associates, a division of Weill Cornell Medicine (actually Cornell University), when he allegedly engaged in the conduct complained of here. Hence, to the extent that there are triable issues of fact with respect to whether Oliveira committed malpractice, there are triable issues of fact as to the other Weill defendants' vicarious liability with respect to those claims.

With respect to the defendants denominated as "ABC Corps. 1-10," and "John Does 1-10," the plaintiff made no showing of any efforts that he made to identify these fictitious defendants, and never sought to amend the caption to substitute any entity or person as a party defendant. Consequently, the plaintiff is precluded from relying on CPLR 1024 to maintain this

action against those fictitious parties (*see generally Fountain v Ocean View II Assocs., L.P.*, 266 AD2d 339 [2d Dept 1999]), and the complaint must be dismissed as against them.

Accordingly, it is,

ORDERED that the motion of the defendants Cristiano Oliveira, M.D., Weill Cornell Medicine, and Weill Cornell Eye Associates for summary judgment dismissing the complaint insofar as asserted against them is denied, provided that, on or before September 12, 2025, the plaintiff submits the contents of the expert report of Kaushal M. Kulkarni, M.D., in the form of an affirmation or affidavit; and it is further,

ORDERED that, on the court's own motion, the complaint is dismissed insofar as asserted against fictitious defendant ABC Corps. 1-10 and John Does 1-10; and it is further,

ORDERED that, on the court's own motion, the attorneys for all of the 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 September 16, 2025, at 10:30 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.

8/13/2025
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:	[ ]	**CASE DISPOSED**		[X]	**NON-FINAL DISPOSITION**		
	[ ]	**GRANTED**	[X] **DENIED**	[ ]	**GRANTED IN PART**	[ ]	**OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**		[ ]	**SUBMIT ORDER**		
CHECK IF APPROPRIATE:	[ ]	**INCLUDES TRANSFER/REASSIGN**		[ ]	**FIDUCIARY APPOINTMENT**	[ ]	**REFERENCE**