SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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CESAR SALAS

Plaintiff,

- v -

THE NEW YORK-PRESBYTERIAN HOSPITAL,

Defendant.

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INDEX NO. 805312/2016

MOTION DATE 07/23/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59

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, the defendant, The New York-Presbyterian Hospital (NYPH), moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that NYPH is awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon NYPH's failures timely to diagnose blood loss after a defibrillator implant procedure, thereafter monitor the plaintiff, order proper testing, provide appropriate postoperative care, and repair the damaged vasculature that was involved, along with other alleged departures from good and accepted practice unrelated to the surgical technique actually employed during the subject procedure, with certain exceptions described below. The motion is otherwise denied, since NYPH failed to establish its prima facie entitlement to judgment as a matter of law in connection with the claim that the implant procedure was negligently performed and proximately caused the injuries claimed by the plaintiff.

The crux of the plaintiff's claim is that, between January 24, 2014 and March 1, 2014, he was both an inpatient and outpatient at NYPH, and that, on February 7, 2014, NYPH cardiac electrophysiologist Vivek Iyer, M.D., negligently placed a dual-chamber Medtronic Automatic Implantable Cardioverter/Defibrillator (AICD) into his chest to treat a heart condition, improperly monitored him thereafter, and inappropriately followed up with his postoperative care. He alleged that these negligent acts caused him to sustain a massive blood loss in which his blood drained into and collected around his heart, ultimately leading to cardiac tamponade, that is, the collection of fluids in the sac surrounding the heart, as well as further cardiac damage.

As set forth more specifically in his complaint, the plaintiff alleged that NYPH departed from good and accepted practice in failing to take a proper medical history, failing properly to prepare him for the placement of the AICD, failing to take appropriate precautionary measures, failing properly to place the device in his body, and failing to realize and treat his massive blood loss in a timely and appropriate fashion. He further averred that NYPH failed to render proper and adequate follow-up care and treatment. The plaintiff additionally contended that NYPH failed to order and perform appropriate diagnostic testing, and employed contraindicated practices, procedures, and techniques. He also faulted NYPH medical personnel for failing to keep abreast of current medical literature relevant to his condition and treatment. In addition, the plaintiff alleged that NYPH medical personnel failed properly to supervise their assistants. He claimed that these departures not only caused or contributed to blood loss and cardiac tamponade, but obligated him to undergo further treatment.

In his bill of particulars, the plaintiff reiterated the allegations set forth in his complaint, adding that NYPH medical personnel committed malpractice by failing properly to gain access to and visualize the veins that led to his heart, failing to ensure that the needle employed in connection with AICD did not penetrate the artery next to the vein that led to his heart, and failing to ensure that the wires placed within the heart chambers did not penetrate the heart. He further claimed that NYPH medical personnel were negligent in failing to realize or diagnose that

blood was leaking into the membranous lining around his pericardium, failing to realize that he was leaking a large amount of blood into his chest cavity, and failing timely to realize the presence of internal bleeding and thereupon repair the conditions that caused the leakage, which he stated that they themselves had caused. In addition, he alleged that NYPH personnel ignored his complaints, signs, and symptoms, made an erroneous diagnosis, and thus afforded improper treatment and administered inappropriate tests, rather than performing appropriate tests such as an electrocardiogram, chest x-ray, and ultrasound scan of the heart. Specifically, he averred that they negligently ignored the distention of his jugular vein, muffled heart sounds, shortness of breath, weakness, drop in arterial blood pressure with inspiration, worsening renal function, atrial flutter, lightheadedness, chest pain, gas, fast heart rate, cough, and drop in overall blood pressure. In his bill of particulars, the plaintiff alleged that NYPH's departures caused or contributed to the loss of four to six liters of his blood, chest pain, shortness of breath, and the placement of a permanent heart drain, specifically percutaneous drainage necessary to control pericardial effusion. He further contended that NYPH's negligence caused him to experience low oxygenation levels, shortness of breath upon mild exertion, exhaustion, difficultly sleeping, the inability to exercise, permanent weakness, headaches, neck pain, diminished renal function, a frequent upset stomach with nausea and vomiting, and the inability to work or conduct the normal activities of daily living. The plaintiff also asserted that he now is required to take Coumadin, a strong blood thinner that requires strict management. The plaintiff asserted that the damage to his arteries and consequent symptoms caused him to undergo two surgeries on February 15, 2014 and February 16, 2014, respectively, to correct the cardiac tamponade, and that all of the damages and sequelae left him with extreme pressure on his heart, consisting of a large effusion and clots around that organ which, in turn, caused further damage to his heart muscle, and created the possibility that he will need a heart transplant in the future.

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]). Moreover, where a party's submission itself reveals the existence of a triable issue of fact, that party is deemed to have failed to establish its

prima facie entitlement to judgment as a matter of law (*see Reading v Fabiano,* 137 AD3d 1686, 1687 [4th Dept 2016]; *Kimber Mfg., Inc. v Hanzus*, 56 AD3d 615, 617 [2d Dept 2008]).

"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]).

"'Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause'" (*McAlwee v Westchester Health Assoc., PLLC*, 163 AD3d 549, 551 [2d Dept 2018], quoting *Burns v Goyal*, 145 AD3d 952, 954 [2d Dept 2016]). Thus, where a moving defendant in a medical malpractice action does, in fact, make a

prima facie showing that it not depart from good and accepted practice, or that the treatment rendered to the plaintiff did not cause or contribute to the plaintiff's injuries, the plaintiff, to defeat summary judgment, must submit an expert affirmation or affidavit in opposition; a plaintiff's failure to submit such an expert affirmation or affidavit under such circumstances requires the court to award summary judgment to the moving defendant (*see Benedetto v Tannenbaum*, 186 AD3d 1596, 1598 [2d Dept 2020]; *Bethune v Monhian*, 168 AD3d 902, 903 [2d Dept 2019]; *Koster v Davenport*, 142 AD3d 966, 969 [2d Dept 2016]; *Whitnum v Plastic & Reconstructive Surgery, P.C.*, 142 AD3d 495, 497 [2d Dept 2016]; *Roques v Noble*, 73 AD3d at 207; *Bailey v Owens*, 17 AD3d 222, 223 [1st Dept 2005]; *cf. Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004] [unsworn affidavit of unnamed expert that was not affirmed under the penalties for perjury is insufficient to raise triable issue of fact as to defendants' alleged malpractice]). Where, however, a defendant fails to make the required prima facie showing, such as where it essentially concedes that it departed or may have departed from accepted practice, thus causing injury (*see Zapata v Buitriago,* 107 AD3d 977, 978-979 [2d Dept 2013] [where defendant's expert admitted that one of the causes of a patient's infection "could have been" an injection administered by the defendant, the defendant "failed to meet his burden of establishing that the infection was not caused by his treatment"]; *see also Deitch v Sands Point Ctr. for Health & Rehabilitation,* 237 AD3d 1043, 1045-1046 [2d Dept 2025]; *Kubera v Bartholomew,* 167 AD3d 1477, 1481 [4th Dept 2018]), the plaintiff need not oppose the motion with an expert affirmation (*see DeGiorgio v Racanelli*, 136 AD3d 734, 738 [2d Dept 2016]).

In support of its motion, NYPH submitted the pleadings, the plaintiff's bill of particulars, relevant medical and hospital records, transcripts of the parties' deposition testimony, a statement of allegedly undisputed material facts, a memorandum of law, the note of issue, an attorney's affirmation, and the expert affirmation of board-certified internist and cardiologist Jay Gross, M.D., who, until two years ago, also was certified in cardiovascular electrophysiology.

He opined that NYPH medical staff did not depart from the applicable standard of care, and that nothing that they did or did not do caused or contributed to the plaintiff's claimed injuries.

Dr. Gross asserted that the plaintiff's heart problems and associated medical issues long preceded and followed the "isolated" events involving the implant, including diffuse left ventricular dysfunction beginning in January 2008 that caused that ventricle to become dilated and weak, resulting in the pumping of blood insufficient to perfuse the body. According to Dr. Gross, left ventricular dysfunction can lead to severe volume overload, respiratory distress, generalized edema, arrhythmias, cardiogenic shock due to pump failure, kidney failure, liver failure, and death. As he interpreted the plaintiff's medical records, in 2008, cardiologist Marrick Kukin, M.D., had diagnosed the plaintiff with idiopathic dilated cardiomyopathy, and that a June 2008 echocardiogram revealed an ejection fraction of only 15%, while a normal ejection fraction is 60%. Dr. Gross asserted that the plaintiff's left and right ventricles were hypokinetic, since they moved less than normal, thus affecting the ability of the heart to efficiently pump blood. He explained that these findings were consistent with heart failure, thus placing the plaintiff at risk for the development of a heart valve problem, arrhythmia, and blood clots, which would produce shortness of breath and fatigue, as well as swelling of the ankles, feet, legs, and veins in the neck, known as jugular venous distention. Dr. Gross further averred that dilated cardiomyopathy can also result in heart valve problems, arrhythmias, and blood clots. According to Dr. Gross, the plaintiff had a history of "varying non-compliance with his medical regimen," and admitted to the use of tetrahydrocannabinol (THC), the active ingredient in marijuana, to self-treat depression prior to the subject 2014 hospital admission. He alleged that the plaintiff's medical records revealed that Dr. Kukin discussed the implantation of a defibrillator with the plaintiff in both January 2008 and February 2010, and explained that an AICD is a type of defibrillator that employs electrical impulses to correct arrythmias.

Dr. Gross opined that the plaintiff, after developing sudden neck pain that radiated to his head, was timely and properly admitted to NYPH on January 24, 2014. He asserted that the

plaintiff's chart reflected that the latter's troponin was elevated, suggesting inadequate perfusion of the heart muscle, while a computed tomography (CT) scan of the plaintiff's head revealed a large hypoattenuation involving the right cerebellar hemisphere, with partial effacement of the adjacent fourth ventricle, that was "compatible" with an acute-to-early-subacute infarct and, thus, consistent with an acute/subacute stroke. As Dr. Gross interpreted the plaintiff's chart, there was a consensus by both NYPH cardiology and neurology consultants that the plaintiff's condition likely was cardioembolic in nature, suggesting "a high probability that the stroke resulted from a clot that emanated from the left side of the heart." Dr. Gross opined that such a diagnosis was timely made, that the treatment for it was appropriate, that the NYPH neurology department was properly consulted, and that neurologists properly recommended medical management. He averred that imaging of the plaintiff's head and neck revealed nothing to suggest an intracerebral/vascular cause. NYPH cardiologists performed a trans-thoracic echocardiogram, and could not exclude the presence of a small thrombus, but nonetheless confirmed that the plaintiff evinced severely decreased left ventricular dysfunction, severe left and right atrial enlargement, reduced right ventricular systolic function, a tethered mitral valve and tricuspid valve, and a small pericardial effusion. According to Dr. Gross, all of these cardiologists agreed that anticoagulation treatment was indicated.

On January 24, 2014, the plaintiff was transferred to the NYPH cardiology department for the management of what Dr. Gross characterized as his "severely decompensated heart failure." As Dr. Gross explained it, as part of this evaluation, the plaintiff underwent left and right heart catheterizations to rule out coronary artery disease, and that, while this study revealed "normal" coronaries, it also reflected the presence of marked heart dysfunction, despite the administration of intravenous agents designed to improve heart function. Moreover, Dr. Gross asserted that telemetry recordings revealed that the plaintiff experienced recurrent runs of rapid ventricular arrhythmia. Hence, NYPH cardiologists referred the plaintiff for consideration of an

AICD implant, particularly in light of what Dr. Gross described as a consensus that the plaintiff was at high risk for sudden cardiac arrest.

As Dr. Gross explained it, the NYPH electrophysiology team met with the plaintiff on February 6, 2014 and discussed the issues surrounding AICD implantation, after which the plaintiff consented to the implant. Dr. Gross more specifically described that an AICD detects and treats life-threatening ventricular arrhythmias by delivering an electric shock or an overdrive pacing to restore normal rhythm. He stated that, in light of the fact that the plaintiff experienced an episode of a type of arrhythmia known as ventricular fibrillation/ventricular tachycardia eight months after the implant, had NYPH physicians not implanted the AICD, that episode easily could have been fatal. Dr. Gross thus concluded that the implant clearly was indicated, if not essential to the plaintiff's future health.

With respect to the implantation procedure itself, Dr. Gross concluded that, on February 7, 2014, Iyer properly performed the placement of the AICD. More specifically, Dr. Gross asserted that Iyer performed a cephalic cutdown, a technique to gain access to the heart, and explained that the cephalic vein is located between the pectoralis and deltoid muscles, thus presenting a lower complication rate than a subclavian puncture, which he described as an alternative approach. He averred that, in accordance with the standard of care, Iyer, under fluoroscopic guidance, properly and successfully introduced sheaths and then advanced a defibrillator lead into the right ventricular apex, along with a pacing lead in the right atrium. Dr. Gross asserted that, "[a]s is standard, Dr. Iyer ensured that the leads were appropriately placed by checking the pacing and sensing thresholds and lead stability and stimulation threshold and sensing." As he interpreted the operative report, the leads were then tested, thus confirming that they were appropriately placed.

Dr. Gross expressly addressed the allegations set forth in the plaintiff's bill of particulars, asserting that

> "[t]here is nothing to suggest cannulation of the artery, which a) would not allow

> placement of the leads into the right side of heart; b) is precluded by direct visualization and cannulation of the cephalic vein; and c) would not lead to cardiac tamponade. Furthermore, no needle is 'inserted into the ventricle' during this procedure', neither correctly or incorrectly. All the appropriate imaging modalities were utilized, all device parameters were normal, and no revision was ever required. There is nothing to indicate lead perforation of the heart. In such circumstances, which is a recognized but infrequent complication, bleeding typically occurs immediately or very shortly after implant. In such a circumstance, pacing leads often malfunction, and imaging studies indicate extra-cardiac locations of the lead tip. None of these abnormal findings were ever detected."

According to Dr. Gross's review of the chart, the plaintiff evinced no signs of any intraoperative complications, but experienced only typical postoperative pain, along with "optimization of his heart failure treatment for six days postoperatively." Dr. Gross asserted that the plaintiff first made new complaints on February 13, 2014, that is, six days after the AICD implant, that consisted of "varying" complaints of nausea and vomiting, which he characterized as very unusual symptoms for cardiac tamponade, but that these symptoms were "mostly" relieved by medications. He stated that, on February 14, 2014, the plaintiff's kidney function was normal.

Dr. Gross, however, asserted that,

> "[o]nly on Feb 15th, eight days after the procedure, does it become clear, that something ha[d] abruptly happened. The patient'[s] physical exam and sense of wellbeing changed, the blood count had dropped, and kidney dysfunction had abruptly developed. The CUU team appropriately obtained an echocardiogram which detected a large pericardial effusion, and the patient was rapidly stabilized by an emergent pericardiocentesis. Over the night, the effusion/hematoma reaccumulated and a pericardial window was placed to address the issue more definitively. On the day prior to the event, the I[nternational] N[ormalized] R[atio] (blood clotting measure) was not yet therapeutic and the patient was still being 'bridged' with a second medication that was being injected subcutaneously (the bridging was only initiated several days post-implant)."

He opined that there was "little doubt" that the administration of anticoagulation medications played a role in this event. Dr. Gross opined that these findings were "highly inconsistent" with an AICD-related complication, since the abrupt development of cardiac tamponade more than one week after the implantation procedure was "rare." According to Dr. Gross, the need for a pericardial window, after a patient already had undergone a pericardiocentesis, would indicate a continuous bleeding process, despite the absence of any detected heart muscle injury

or extracardiac lead location. As crucial to this motion, however, Dr. Gross conceded that

> "[o]ne *cannot absolutely exclude subclinical myocardial irritation from the procedure that was manifest only after anticoagulation* (though I have no idea how any clinician can recognize that intraoperatively)"

(emphasis added). He thus concluded that it was "equally plausible," with the caveat that it thus was equally unlikely, that the tamponade was "a delayed *result of myocardial or vascular injury resulting from the cardiac catheterization* performed days earlier" (emphasis added).

As Dr. Gross explained it, a more cogent argument is that the plaintiff's mild, preoperative pericardial effusion indicated a preceding pericardial irritation that resulted in abrupt bleeding only after a therapeutic anticoagulation level was reached. He concluded that, in accordance with Iyer's preoperative and postoperative recommendations, anticoagulation medications were timely and properly administered in appropriate dosages following the AICD implantation. Dr. Gross noted that the risks associated with early administration of an anticoagulant following AICD implantation include bleeding and hematoma formation at the surgical site. In this respect, he asserted that Iyer properly prescribed "bridging anticoagulation," that is, the administration of a short-acting blood thinner such as Lovenox, which had been prescribed to the plaintiff on February 12, 2014, until the administration of the longer-acting blood thinner Coumadin could be resumed. As he explained it, to reach that determination, the plaintiff's INR level, which measures the time it takes blood to clot, is monitored, with the goal to achieve a therapeutic INR index of 2.0-2.5, noting that the lower the INR level, the higher risk of developing a clot, and that once a patient's INR index reaches an appropriate level, a patient may be restarted on Coumadin.

Dr. Gross read the plaintiff's chart as indicating that the latter's INR index was below the therapeutic goal of 2.0 from February 8, 2014 through February 14, 2014, thus suggesting that the plaintiff was at an elevated risk for clotting, but that INR was being closely monitored. Nonetheless, he asserted that the reading was "slowly uptrending during those days," but had yet to reach an optimum level to render it "therapeutic." Hence, Dr. Gross concluded that the

plaintiff's need for anticoagulation was far more pressing than most, particularly because the plaintiff's original hospital admission was due to a stroke that, in turn, "was likely due to a blood clot." As he explained it, as of 2024, that is, 10 years after the procedure, it was common for cardiac electrophysiologists to perform AICD implants on "uninterrupted" anticoagulation in patients such as the plaintiff, and he thus concluded that the approach employed by Iyer was far more conservative. In connection with the plaintiff's case, Dr. Gross asserted that every clinical decision, including the right ones, can result in unintended consequences and that, "[f]ortunately, the emergency that developed" here was "appropriately diagnosed and treated."

Dr. Gross ultimately concluded that the evolution of the plaintiff's pericardial effusion was due not to any malfeasance by Iyer or NYPH staff, and that a pericardiocentesis was properly performed upon the plaintiff, explaining that approximately 1,500 cubic centimeters of bloody fluid were removed and that a drain was placed, thus resolving the hemopericardium and improving the plaintiff's blood pressure. He noted that the plaintiff later underwent a subxiphoid window only because fluid re-accumulated in the plaintiff's heart sac, a phenomenon that he described as "not rare," since the need for a such secondary procedure is "always" recognized as a possibility. As Dr. Gross explained it, the plaintiff presented with a stroke, had heart failure during his hospital stay that was difficult to treat, and underwent many diagnostic procedures, along with an AICD implant that eventually protected him from a life-threatening arrhythmia. He asserted that, one week after the procedure, the plaintiff abruptly developed a bloody pericardial effusion of "uncertain cause," and that the latter's life was saved by expeditious diagnosis and treatment by NYPH staff. As Dr. Gross framed the issue, the plaintiff has since encountered many subsequent challenges, including the need for the implantation of a left ventricular assist device, and the revision of that system, but that, "[o]f all the challenges that the patient has faced, an apparently uncomplicated ICD implantation that provided probable lifesaving therapy is the least of these problems."

In addition, Dr. Gross concluded that NYPH hospital staff members were properly supervised by all of the attending physicians who treated the plaintiff, an opinion that he premised upon the deposition testimony of NYPH physician Veli K. Topkara, M.D., who, in 2014, was either a resident or fellow acting under the supervision of an attending physician.

In opposition to NYPH's motion, the plaintiff submitted only an attorney's affirmation and a counter statement of material facts, but did not submit an expert's affirmation. Counsel argued in his affirmation that NYPH failed to establish its prima facie entitlement to judgment as a matter of law in connection with the plaintiff's claim that some type of irritation or breach of a blood vessel caused the perfusion of blood into the sac around the plaintiff's heart, and the concomitant need for additional surgery to repair that problem and resolve that condition. Specifically, counsel adverted to Dr. Gross's concessions that "[o]ne cannot absolutely exclude subclinical myocardial irritation from the procedure that was manifest only after anticoagulation" and that it was "equally plausible" that cardiac tamponade was "a delayed result of myocardial or vascular injury resulting from the cardiac catheterization performed days earlier." Moreover, counsel argued that, inasmuch as Dr. Gross admitted that the plaintiff's symptoms were caused by a buildup of blood in the sac surround the heart, and that the follow-up procedure to repair the cause of the perfusion and resolve the buildup was necessary to address the plaintiff's conditions, NYPH's own submissions reflected the existence of triable issues of fact as to whether Iyer negligently performed the procedure and whether Iyer's negligence proximately caused injury to the plaintiff.

In reply, NYPH submitted an attorney's affirmation, in which counsel noted Dr. Gross's apparent concessions, but argued that Dr. Gross adequately explained his doubts and caveats as to why iatrogenic injury was less likely to be the source of the plaintiff's condition than an expected adverse reaction to anticoagulants, or an unexplained, idiopathic cause. Counsel nonetheless asserted that, if the court were to deem Dr. Gross's opinion as insufficient to establish NYPH's prima facie entitlement to judgment as matter of law in connection with the

propriety of the techniques employed during the procedure, the court should still award summary judgment dismissing the plaintiff's other claims, as set forth in the complaint and bill of particulars, since the plaintiff submitted no opinions by any expert to contradict Dr. Gross's opinions is these respects. These claims included allegations that Iyer failed to take a proper medical history, failed properly to prepare the plaintiff for the placement of the AICD, failed timely to realize the nature and extent of the perfusion, failed timely to diagnose the plaintiff's condition, failed properly to supervise other medical personnel, failed to order and perform appropriate diagnostic testing, and failed to render proper and adequate follow-up care and treatment. They also included the plaintiff's allegations that Iyer failed to ensure that the needle employed in the procedure did not penetrate the artery next to the vein that led to his heart and failed to ensure that the wires placed within the heart chambers did not penetrate the heart.

The court agrees with the plaintiff that NYPH, by submitting an expert affirmation that admitted that iatrogenic injury arising from improper surgical technique could have caused the plaintiff's injuries, failed to establish its prima facie entitlement to judgment as a matter of law in connection with so much of the medical malpractice action as was premised upon allegedly improper technique employed by Iyer and his assistants in the course of implanting the AICD (*see Zapata v Buitriago,* 107 AD3d at 978-979; *Rivera v Jewish Home Life Care*, 2024 NY Slip Op 33887[U], *5-6, 2024 NY Misc LEXIS 13868, *8 [Sup Ct, N.Y. County, Oct. 30, 2024] [summary judgment must be denied where defendant's expert admits that the cause of the decedent's injuries was inconclusive]). Nonetheless, the court agrees with NYPH that summary judgment should be awarded to NYPH dismissing so much of the medical malpractice cause of action as was premised upon other claims, including claims that the allegedly improper technique involved the penetration of a needle into the artery next to the vein that led to plaintiff's heart, and the penetration of wires that had been placed within the heart chambers into the heart muscle itself.

"'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]). Since there is no dispute that Iyer, the nonparty physician whose alleged negligence underpins the plaintiff's claims, was employed by NYPH during the time that he rendered care, to the extent that the court has determined that there are triable issues of fact as to whether Iyer or his team committed malpractice, there are triable issues of fact as to whether NYPH may be held vicariously liable therefor.

In light of the foregoing, it is,

ORDERED that the defendant's motion for summary judgment dismissing the complaint is granted only to the extent that summary judgment is awarded to the defendant dismissing all claims premised upon departures from good and accepted medical practice *other than* the defendant's alleged negligence in the surgical techniques used by its medical employees during the February 7, 2014 implantation procedure, except as to allegations of improper technique alleging the penetration of a needle into the artery next to the vein that led to plaintiff's heart, and the penetration of wires from the plaintiff's heart chambers and into the heart muscle itself, those claims are dismissed, and the motion is otherwise denied; 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 12 noon., 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.

8/26/2025
DATE

JOHN J. KELLEY, J.S.C.

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