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

**PRESENT:** **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

***Justice***

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GARY MERCER and LIZ MERCER,

Plaintiffs,

- v -

JENNIER KUO, M.D., CLAIRE GRAVES, M.D., and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

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**INDEX NO.** 805205/2019

**MOTION DATE** 07/23/2025

**MOTION SEQ. NO.** 008

**DECISION AND ORDER ON MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 008) 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134

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, lack of informed consent, negligent hiring, training, supervision, and retention of health-care personnel, and loss of spousal consortium, the defendants Jennifer Kuo, M.D., and New York Presbyterian Hospital (together the NYPH defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiffs oppose the motion. The motion is granted only to the extent that the NYPH defendants are awarded summary judgment dismissing the negligent hiring, training, supervision, and retention cause of action insofar as asserted against them, and the motion is otherwise denied, as there are triable issues of fact in connection with the remaining causes of action.

The crux of the plaintiffs' claim is that, on January 2, 2019, the defendant endocrine surgeon Kuo, in the course of her employment with the defendant New York Presbyterian Hospital (NYPH), departed from good and accepted practice in prematurely determining to perform surgery to remove an adrenal mass from the kidney of the plaintiff Gary Mercer (the

patient), in commencing the surgery via a retroperitoneal laparoscopic approach, and in causing iatrogenic injuries to the patient's pleural barrier and other organs and tissues, including his pancreas, before intraoperatively converting the laparoscopic procedure to an open procedure.

In their complaint, the plaintiffs alleged that Kuo departed from good and accepted medical care beginning on December 20, 2018, when the patient first presented to her, and continuing through February 1, 2019, when Kuo and NYPH last examined or saw the patient. They further asserted that NYPH was vicariously liable for Kuo's negligent acts, that Kuo did not obtain the patient's fully informed consent to the procedure, and that NYPH negligently hired, trained, supervised, and retained health-care personnel.

In their bill of particulars, the plaintiffs alleged that Kuo departed from good and accepted medical practice in negligently and carelessly rendering medical, surgical, and internal care and treatment, in failing to take a full and proper history of the patient, in failing properly to perform a left retroperitoneal laparoscopic adrenalectomy on January 2, 2019, in negligently puncturing a splenic vein during the procedure, and in failing to appreciate and diagnose the puncture when it occurred. They further asserted that Kuo failed to appreciate signs that there was free air present in the patient's chest during the procedure, despite the results of a chest x-ray performed on January 2, 2019 that revealed that condition and, thus, failed to place a chest tube intraoperatively to remove the free air. In addition, the plaintiffs averred in their bill of particulars that Kuo failed to appreciate the signs and symptoms of infection with which the patient presented postoperatively, such as fever and elevated white blood cell count, failed to request an infectious disease consultation between January 3, 2019 and February 9, 2019, and failed properly to treat the infection that the patient actually sustained as a consequence of the surgery, which ultimately required negative pressure wound therapy that had to be effectuated through the employment of a wound vac device. Moreover, they claimed that Kuo failed to appreciate the patient's symptoms of blood clot on January 24, 2019 and negligently attempted to discharge him from NYPH despite the presence of fever and an elevated white blood cell

count. The plaintiffs also faulted Kuo for negligently supervising the prescription of medicine and for negligently failing to order x-rays and a computed tomography (CT) scan, thus failing to appreciate the patient's left shoulder pain for approximately one week in February 2019, and in causing fluids to collect and remain in the surgical area, thus failing to diagnose the patient with, and properly treat him for, postoperative left lung collapse. They further asserted, in this respect, that Kuo failed to monitor and test the patient at sufficiently frequent intervals, and failed properly to analyze and interpret the diagnostic tests that she did order. They asserted that, as a consequence of these departures, the patient suffered from a puncture of his splenic vein, splenic artery rupture, a medically induced coma, infections and wounds requiring wound vac therapy, a collection of pancreatic fluid that eroded his artery, pneumonia, the concomitant need for intubation, blood clots in his right legs, fever, chest pain, left shoulder pain, left lung collapse, dehydration, malnutrition, and permanent scarring, along with fear and anxiety, loss of personal dignity and enjoyment of life, depression, and anguish.

In addition, the plaintiffs, in their bill of particulars, alleged that the defendants failed to provide the patient with information sufficient to allow him to render an informed consent, since he was not made aware of the risks of infection or lung collapse, nor was he provided with information concerning the prevention of infection. They also contended that the patient was not informed of alternatives to immediately proceeding with the procedure laparoscopically.

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]). Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the outcome was caused by improper surgical or medical technique, rather than by an unexplained or incidental event (*see Matney v Boyle,* 237 AD3d 1382, 1384-1385 [3d Dept 2025]; *Bengston v Wang*, 41 AD3d 625, 626 [2d Dept 2007]; *see also Hoffman v Taubel*, 2021 NY Slip Op 31523[U], *4-5, 2021 NY Misc LEXIS 2379, *8-9 [Sup Ct, N.Y. County, Apr. 30, 2021] [Kelley, J.], *affd* 208 AD3d 1099 [1st Dept 2022] [merely because the transection of a ureter is a known risk of a hysterectomy, it does not follow that a surgeon or a surgeon's assistant is excused from properly performing the procedure]; *Mathias v Capuano*, 2015 NY Slip Op 32160[U], *5-6, 2015 NY Misc LEXIS 4141, *12-14 [Sup Ct, Suffolk County, Nov. 5, 2015]; *cf. Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019]

[plaintiff failed to raise triable issue of fact in opposition to physician's showing that injury was a "known risk that may occur despite competent surgical care having been provided"]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a

departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

In support of their motion, the NYPH defendants submitted the pleadings, the plaintiffs' bill of particulars, the note of issue, relevant medical and hospital records, the transcripts of the parties' deposition testimony, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of surgeon Matthew Nehs, M.D., who opined that the NYPH defendants did not depart from good and accepted practice, and that nothing that they did or did not do caused or contributed to the patient's injuries.

As Dr. Nehs recapitulated the patient's medical history, in 2018, Prabhat Tandon, M.D., was the patient's treating endocrinologist in Florida. According to Dr. Nehs, in late 2018, the patient was 58 years old, weighed 269 pounds with a body mass index (BMI) of 37.37, and, thus, suffered from obesity. He asserted that the patient was a Type II diabetic with essential hypertension, kidney stones, and chronic obstructive pulmonary disease (COPD). Dr. Nehs further noted that, at that time, the patient smoked 21-30 cigarettes per day. He stated that, in a

workup for kidney stones, an October 22, 2018 CT scan revealed the presence of a left adrenal mass measuring 3.2 centimeters (cm) by 3.1 cm, while a November 5, 2018 abdominal magnetic resonance imaging (MRI) scan revealed a mass measuring 3.2 cm by 2.7 cm in the patient's left adrenal gland, which he described as having signal characteristics and enhancement pattern suggestive of an adrenal adenoma. According to Dr. Tandon's December 5, 2018 chart entry, the patient had made plans to travel to New York for adrenal gland surgery.

According to Dr. Nehs, the patient's sister-in-law Maiy Cotogno, R.N., obtained a recommendation for Kuo from a surgeon with whom she had worked at NYU Langone Hospital, and provided Kuo's name and credentials to the patient. Specifically, Cotogno told the patient that Kuo would be able to perform a laparoscopic procedure in connection with the adrenal mass. On December 20, 2018, the patient first consulted with Kuo, at which time Kuo performed a physical examination and reviewed the CT and MRI scans. As Dr. Nehs explained it, Kuo diagnosed the patient with a likely pheochromocytoma in light of the size of the tumor, as well as the fact that the metanephrine[1] levels in the patient's urine and plasma samples were twice the upper limit of the applicable reference range. Kuo thus recommended surgical resection, specifically a laparoscopic retroperitoneal left adrenalectomy, particularly in light of what Dr. Nehs described as "the overall clinical picture." Dr. Nehs explained that Kuo ordered the patient to undergo a positron emission tomography (PET) CT scan, using a radioactive gallium dotatate tracer, which he characterized as the most sensitive imaging test for pheo/paraganglioma. He asserted that, based on the results of that scan, Kuo evaluated the patient with a possible adenoma and/or pheochromocytoma, and that she wrote in the patient's chart that the patient would benefit from a laparoscopic retroperitoneal approach, since his BMI was less than 40 and the tumor was less than 6 cm in size, and because that approach "can

[1] Metanephrines are breakdown products of epinephrine and norepinephrine.

produce less pain, allows a faster return to normal activities, [and] has fewer complications" than an open procedure, and "has a better cosmetic approach."

As Dr. Nehs described it, after beginning the laparoscopic retroperitoneal left adrenalectomy on January 2, 2019, a "pleural defect medially was noted," upon which Kuo stopped the procedure to repair the defect, but, during the repair process, "a defect in the peritoneum occurred," although Dr. Nehs did not specifically explain the etiology of those two defects. He stated that, when sufficient insufflation was unable to be achieved, Kuo closed the retroperitoneal space and initiated a transabdominal approach to completing the surgery. Dr. Nehs asserted that, once the patient was placed in a supine position, his ventilation and oxygenation improved, upon which Kuo entered into the peritoneum laparoscopically, but that when ventilation became tenuous and adequate insufflation was unable to be achieved, the laparoscopic dissection had to be discontinued. He stated, at that juncture, Kuo initiated an open surgical approach, and ascertained that the mass that she initially thought was the targeted adrenal mass, and had begun to dissect was, in fact, the patient's distal pancreas. Kuo thereupon obtained an intraoperative consultation, and thereafter placed hemostatic sutures on the distal pancreas. According to Dr. Nehs, the presence of a tremendous amount of the patient's body fat, even in the open approach, "made visualization and orientation incredibly difficult[,] and when the distal pancreas was mobilized, an injury to the splenic vein necessitated ligation of the vein." He averred that, once hemostasis was achieved, the true adrenal gland and mass were identified and dissected away from adjacent structures, while the adrenal vein remained and was divided with LigaSure, a surgical device that is employed to seal blood vessels during surgery. Dr. Nehs further explained that, at the end of the procedure, the patient's distal pancreas, spleen, and kidney all remained viable. He also asserted that Kuo repaired another small defect, this one near the ligament of Treitz, which was within the patient's duodenum, but that she could not adequately visualize the pleural defect in order to attempt a further repair. Kuo obtained a chest x-ray, and noted that the right upper lobe of

patient's lung was collapsed. She completed the surgery and transferred the patient to the NYPH intensive care unit (ICU) in what she described as a "stable" condition.

Dr. Nehs opined that, based upon the evaluations of laboratory test results, the imaging of the nodule in the left adrenal gland, and the preoperative workup, left retroperitoneal adrenalectomy surgery was indicated, and that the standard of care for the treatment of a suspected pheochromocytoma and/or an adrenal adenoma is the complete surgical removal of the mass, whether potentially cancerous or benign. In this regard, he explained that the mass must be completely removed regardless of whether it is malignant, since a biopsy can cause leakage from the capsule of the adrenal gland, and the leakage can cause seeding of the tumor about the peritoneal cavity. As relevant to the plaintiffs' claims here, Dr. Nehs concluded that Kuo's determination to employ a retroperitoneal laparoscopic approach was appropriate and within the standard of care. He explained that only a handful of endocrine surgeons in the United States perform an adrenalectomy procedure laparoscopically from the back of the patient. He opined that, even in connection with a patient suffering from obesity, both that approach, as well as a transabdominal laparoscopic approach that Kuo also attempted, are appropriate and within the standard of care. Dr. Nehs further opined that known the risks of either of those two procedures included bleeding, infection, and injury to surrounding organs, and the sequelae of those conditions. He also stated a laparoscopic retroperitoneal approach can result in less pain, allows a faster return to normal activities, has fewer complications, and has a better cosmetic approach than open surgery.

Dr. Nehs asserted that, when Kuo "inadvertently entered the pleural space of the lung with her trocar, this was a known risk or complication of a retroperitoneal laparoscopic approach, and not a departure from good and accepted practice." As he explained it, anatomically, where a surgeon's trocars are blindly inserted to address a mass in the middle of a patient's abdomen at the adrenal gland, there are usually three or four trocars that are placed below the twelfth rib, and that it was "likely that Defendant DR. KUO inadvertently entered a

portion of the pleural space with the trocar." He reiterated that Kuo's "inadvertent" trocar puncture is a "known complication of a retroperitoneal laparoscopic approach, and not a departure from good and accepted practice, and additionally concluded that a collapsed lung, caused by an inadvertent entry into the pleural space, is also a known risk associated with the procedure that did not represent a departure from good and accepted practice.

Dr. Nehs further stated that Kuo's initial conversion of the surgical procedure to a transabdominal laparoscopy was appropriate and within the standard of care, inasmuch as sufficient insufflation could not be achieved with the retroperitoneal approach, and that, when the patient could not be properly ventilated and adequate insufflation was still unable to be achieved with the transabdominal laparoscopic approach, a conversion to an open procedure was appropriate and within the standard of care. He also concluded that, "when insult to the distal pancreas occurred, an intraoperative consult was obtained and hemostasis was achieved," all of which was in accordance with the standard of care, because that insult to the distal pancreas also was a known risk or complication associated with the procedure, and did not represent a departure from good and accepted practice. In addition, Dr. Nehs averred that, "when insult to the splenic vein occurred[,] hemostasis was achieved," which was in accordance with the standard of care, and that, in any event, "that insult to the splenic vein" was another known risk or complication associated with the procedure, and did not represent a departure from good and accepted practice. As he framed the issue,

> "the multiple complications, including, puncture of the splenic vein, infections, blood clots, pancreatic fluid collection and lung collapse, during and immediately following Plaintiff GARY MERCER'S surgery on January 2, 2019 were all known risks and/or complications associated with the procedure and do not represent departures from good and accepted practice,"

while the patient's lung collapse, which he conceded was "due to the inadvertent entry into the pleural space, and subsequent development of pneumonia," were also "known risks or complications associated with this procedure and aftermath of being immobilized in the hospital and do not represent departures from good and accepted practice." While Dr. Nehs also

conceded that, at some point during the procedure, there was a leak from the capsule of the pancreas, he opined that, in the course of a procedure such as the one at issue here, which involves the removal of an adrenal mass, the pancreas needs to be mobilized, and that such leakage is another known risk or complication associated with the procedure and mobilization of the pancreas that did not represent a departure from good and accepted practice. In this respect, he explained that that the leakage of pancreatic fluids, which can take days or weeks to destroy tissue, cannot be assessed even with an intraoperative consultation, as was the case here. He asserted that, although this leakage of pancreatic fluids was, in fact, the etiology of the patient's bleed from the splenic artery, the latter constituted another known risk or complication associated with the procedure, and did not represent any departure from good and accepted practice. In any event, he opined that this bleed was resolved with an embolization performed by an interventional radiologist, which itself was in accordance with the standard of care.

Dr. Nehs also concluded that the patient's development of a deep vein thrombosis (DVT), and the ultimate need for the insertion of an inferior vena cava (IVC) filter, also were known risks or complications associated with the procedure that were not caused by any departure from good and accepted practice, as was the patient's development of pneumonia and his extended admission to the ICU. He attributed these conditions, in part, to the patient's obesity and the patient's immobilization in the ICU for several weeks following the procedure.

In opposition to the motion, the plaintiffs relied on many of the same documents that the NYPH defendants had submitted. They also submitted an attorney's affirmation, a counter statement of material facts, a memorandum of law, and the expert affidavit of adrenal and kidney surgeon Francisco Gelpi-Hammerschmidt, M.D., who opined that Kuo did, in fact, depart from good and accepted practice, and that her departures from good practice caused and contributed to the injuries that the patient identified in the complaint and bill of particulars.

Dr. Gelpi-Hammerschmidt averred that, in his practice, he performs surgery on adrenal glands, has performed approximately 50 to 60 adrenalectomies, and has performed more than

100 kidney surgeries using the laparoscopic retroperitoneal approach. He expressly stated that he was familiar with the standard of care applicable to adrenal surgery in New York. He opined that Kuo departed from good and accepted practice by performing any surgical procedure upon the patient "at the time she undertook them," inasmuch as "surgery was not urgent or emergent." As he explained it, the tumor itself was "small," and the preoperative workup that Kuo performed was "inconclusive" as to whether the mass was malignant. He stated that there was little in the way of clinical symptomology, such as complaints of headaches, to indicate an active adrenal issue necessitating immediate surgery. Dr. Gelpi-Hammerschmidt noted that the patient was "very large" at the time of the surgery on January 2, 2019, with a BMI of 39.32 and a weight of 274 pounds. He asserted that the chances for a safer, complication-free surgery would have been significantly improved by having the patient lose weight while monitoring him. As Dr. Gelpi-Hammerschmidt framed the issue, instead, the large amount of fat in the patient made visualization and orientation of relevant organs and membranes difficult for Kuo, which resulted in a "cascade of preventable complications during Dr. Kuo's surgery."

Dr. Gelpi-Hammerschmidt expressly asserted that it was a departure from the standard of care for Kuo to have utilized the surgical approach that she elected, as it was "bound to result in enhanced opportunities for the occurrence of avoidable complications." He explained that the retroperitoneal laparoscopic approach for removal of an adrenal mass is more challenging than the conventional transabdominal approach, and that the patient's weight and BMI made the retroperitoneal laparoscopic approach even riskier. He further stated that it was not until Kuo began the surgery, and already had "caused injuries to the patient," that she changed course and adopted the more conventional, open approach. Dr. Gelpi-Hammerschmidt asserted that those iatrogenic injuries, including the injury to the pleural barrier, resulted, in the first instance, from Kuo's choice to proceed with a retroperitoneal laparoscopic approach. He further opined that Kuo departed from the applicable standard of care by failing to abort the surgery once the "serious injuries to the patient began occurring." Dr. Gelpi-Hammerschmidt asserted that Kuo

first injured the patient's pleural barrier, and then experienced ventilation issues, which he characterized as circumstances warranting the termination of the surgery, which would have allowed the patient to heal, and permitted the consideration of a different approach to the removal of the adrenal mass. As he phrased, it, "[i]nstead, Dr. Kuo forged ahead, changing the patient's positioning and her surgical approach, and continued causing injuries to him, *including dissecting his pancreas after mistaking it for his adrenal gland*" (emphasis added).

Dr. Gelpi-Hammerschmidt explicitly disagreed with Dr. Nehs's opinion that, in essence, all of the care that Kuo rendered to the patient was within the standard of care and did not cause any of the claimed injuries. While he agreed with Dr. Nehs that the standard of care applicable to the type of adrenal mass presented by the patient was surgical removal, he reiterated that surgery was not yet indicated because of the patient's weight and BMI, and expressly disagreed with Dr. Nehs that the patient's injuries were known risks and complications associated with the procedure, and were not the products of a departure from the standard of care. In addition to his opinions that surgery was not urgent and that Kuo's initial surgical approach departed from the standard of care, Dr. Gelpi-Hammerschmidt opined that Kuo caused the patient's initial injuries, which he characterized as "significant," and reiterated that the significance of those injuries should have caused Kuo to abort the procedure, which "would have prevented the many additional injuries suffered by Mr. Mercer from happening."

In reply, the NYPH defendants submitted an attorney's affirmation, in which counsel argued that Dr. Gelpi-Hammerschmidt was not qualified to render an opinion because he never performed a retroperitoneal laparoscopic adrenalectomy, which was the type of surgery that Kuo performed on the patient. In this respect, counsel contended that the plaintiffs' expert attempted "to fool the Court into believing that the two (2) surgeries he purports to perform: removal of the adrenal glands, and KIDNEY (an entirely different organ) surgeries using the 'laparoscopic retroperitoneal approach' make him somehow qualified to opine as to the surgery in question---removal of the adrenal glands with a laparoscopic retroperitoneal approach."

Counsel further argued that the patient never explicitly asserted in the bill of particulars that Kuo departed from good practice by performing the surgery prematurely.

The court concludes that, while Dr. Nehs's affirmation bordered on the speculative, since he characterized almost every injury-causing surgical cut made by Kuo as "inadvertent" and a known risk of the procedure, the NYPH defendants nonetheless made the necessary prima facie showing of entitlement to judgment as a matter of law in connection with the medical malpractice cause of action as asserted against Kuo (*see Matney v Boyle,* 237 AD3d at 1384-1385). Initially, the court rejects the NYPH defendants' contention that the plaintiffs' expert was not qualified to render an opinion as to the propriety of Kuo's approach, and, in the exercise of its discretion (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]), concludes that Dr. Gelpi-Hammerschmidt was, in fact, qualified by training, education, and experience to render all of the opinions set forth in his affidavit (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247,1248 [4th Dept 2008]; *Julien v Physician's Hosp.*, 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp.*, 161 AD2d 352, 355 [1st Dept 1990]). There is no requirement that the plaintiffs' expert even have the same specialty within the field of adrenal surgery as Kuo in order to opine about the applicable standard of care (*see Benfer v Sachs*, 3 AD3d 781, 782 [3d Dept 2001]), let alone that he had to have performed the precise surgery that is the subject of this action. In any event, the adrenal glands are situated immediately on top of the kidneys, and the plaintiffs' expert not only has performed numerous adrenalectomies, but has performed laparoscopic retroperitoneal procedures on the kidneys, which qualifies him to opine as to whether or when such a procedure should be performed on the adrenal glands. Moreover, while a concededly "inadvertent" transection of an organ or membrane during a laparoscopic procedure does not automatically constitute a departure from good and accepted practice (*see Toomey v Adirondack Surgical Assocs. P.C.* 280 AD2d 754, 754-755 [3d Dept 2001]), here, the plaintiffs

raised triable issues of fact as to whether the several transections and punctures committed by Kuo constituted departures from good and accepted practice due to Kuo's inability to visualize the patient's surgical field, which Dr. Gelpi-Hammerschmidt opined was, in turn, due to Kuo's choice of surgical approaches and the patient's weight and BMI (*see Georges v Forest Manor Care Ctr., Inc.,* 2024 NY Misc LEXIS 17623, *13-14 [Sup Ct, Queens County, Mar. 26, 2024]). In addition, the court concludes that Dr. Gelpi-Hammerschmidt's opinion that Kuo's surgery was premature was subsumed in the plaintiffs' allegations of improper surgery; to the extent that prematurity was not expressly identified as a departure, a motion to conform the pleadings to the proof "may be made at any time and should be liberally granted 'unless doing so results in prejudice to the nonmoving party'" (*Lakshmi Grocery & Gas, Inc. v GRJH, Inc.,* 138 AD3d 1290, 1291 [3d Dept 2016], quoting *Matter of Mogil v Building Essentials, Inc*., 129 AD3d 1378, 1380 [3d Dept 2015]; *see* CPLR 3025[c]; *Murray v City of New York*, 43 NY2d 400, 405 [1977]; *Lewis & Clarkson v October Mtn. Broadcasting Co*., 131 AD2d 15, 17 [3d Dept 1987]), and the NYPH defendants have not shown any prejudice or inability to contest the evidence which may underly the basis for any proposed amendment to the complaint and bill of particulars that the plaintiffs might hereinafter seek (*see Gonfiantini v Zino*, 184 AD2d 368, 369-370 [1st Dept 1992]).

In light of the foregoing, the court must deny that branch of the NYPH defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Kuo.

"'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 Kuo was employed

by NYPH during the time that she rendered care to the patient, to the extent that the court has determined that there are triable issues of fact as to whether Kuo committed malpractice, there are triable issues of fact as to whether NYPH may be held vicariously liable therefor.

The elements of a cause of action to recover for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a physician, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the [medical] procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]). Nonetheless, expert testimony is not necessary with respect to the issue of whether a reasonably prudent person, fully informed, would not have consented to the treatment (*see Gray v Williams*, 108 AD3d 1085, 1086-1087 [4th Dept 2013]; *Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept 2000]; *Hardt v*

*LaTrenta*, 251 AD2d 174, 174 [1st Dept 1998]; *Osorio v Brauner*, 242 AD2d 511, 511-512 [1st Dept 1997]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy the burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, were discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

Dr. Nehs asserted that the patient's chart and the parties' deposition testimony established that Kuo informed the patient of the risks and benefits of, alternatives to, and indications for the operation, including bleeding, infection, and injury to surrounding organs, as well as the patient's specific risk profile. He averred that Kuo spent 30 minutes of face-to-face time with the patient. Dr. Nehs further noted that the patient signed an informed consent form referable to a left retroperitoneal laparoscopic adrenalectomy and related procedures, in which he attested that the "nature and purpose of the surgery or procedure and the potential benefits, risks and side effects" had been explained to him, as had all "reasonable alternative care/ treatment choices including no treatment and the respective medical risks, benefits and side effects." Dr. Nehs further asserted that the form itself had advised the patient that "the practice of medicine is not an exact science and no guarantee has been made" to him "about the outcome of the surgery or procedure." The form also notified the patient that he "had the chance to ask questions," that any questions were "answered to [his] satisfaction," and that he "consent[ed] to the procedure." Dr. Nehs concluded that Kuo appropriately and fully conveyed the risks of the procedure to the patient, and that he thereupon consented to the procedure.

Dr. Gelpi-Hammerschmidt, however, expressly disagreed with Dr. Nehs's opinion as to the qualitative sufficiency of the informed consent given by the patient because Kuo never informed either the patient or his wife, the plaintiff Liz Mercer, that the risks of the surgery included a pierced pleural barrier, a collapsed lung, a dissected pancreas, a nicked splenic vein, blood clots, pancreatic fluid collection, pneumonia, DVT, the need for the insertion of an IVC filter, the need to undergo months of unanticipated hospitalization and rehabilitation, the need for multiple placements of stents, and lifelong pain and mental confusion. He adverted to the patient's deposition testimony, in which the patient averred that Kuo informed him only about her planned approach, and the possibility of the intraoperative conversion of the procedure to an open left adrenalectomy. Moreover, the patient testified that Kuo met with him only for 10 minutes on the morning of the procedure, and told him that the procedure would take only about 40 minutes, but that he first awoke from the procedure four days later. Liz Mercer testified that Kuo told her only that there were risks inherent in any surgery, and discussed the possibility of converting the procedure and proceeding through the patient's front, rather than his back. The plaintiffs' expert thus opined that the consent obtained by Kuo was qualitatively insufficient, and suggested that, had the patient known of the risk that he would experience the injuries that he actually sustained, he would not have consented to undergoing an adrenalectomy via a retroperitoneal laparoscopic approach. Consequently, although the NYPH defendants established their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action, the plaintiffs raised a triable issue of fact in opposition to that showing, and that branch of the motion seeking summary judgment dismissing that cause of action insofar as asserted against the NYPH defendants must be denied.

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 defendants established, prima facie, that Kuo and all other health-care personnel working for both Kuo and NYPH were properly trained. Since the plaintiffs, in their opposition papers, adduced no facts with respect to whether the NYPH defendants knew or should have known of the propensity of any employee to commit acts of malpractice, that branch of the motion seeking summary judgment dismissing that cause of action against them must be granted.

The court notes that, although Dr. Gelpi-Hammerschmidt's affidavit was sworn to and executed in Texas, it was not accompanied by the certificate of conformity required by CPLR 2309. A certificate of conformity is a written instrument, pursuant to which a person qualified by the laws of the state in which an affidavit or affirmation is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit or affirmation has indeed been drafted, executed, and notarized in conformity with the laws of that state. The absence of the certificate of conformity, however, does not require the court to disregard or reject Dr. Gelpi-Hammerschmidt's affidavit, as the failure to include a certificate of conformity is a mere irregularity that may be cured by the submission of the proper certificate nunc pro tunc (*see Khurdayan v Kassir*, 223 AD3d 590, 591 [1st Dept 2024]; *Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]). Consequently, the court directs the plaintiff to serve and file the necessary certificate of conformity on or before September 30, 2025.

As a derivative claim, the loss of consortium cause of action asserted by Liz Mercer, as the patient's wife, remains viable to the extent that the patient's medical malpractice and lack of informed consent causes of action remain viable (*see Robinson v Northwell Health, Inc.*, 2021 NY Slip Op 33146[U], *8. 2021 NY Misc LEXIS 8552, *16-17 [Sup Ct, Queens County, Dec. 6,

2021]; *see generally Clarke v City of New York*, 82 AD3d 1143, 1144 [2d Dept 2011]; *Kaisman v Hernandez*, 61 AD3d 565, 566 [1st Dept 2009]).

Since the plaintiffs have not established that the defendant Claire Graves, M.D., was ever properly served with process pursuant to the CPLR, or that this court acquired personal jurisdiction over her, the court is constrained to dismiss the complaint insofar as asserted against her (*see Diaz v Perez*, 113 AD3d 421, 421 [1st Dept 2014] [affirming sua sponte dismissal of complaint insofar as asserted against individual defendant who was never served with summons]).

Accordingly, it is,

ORDERED that the motion of the defendants Jennier Kuo, M.D., and New York Presbyterian Hospital for summary judgment dismissing the complaint insofar as asserted against them is granted only to the extent that they are awarded summary judgment dismissing the negligent hiring, training, supervision, and retention cause of action insofar as asserted against them, the negligent hiring, training, supervision, and retention cause of action is dismissed insofar as asserted against the defendants Jennier Kuo, M.D., and New York Presbyterian Hospital, and the motion is otherwise denied; and it is further,

ORDERED that, upon the court's own motion, the complaint is dismissed insofar as asserted against the defendant Claire Graves, M.D., and the action is severed against that defendant; and it is further,

ORDERED that, on the court's own motion, on or before September 30, 2025, the plaintiffs are directed to serve and file a certificate of conformity referable to the affidavit of Francisco Gelpi-Hammerschmidt, M.D.; and it is further,

ORDERED 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 September 16, 2025, at 12:30 p.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.

**8/29/2025**
**DATE**

**JOHN J. KELLEY, J.S.C.**

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