SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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RICHARD PRELI,

Plaintiff,

- v -

SANJAY PARASHAR, M.D., JACK S. SHANEWISE, M.D., CRAIG R. SMITH, M.D., and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805036/2024

MOTION DATE 10/14/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 75, 76, 77, 78, 79, 80, 81, 82 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 defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that summary judgment is awarded to the defendant Sanjay Parashar, M.D., dismissing the complaint insofar as asserted against him, and to the defendants Craig R. Smith, M.D., and New York Presbyterian Hospital (NYPH) dismissing, insofar as asserted against them, so much of the medical malpractice caused of action as was premised upon allegations that Smith and his assistants excessively retracted the plaintiff's chest cavity during mitral valve surgery. The motion is otherwise denied. Specifically, that branch of the motion seeking summary judgment dismissing the complaint insofar as asserted against the defendant Jack S. Shanewise, M.D., is denied as academic, since, pursuant to a stipulation dated April 3, 2024, the plaintiff discontinued the action against him, while those branches of the motion seeking summary judgment dismissing the remainder of the complaint insofar as asserted against Smith and NYPH are denied on the merits.

In his complaint, the plaintiff alleged that, on August 22, 2023, the defendant cardio-thoracic surgeon Smith performed a lengthy surgical procedure upon him at the NYPH, with the defendant anesthesiologists Shanewise and Parashar providing anesthesia services. He further asserted that these three physicians were employed by NYPH. The plaintiff alleged that, while he was under anesthesia, Smith, Shanewise, and Parashar improperly positioned him by, among other things, failing to prevent excessive compression to his left arm. He claimed that, as a consequence, he sustained left "brachial plexopathy," constituting an injury to his left ulnar nerve across his elbow, and that this injury was verified by electromyography (EMG) testing. The plaintiff further asserted that he would also be relying on the doctrine of res ipsa loquitur. In his initial and amended bills of particulars, the plaintiff asserted that

> "[a]ll defendants were negligent in improperly positioning plaintiff during a lengthy surgery and allowing excessive compression to occur to the ulnar nerve at the level of the cubital tunnel in the left arm. Defendant Hospital is vicariously liable for the acts/omissions of its employees. Defendant Shanewise was supposed to supervise defendant Parashar,"

and that Smith and surgical assistants were negligent in retracting his chest cavity too widely during the subject procedure. He claimed that, as a consequence of the defendants' malpractice, he was compelled to undergo a left cubital tunnel decompression procedure.

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]). 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 MD'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]; *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]; *Jones v Ricciardelli*, 40 AD3d 935, 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 the burden on a summary judgment motion, 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, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 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; *Luu v Paskowski*, 57 AD3d 856, 857 [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).

Although a plaintiff asserting a medical malpractice claim usually must demonstrate that the defendant physician deviated from acceptable medical practice, and that such deviation was a proximate cause of the plaintiff's injury (*see Rivera v Kleinman*, 16 NY3d 757, 759, [2011]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24; *Terranova v Finklea*, 45 AD3d at 572; *Zellar v Tompkins Community Hosp.*, 124 AD2d 287, 288-289 [3d Dept 1986]), the theory of res ipsa loquitur may be applied to occurrences "[w]here the actual or specific cause of an accident is unknown" (*Kambat v St. Francis Hosp.*, 89 NY2d 489, 494 [1997]). Under such circumstances,

"a jury may . . . infer negligence merely from the happening of an event and the defendant's relation to it" (*id.*; *see States v Lourdes Hosp.*, 100 NY2d 208, 211-212 [2003]; Restatement [Second] of Torts § 328D). To establish a prima facie case of negligence in support of a res ipsa loquitur charge, plaintiff must establish three elements:

> "[1.] the event must be of a kind that ordinarily does not occur in the absence of someone's negligence;
>
> "[2.] it must be caused by an agency or instrumentality within the exclusive control of the defendant; and
>
> "[3.] it must not have been due to any voluntary action or contribution on the part of the plaintiff"

(*Kambat v St. Francis Hosp.,* 89 NY2d at 494; *see James v Wormuth*, 21 NY3d 540, 545-546 [2013]; *Ebanks v New York City Tr. Auth.*, 70 NY2d 621, 623 [1987]; Prosser and Keeton, Torts § 39 at 244 [5th ed]). Res ipsa loquitur, a doctrine of ancient origin (*see Byrne v Boadle*, 2 H & C 722, 159 Eng Rep 299 [1863]), derives from the understanding that some events ordinarily do not occur in the absence of negligence (*see id.; see also Dermatossian v New York City Tr. Auth.*, 67 NY2d 219, 226 [1986]). Once a plaintiff satisfies the burden of proof on these three elements, the res ipsa loquitur doctrine permits the jury to infer negligence from the mere fact of the occurrence (*see States v Lourdes Hosp.*, 100 NY2d at at 211-212; *Kambat v St. Francis Hosp.,* 89 NY2d at 495). Thus, for example, where "a foreign object is left in the body of the patient, or the patient, while anesthetized, experiences an unexplained injury in an area which is remote from the treatment site" (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 827 [2d Dept 2016] [citation omitted]), the invocation of the doctrine of res ipsa loquitur may be warranted (*see id.; see also Mattison v OrthopedicsNY, LLP*, 189 AD3d 2025, 2027 [3d Dept 2020]*; Swoboda v Fontanetta*, 131 AD3d 1042, 1045 [2d Dept 2015]; *DiGiacomo v Cabrini Med. Ctr.*, 21 AD3d 1052, 1054 [2d Dept 2005]; *Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]; *Leone v United Health Servs.*, 282 AD2d 860, 860-861 [3d Dept 2001]; *Hill v Highland Hospital*, 142 AD2d 955, 956 [4th Dept 1988]).

The doctrine of res ipsa loquitur frequently has been found applicable to circumstances in which an anesthetized patient sustained an injury during surgery in an area remote from the surgical site, and the defendants provided no evidentiary proof as to what caused the injury (*see Rosales-Rosario v Brookdale Univ. Hosp. & Med. Ctr.,* 1 AD3d 496, 497 [2d Dept 2003] [infliction of burn on the inner portion of patient's right knee while she was hospitalized to give birth]; *Babits v Vassar Bros. Hosp.*, 287 AD2d 670, 671 [2d Dept 2001] [infliction of a third-degree burn on the rear area of the plaintiff's right upper thigh during orthoscopic knee surgery]; *Mack v Lydia E. Hall Hosp.*, 121 AD2d 431, 431-433 [2d Dept 1986] [infliction of third degree burns on the side of patient's left thigh during the course of a surgical procedure for the treatment of rectal cancer]).

In support of their motion, the defendants submitted the pleadings, the plaintiff's bills of particulars, the note of issue, relevant medical and hospital records and reports, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmations of board-certified psychiatrist/neurologist, electrodiagnostic medicine, and clinical neurophysiology specialist Kiril Kiprovski, M.D., board-certified general and thoracic surgeon George Tolis, Jr., M.D., and board-certified cardiac anesthesiologist Marc S. Kanchuger, M.D., all of whom opined that the defendants practicing within each of those experts' specialties did not depart from good and accepted practice in the care that they rendered to the plaintiff, and that nothing that they did or did not do caused or contributed to the plaintiff's injuries. In his affirmation, the defendants' attorney contended, among other things, that the doctrine of res ipsa loquitur was not applicable to the facts of this case.

As Dr. Kiprovski interpreted the relevant medical charts, on June 22, 2023, the plaintiff presented to Smith's office, following a May 2023 hospital admission for bacteremia, presumably from urosepsis/prostatitis, during which he was found to have endocarditis. The plaintiff sought a second opinion from Smith as to whether mitral valve repair surgery was warranted, and informed Smith of a longstanding history of mitral valve prolapse and mitral

valve regurgitation. In his records, Smith reported that, on May 30, 2023, the plaintiff had undergone a transesophageal echocardiogram, which had revealed an echodensity measuring 8 millimeters (mm) by 2.5 mm on the left atrial surface of the mitral valve. According to Dr. Kiprovski, the results of this imaging study were suspicious for a "vegetation," and also revealed the presence of degenerative mitral valve disease, severe mitral valve regurgitation, and a severely dilated left atrium, albeit with a normal ejection fraction. He noted that, at the time that the plaintiff presented to Smith, he was in the midst of a six-week course of the intravenous antibiotics Ampicillin and Ceftriaxone. Dr. Kiprovski explained that Smith's plan was to have the plaintiff complete the course of antibiotics and thereupon proceed with mitral valve repair surgery after a reevaluation that was necessary to determine the timing of the surgery.

On August 21, 2023, the plaintiff was admitted to NYPH, with preoperative diagnoses of mitral valve prolapse, severe mitral regurgitation, and mitral valve endocarditis, the latter of which had been treated with the aforementioned intravenous antibiotics, and, although the treatment of the infection was complicated by acute heart failure, Dr. Kiprovski concluded that the infection had by then resolved. On that date, the plaintiff also underwent a cardiac catheterization, which, according to Dr. Kiprovski, revealed non-obstructed coronary arteries. On August 22, 2023, the Smith performed mitral valve repair surgery on the plaintiff, assisted by nonparty resident physician William Erwin, M.D., while anesthesiology services were provided by Shanewise and Parashar, the latter of whom then was a resident.

As Dr. Kiprovski described the surgery, the plaintiff was supine, in what is known as the Trendelenburg position, with support devices in place, including bolsters and positioning rolls. He asserted that, when a patient is in the Trendelenburg position, he or she is laid supine on the surgical table, with his or her head angled downward. Dr. Kiprovski stated that, in the plaintiff's case, his head and neck were in neutral position, with his arms tucked at his sides, secured, padded, supported, and extended to less than 90 degrees. He explained that pressure points were padded and checked, and that the parts of the plaintiff's arms where the ulnar nerves lay

were very carefully padded with abdominal (ABD) gauze pads, and positioned to minimize pressure on the ulnar nerves, while his arms were also padded and wrapped with foam cushions, and tucked at the sides. Dr. Kiprovski recounted that the surgery proceeded with a median sternotomy, and that Smith utilized a Cosgrove retractor to obtain good exposure of the valve, spreading the sternum/breastbone only as far as was necessary to visualize that portion of the anatomy being operated upon. He stated that the plaintiff's mitral valve was repaired with a quadrangular resection and sliding annuloplasty, and reinforced with a 34-mm Cosgrove ring. Based upon his review of the operative report, Dr. Kiprovski concluded that, after the bypass procedure was terminated, a transesophageal echocardiogram showed zero mitral insufficiency, but that Smith was concerned about acceleration across the mitral valve and the presence of an excessive level of mitral stenosis. Smith thus re-arrested the plaintiff's heart, exposed the valve, and removed three supplementary repair sutures, after which a transesophageal echocardiogram revealed only trace mitral insufficiency, without any mitral stenosis.

Dr. Kiprovski asserted that the surgery started at approximately 8:40 a.m. on August 22, 2023, and was completed at approximately 1:03 p.m. on that date, while anesthesia was induced at approximately 7:50 a.m. on August 22, 2023, and ended at approximately 1:40 p.m. on that date. He conceded that, on August 23, 2023, the plaintiff complained of tingling in his left arm and hand, with a mild decrease in strength, and that, upon a physical examination, the plaintiff's left hand grip strength was four on a scale of five. Dr. Kiprovski asserted that NYPH cardiologist Gregg Rosner, M.D., who had been assigned as the plaintiff's attending physician, attributed the symptoms to a "likely stretch injury from surgical positioning." After the plaintiff made similar complaints on August 24, 2023, Dr. Rosner requested a neurology consultation with NYPH attending neurologist John Brust, M.D., who, after examining the plaintiff, concluded that that the plaintiff had sustained a brachial plexopathy injury, probably secondary to mechanical stretch injury during surgery. Dr. Brust reported that the plaintiff's prognosis was

good for spontaneous improvement. On August 24, 2023, Smith examined the plaintiff's left hand. On August 27, 2024, the plaintiff was discharged from NYPH.

Dr. Kiprovski conceded that, on September 13, 2023, the plaintiff underwent an EMG test at Stamford Health Medical Group (SMHG), in Stamford, Connecticut, which revealed electrodiagnostic evidence of moderate-to-severe left ulnar mononeuropathy, also known as cubital tunnel, across his left elbow, but no evidence of a more widespread neuropathy, cervical radiculopathy, or myopathy. On September 28, 2023, the plaintiff presented to Smith for a follow-up consultation and examination, upon which Smith himself noted that the surgery was complicated by left brachial plexopathy.

On January 5, 2024, the plaintiff presented to orthopedist Brandon Shulman, M.D., for evaluation of ulnar neuropathy of the left upper extremity. Dr. Shulman ultimately recommended a left ulnar nerve release procedure at the level of the elbow. On January 17, 2024, the plaintiff consulted with neurosurgeon Christopher Winfree, M.D., who noted that the plaintiff's arm had largely recovered, except for weakness in the left hand, and that the electrodiagnostic studies from September 13, 2023, were consistent with a left ulnar neuropathy at the elbow. Dr. Winfree opined that the plaintiff likely had an ulnar neuropathy at the elbow in the setting of a more proximal plexopathy which, however, was largely recovered. On February 6, 2024, the plaintiff underwent magnetic resonance imaging (MRI) imaging of the left brachial plexus at the Hospital for Special Surgery (HSS) in Manhattan, which, according to Dr. Kiprovski, evinced no evidence of a plexopathy or active denervation effect of regional musculature. That same date, the plaintiff underwent an ultrasound scan of the left ulnar nerve at HSS, which, as Dr. Kiprovski described it, revealed severe nerve thickening and mild hypermobility at the cubital tunnel and mild denervation change in the left flexor carpi ulnaris muscle belly.

On February 12, 2024, the plaintiff presented to orthopedist/hand surgeon Steven K. Lee, M.D., who assessed the plaintiff with left cubital tunnel syndrome, possible cervical

radiculopathy, and a resolving/resolved left brachial plexopathy, and tentatively scheduled the plaintiff for a left cubital tunnel release procedure. On February 28, 2024, the plaintiff returned to see Dr. Winfree, who reported that the plaintiff was an excellent candidate for left ulnar nerve decompression surgery. On March 5, 2024, the plaintiff underwent an EMG at HSS, which, according to Dr. Kiprovski, revealed evidence of an ulnar neuropathy at the elbow, that is, cubital tunnel syndrome, bilaterally, albeit with the neuropathy on the left greater than on the right, but without any evidence of a lower trunk/medial cord brachial plexopathy/thoracic outlet syndrome or cervical radiculopathy. The plaintiff returned see to Dr. Lee on that date, and discussed both surgical and non-surgical treatment options with him, ultimately electing to proceed with surgery. On March 20, 2024, the plaintiff underwent a cubital tunnel release and subcutaneous transposition and neuroplasty of the left side medial antebrachial cutaneous nerve. Both the preoperative and postoperative diagnoses were left cubital tunnel syndrome.

Based on both HSS and SMHG records, Dr. Kiprovski agreed with the plaintiff that the latter had sustained an ulnar neuropathy secondary to pressure on the ulnar nerve, but asserted that the EMG performed at HSS showed no abnormalities evidencing a left brachial plexopathy or a brachial plexus injury. He characterized the results of the EMG performed at SMHG as indicative that ulnar nerve injury was “partial,” that is, only “moderate to severe,” and concluded that the plaintiff’s injury was a compression injury. He explained that this type of injury is a known, albeit rare, risk of open-heart mitral valve repair surgery that can occur despite appropriate and best efforts, since, even when a patient’s arm is in an optimal position, as he characterized the positioning during the surgery at issue, compression from the arm resting on an operating room table can result in ulnar neuropathy. Dr. Kiprovski opined that the defendants properly positioned the plaintiff during the open-heart mitral valve repair surgery, inasmuch as they satisfied the standard of care by placing the plaintiff in a supine orientation in the Trendelenburg position, with the head and neck in the neutral position, and with the patient’s arms secured at the side and extended less than 90 degrees. He further stated that the

standard of care required that support devices be put in place and that pressure points be padded, which the defendants did here. Dr. Kiprovski further opined that there was nothing else that could or should have been done to prevent or avoid an ulnar nerve injury to the plaintiff and that, as such, there was no merit to any claims that the defendants improperly positioned the plaintiff or allowed excessive compression on the plaintiff's ulnar nerve.

In addition, Dr. Kiprovski concluded that the spacer that Smith and his assistant employed to retract the plaintiff's sternum/breastbone could not have caused injury to the ulnar nerve at the level of the cubital tunnel, since that tunnel is located on the inner side of the elbow, and that there was no conceivable mechanism by which the retraction of the sternum, no matter how wide, could cause compression on the ulnar nerve at the level of the cubital tunnel that could have resulted in ulnar nerve injury. As he explained it, the sternum retraction places pressure on the shoulder area, and does not compress the ulnar nerve at the level of the cubital tunnel in any way. Moreover, since Dr. Kiprovski concluded that postoperative imaging and testing did not reveal the presence of any brachial plexus injury in the first instance, there was no merit to the plaintiff's claim that improper retraction of the sternum caused such an injury.

Dr. Kiprovski further asserted that NYPH personnel ordered and performed all necessary and proper tests to determine the etiology of all of the plaintiff's conditions, and formulated appropriate treatment plans. In this respect, he concluded that the attending cardiologist, Dr. Rosner, properly requested a neurology consultation after the plaintiff complained of tingling and decreased strength, which led to the performance of neurological examinations upon the plaintiff. Hence, he opined that there was no reason for Smith to have ordered more testing.

In his affirmation, Dr. Tolis reiterated the factual history of the treatment that the defendants rendered to the plaintiff. He agreed with Dr. Kiprovski that the defendants properly positioned the plaintiff during the subject surgery. Dr. Tolis further agreed with Dr. Kiprovski that there is only one way to position a patient for an open-heart mitral valve repair surgery, and that the defendants indeed positioned him in exactly that manner, which was precisely the

positioning that Dr. Kiprovski had described. He thus concluded that there was no merit to the plaintiff's claims that the defendants improperly positioned the plaintiff or allowed excessive compression on the ulnar nerve. Dr. Tolis added that the defendants also were not required to reposition the plaintiff once the valve repair had commenced, since the standard of care does not require any repositioning during an open-heart mitral valve repair surgery. In this respect, he asserted that, because the plaintiff was undergoing a life-saving open-heart surgery, the defendants should not have attempted any repositioning during the procedure because that would have presented serious concerns.

In addition, Dr. Tolis opined that the valve repair surgery did not take an excessive amount of time. As he explained it, while the standard of care does not call for open-heart mitral valve repair surgery to be performed within any specific amount of time, and the timing for such a procedure is based on several factors, including the complexity of the repair, a mitral valve repair surgery performed via median sternotomy typically takes between three to six hours. He noted that the plaintiff's surgery, which was in fact performed via median sternotomy, took slightly under four and a half hours, "placing it squarely within the usual and expected time for such a surgery." Dr. Tolis further concluded that the plaintiff's chest cavity was not spread too widely during the surgery. In connection with this issue, he opined that the standard of care requires that the surgeon only spread the sternum/breastbone as far as is necessary to visualize the surgical site and the anatomy being operated upon, and that, in the plaintiff's case, there were no issues with exposure, and the surgical team did not need to excessively spread the sternum to access the operative field. Dr. Tolis reiterated Dr. Kiprovski's description of Smith's employment of a Cosgrove retractor to obtain good exposure of the valve, and concluded that there was "no evidence in the medical records or deposition testimonies that any further or unnecessary spreading was undertaken." He adverted to Smith's deposition testimony, in which the latter testified that his general approach and standard practice is to open the sternum only "as far apart as is necessary to see what is necessary to be seen," without any

other spreading unnecessary to exposure. Dr. Tolis thus concluded that Smith performed the procedure in a matter consistent with accepted standards of care, and that there thus was not merit to the plaintiff's claims that NYPH, Smith, or Smith's assistant retracted the plaintiff's chest cavity too widely.

With respect to the equipment employed during the subject procedure, Dr. Tolis asserted that the standard of care does not require that armrests be attached to the surgical table, inasmuch as armrests are not involved in patient positioning for mitral valve repair surgeries. He thus rejected any claim that a purportedly "missing" armrest somehow affected the plaintiff's positioning or otherwise affected the surgery.

Dr. Tolis expressly agreed with Dr. Kiprovski's opinion that the proper postoperative consultation with a neurologist was ordered and conducted, that all necessary postoperative diagnostic tests were ordered, and that there was no reason for Smith to order more tests.

Dr. Tolis ultimately concluded that nothing that the defendants did or did not do caused or otherwise contributed to any of the plaintiff's alleged injuries. He concurred with Dr. Kiprovski's opinion that injury to the ulnar nerve is a known and accepted risk of mitral valve repair surgery performed via median sternotomy, which can and does occur in the absence of any malpractice or negligence. In this respect, he opined that, even when a patient's arm is in an optimal position, as the plaintiff's arm was during the surgery at issue, compression from the arm resting on an operating room table can result in ulnar neuropathy.

In his affirmation, Dr. Kanchuger explicitly agreed with Drs. Kiprovski and Tolis that the defendants properly positioned the plaintiff during the subject procedure, and agreed with Dr. Tolis that it would have been improper to reposition the plaintiff during the course of the procedure, explaining that the only exception would be where patient's arm had slipped out of position or an arm needed to be accessed for placement of an intravenous or arterial line. He asserted that the latter scenario is exceedingly rare, as there are other intravenous lines available, while, alternatively, a femoral arterial could be inserted. Dr. Kanchuger opined that

the plaintiff's arm did not slip out of position during the subject procedure, and that, consequently, there was no need to place an additional intravenous or arterial line. He concluded that repositioning the plaintiff during the subject procedure would have been contraindicated, and that there was no merit to the plaintiff's claims that the defendants improperly positioned him or allowed excessive compression on the ulnar nerve.

Dr. Kanchuger agreed with Dr. Tolis that the subject surgery did not take an excessive or unusual amount of time to perform or that armrests were necessary appurtenances to the surgical table, and repeated verbatim Dr. Tolis's explanations for those conclusions.

With respect to the extent of retraction of the plaintiff's sternum during the procedure, Dr. Kanchuger explained that anesthesiologists have no role in placing spreaders or in retracting the sternum/breastbone during mitral valve repair surgeries via median sternotomies, and that Parashar and Shanewise neither placed the spreader, retracted the sternum, nor were involved in any decision-making regarding how far to spread the sternum. In addition, he asserted that, while the standard of care does require anesthesiologists to supervise resident physicians assisting them, there was no evidence in the medical records or deposition testimony that Shanewise failed to supervise Parashar. In this regard, Dr. Kanchuger referred to Parashar's testimony that he was the resident providing anesthesia, that Shanewise was his attending physician, and that Parasher was practicing and performing various tasks under Shanewise's supervision. Parashar further testified that Shanewise was present in the operating room for the critical portions of the surgery, including induction, the placement of lines, the initiation of bypass, and the performance of the postoperative transesophageal echocardiogram.

Dr. Kanchugar also reiterated the opinions of Drs. Kiprovski and Tolis that the plaintiff's claimed injuries are known and accepted risks of open-heart mitral valve repair surgery that can and do happen in the absence of malpractice or negligence, and could occur even with proper patient positioning. He thus concluded that there were no further precautions that could have been taken to prevent the plaintiff's claimed injuries.

In opposition to the defendants' motion, the plaintiff relied on many of the same documents that the defendants submitted in support of the motion. He also submitted an attorney's affirmation and the expert affirmations of neurologist Richard Lechtenberg, M.D., and board-certified anesthesiologist Stephen A. Vitkun, M.D.

Dr. Lechtenberg accepted, as true, the timeline of events described by the defendants' experts. Dr. Lechtenberg, however, asserted that he strongly disagreed with Dr. Tolis's opinion that, "[e]ven when a patient's arm is in optimal position, as the plaintiff's arm was for the surgery at issue, compression from the arm resting on the operating room table can result in ulnar neuropathy." As he explained it,

> "[s]everal basic principles of Neurology play an important role in analyzing this case. The first is that most neurological injuries caused by minor trauma resolve either quickly or within a year. Mr. Preli's injury, which occurred during his surgery of August 22, 2023, to date has not resolved and is therefore considered permanent. The second principle is that for the neurologic injury to be permanent, the original trauma must have been significant. Mr. Preli has undergone two EMG studies, and both indicate that the injury to his ulnar nerve on his left arm is 'moderate to severe.'"

Dr. Lechtenberg opined that a "departure from the standard of care occurred during the August 22, 2023, surgery which resulted in the ulnar nerve being subjected to excessive compression or stretching because of mal-positioning." He asserted that excessive compression occurs if the arm is inadequately padded or improperly positioned, while excessive stretching occurs if the patient's position during the surgery is improper. Dr. Lechtenberg averred that Drs. Rosner and Brust, the attending cardiologist and attending neurologist at NYPH, who respectively examined the plaintiff on postoperative day one and postoperative day two, attributed the plaintiff's symptoms to a likely stretch injury from surgical positioning. Dr. Lechtenberg further adverted to the medical records of Dr. Shulman, the orthopedist at SMHG, who concluded that the most likely scenario would be from compression or positioning during the unexpectedly long surgery, and HSS neurosurgeon Dr. Winfree, who wrote in the plaintiff's chart that "[h]e may have a double crush syndrome with the entrapment at the elbow and an

episode of compression more proximally." Dr. Lechtenberg explained that double crush syndrome is a condition where a peripheral nerve is compressed at two or more points along its pathway. He expressly agreed with the conclusions reached by Drs. Rosner, Brust, Shulman, and Winfree. Dr. Lechtenberg explained that a short-lived neuropathy may be a complication of any surgery, but that the moderate-to-severe, permanent injury that the plaintiff actually sustained "does not occur absent some departure from the standard of care," and that the plaintiff's injuries were "the result of compression and/or stretching/positioning, both of which had to have been excessive and preventable."

Dr. Vitkun, as did Dr. Lechtenberg, accepted the timeline of events, as described by the defendants' experts. Dr. Vitkun concluded that the plaintiff would not have sustained a permanent, moderate-to-severe ulnar neuropathy "unless a departure from the standard of care occurred during his surgery on August 22, 2023." He agreed with Dr. Lechtenberg that, while a transient, short-lived neuropathy may occur as a risk of any surgical procedure, the fact that plaintiff's injury has proved to be permanent "bespeaks to the seventy of the injury and how long the compression of the ulnar nerve lasted during the surgery." As did Dr. Lechtenberg, Dr. Vitkun expressly agreed with Dr. Winfree's conclusion that the plaintiff had sustained double crush syndrome during the surgery because a peripheral nerve had been compressed at two or more points along its pathway. While he noted that the anesthesia record in the NYPH chart reported that "arms [were] tucked at patient's sides" and "arms padded supported," he explained that this note was computer generated *before* the surgery commenced and *before* the plaintiff was covered. In this respect, he further explained that a drop-down program automatically inserts this note into every surgical record requiring the type of positioning necessitated by the mitral-valve replacement surgery that the plaintiff underwent here. Dr. Vitkun opined that, contrary to the opinions of the defendants' experts, the inclusion of this type of note in a hospital chart is *not* a guarantee that every precaution identified therein was meticulously carried out.

Dr. Vitkun concluded that, during the surgery, the plaintiff's left arm slipped below the level of the table, and suffered from a crush injury caused by someone leaning against the arm or by the improper placement of padding. He explained that preformed arm cradles, known as "sleds," can be employed to hold the abducted arms in place after tucking with a sheet, or even as the primary device for securing the arms in place. He concluded that it was the responsibility of the entire surgical team, the circulating nurse, the anesthesiologist, the residents, and the surgeon to insure that improper positioning, improper stretching, and excessive compression did not occur during the surgery, and that the defendants departed from good and accepted medical practice by permitting the plaintiff's left arm to fall below table level or by leaning against that arm, and by failing to employ sleds to secure the plaintiff's arm during the 4.5-hour procedure, thus causing or contributing to his injuries.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the opinions of the plaintiff's experts were conclusory, speculative, and unsupported by the medical records in evidence. In addition, counsel argued that all of the facts alleged by the defendants in their motion papers must be deemed admitted, since the plaintiff did not submit a counter statement of material facts. He further asserted that the court should reject the plaintiff's opposition papers because they were not accompanied by a certificate attesting to a proper word count. He also contended that, inasmuch as the plaintiff served a document designated as an "amended bill of particulars," which simply added a new alleged departure from good practice, that amended bill of particulars completely superseded and displaced the initial bill of particulars, and, hence, the departures alleged in the initial bill, upon which the plaintiff's experts opined, were withdrawn. Counsel further argued that the plaintiff's experts were not qualified to render the opinions to which they attested. He further reiterated that the doctrine of res ipsa loquitur was not applicable to the facts of this action, and that Parashar, as a resident physician acting under the supervision of Shanewise, was immune from liability.

The court excuses the plaintiffs' failure to include a word count, particularly because the defendants were not prejudiced thereby and made no allegations that the plaintiff exceeded the limitations on the length of motion papers, as set forth in 22 NYCRR 202-8-b(a), and "since the court may "overlook[ ] such a technical defect" (*Anuchina v Marine Transp. Logistics, Inc*., 216 AD3d 1126, 1127 [2d Dept 2023]; *see Golub v Modern Yachts, LLC,* 2024 NY Slip Op 30862[U], *17, 2024 NY Misc LEXIS 1284, *20-21 [Sup Ct, N.Y. County, Mar. 11, 2024]; *LaBarbera v W.F. Master R.E.O., LLC,* 2023 NY Misc LEXIS 24069, *1-2 [Sup Ct, Richmond County, Sep. 28, 2023]). Moreover, on August 31, 2022, the court rule cited by the defendants, 22 NYCRR 202.8-g, was amended, so that the submission of statements of material fact in connection with summary judgment motions was no longer mandatory. The submission of such a statement now is only necessary where the court directs it (*see* 22 NYCRR 202.8-g[a]). The presumption that, in the absence of a counter statement, the facts set forth in a movant's statement are deemed admitted, only applies where the court directed the submission of both the statement and counter statement (*see* 22 NYCRR 202.8-g[e]), which the court did not do here. In any event, neither the plaintiff nor his experts contested any of the facts alleged by the defendants and their experts, but only the opinions and conclusions rendered by the defendants' experts. Hence, deeming the facts alleged by the defendants to be admitted would not alter the court's consideration of the parties' submissions in the instant matter. In addition, the defendants have cited, and research has revealed, no authority for the proposition that the service of an amended bill of particulars completely supersedes and displaces the original bill of particulars, in the same manner as an amended complaint would displace an original complaint (*see Pomerance v McGrath*, 104 AD3d 440, 442 [1st Dept 2013]; *Plaza PH2001, LLC v Plaza Residential Owner L.P.*, 98 AD3d 89, 99 [1st Dept 2012]). The court rejects the defendants' arguments in this regard, since an amended bill of particulars is, by its very definition, employed solely to add a new theory of liability that had not previously been asserted (*see Stovall v Lenox*

Hill Hosp., 200 AD3d 570, 571 [1st Dept 2021]) or to identify new injuries that had not previously been disclosed (see *Vargas v Villa Josefa Realty Corp.*, 28 AD3d 389, 391 [1st Dept 2006]).

The determination of whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court, the provident exercise of which will not be disturbed absent a serious mistake or an error of law (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]). The courts of this State repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (*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]). Nonetheless, a practitioner who is put forward by a party as an expert qualified to support or oppose a summary judgment motion must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was applicable (*see Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus,

> *"the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [or dentistry at issue], whether acquired through his practice or studies or in some other way'* (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; *see also Atkins v Beth Abraham Health Servs.*, 133 AD3d

> 491 [1st Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.,* 126 AD3d 653 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg,* 44 AD3d 1018 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment])"

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]).

Consequently, where, as here, the physicians proffering an allegedly expert affirmation demonstrate familiarity with, training in, and experience with certain aspects of the defendants' specialty, specifically, the proper protocol for positioning a patient who is placed under anesthesia, and the consequences of that positioning on the development of an ulnar nerve injury, he or she will be deemed to have the requisite experience, training, and knowledge necessary to render an opinion as to whether that defendant departed from standards of good practice that proximately caused injury to the plaintiff (*see Fuller v Preis*, 35 NY2d at 431 [neurologist was permitted to give an opinion in the closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide]; *Humphrey v Jewish Hosp. & Med. Ctr.*, 172 AD2d 494 [2d Dept 1991] [general surgeon was deemed to be qualified to render an opinion in the specialty of obstetrics and gynecology]; *Matter of Sang Moon Kim v Ambach*, 68 AD2d 986, 987 [3d Dept 1979] [opinion testimony of qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon committed during spinal surgery]; *Matter of Lincoln v New York City Health & Hosps. Corp.*, 2018 NY Slip Op 34085[U], *5, 2018 NY Misc LEXIS 14236, *8 [Sup Ct, Bronx County, May 3, 2018] [internist is qualified to render opinion as to the standard of care governing medical care and treatment of patients who undergo breast examinations and breast imaging studies, despite not being a radiologist, oncologist, or breast surgeon]). Dr. Vitkun is an anesthesiologist, and, thus, is qualified to render an opinion as to the proper positioning of an anesthetized patient over a particular period of time. Dr. Lechtenberg, although not a surgeon, is qualified by his experience as a neurologist

to render an opinion as to how to position a patient in order to avoid causing ulnar nerve injury, and as to the limited number of causes of ulnar nerve injury that could conceivably be applicable to the plaintiff's situation (*cf. Vargas v Bhalodkar,* 204 AD3d 556, 557 [1st Dept 2022] ["(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether [defendant] deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York*., 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that [defendant] departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai*, 179 AD3d 860 [2d Dept 2020] [general and vascular surgeon not qualified to render opinion as to orthopedics or family medicine]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *Steinberg v Lenox Hill Hosp*., 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation[,as h]e specializes in cardiovascular surgery, not neurology or ophthalmology [and] failed to 'profess the requisite personal knowledge' necessary to make a determination on the issue of whether [an arterial] perforation was responsible for plaintiff's visual impairment"]).

With respect to the claims asserted against Parashar,

> "a hospital is sheltered from liability in those instances where its employees follow the directions of the attending physician (*Filippone v St. Vincent's Hosp. & Med. Ctr*., 253 AD2d 616, 618; *Christopher v St. Vincent's Hosp. & Med. Ctr*., 121 AD2d 303, 306, *appeal dismissed* 69 NY2d 707), unless that doctor's orders '"are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders"' (*Warney v Haddad*, 237 AD2d 123, quoting *Toth v Community Hosp*., 22 NY2d 255, 265 n 3; *see also, Somoza v St. Vincent's Hosp. & Med. Ctr*., 192 AD2d 429, 431)"

(*Walter v Betancourt*, 283 AD2d 223, 224 [1st Dept 2001]; *see Irizarry v St. Barnabas Hosp.,* 145 AD3d 529, 530 [1st Dept 2016]; *MacDonald v Beth Israel Med. Ctr*., 136 AD3d 516, 516-

517 [1st Dept 2016]; *Suits v Wyckoff Hgts. Med. Ctr.*, 84 AD3d 487, 488 [1st Dept 2011]; *Sela v Katz*, 78 AD3d 681, 682 [2d Dept 2010]). In other words, where the resident or fellow did not exercise independent judgment or make an independent decision with respect to a patient's care or treatment, neither that physician nor the facility for which he or she was working may be held liable (*see Groff v Kaleida Health*, 161 AD3d 1518, 1520 [4th Dept 2018]; *Bellafiore v Ricotta*, 83 AD3d 632, 633 [2d Dept 2011]). Where, however, a resident or fellow exercised independent judgment or made an independent decision with respect to such care, both that physician and the facility may be held liable (*see Burnett-Joseph v McGrath*, 158 AD3d 526, 527 [1st Dept 2018] [attending physician's deposition testimony raised triable issue of fact as to whether resident exercised independent judgment]). The defendants established, prima facie, that Parashar was a resident at the time of the plaintiff's surgery, that he acted at all times under Shanwise's supervision and direction, that he exercised no independent judgment, and that neither Smith's nor Shanewise's directives were "so clearly contraindicated by normal practice." In opposition to that showing, the plaintiff failed to raise a triable issue of fact in connection with any of those issues. Hence, summary judgment must be awarded to Parashar dismissing the complaint insofar as asserted against him.

With respect to the merits of the motion insofar as made on behalf of Smith and NYPH, the defendants made the necessary prima facie showing of entitlement to judgment as a matter of law in connection with so much of the medical malpractice cause of action as was premised upon Smith's alleged departures from good practice. The court nonetheless concludes that the plaintiff raised triable issues of fact with his submissions, except as to the allegation that Smith or other physicians excessively retracted his chest cavity during surgery, since neither of his experts addressed that issue. The court concludes that the opinions of the plaintiff's experts were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the plaintiff's decedent (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with

respect to the positioning of the plaintiff during the subject surgery, and the failure to provide certain apparatus to prevent the plaintiff's arm from being subject to excessive or improper pressure, or from awkwardly falling below the table during surgery. It is well settled that a battle of experts, such as presented here, raises credibility issues which must be resolved by a fact finder and which preclude summary judgment (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 25). Moreover, the defendants conceded that the plaintiff was indeed injured during the procedure, while Smith's and the defendants' experts' opinions as to the mechanism of that injury bordered on the speculative, and there is a sharp dispute between the parties' experts as to whether that injury could have occurred in the absence of negligence. The court thus declines to award summary judgment dismissing so much of the medical malpractice cause of action against Smith as was premised upon the doctrine of res ipsa loquitur.

"'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 Smith was employed by and working for NYPH during the subject procedure, to the extent that the court has determined that there are triable issues of fact in connection with the plaintiff's medical malpractice claims against Smith, there are triable issues of fact as to whether NYPH may be held vicariously liable therefor.

The court notes that, although CPLR 2106 was amended, effective January 1, 2024, to authorize the use of an affirmation in lieu of an affidavit by "*any person* wherever made," as long as the statement set forth therein had been "affirmed by that person to be true under the

penalties of perjury" (L 2023, ch 559) (emphasis added), that statute did not repeal the requirement, set forth in CPLR 2309, that an

> "*affirmation* taken without the state shall be treated as taken within the state if it is accompanied by such certificate or certificates as would be required to entitle a deed acknowledged without the state to be recorded within the state if such deed had been acknowledged before the officer who administered the . . . *affirmation*."

(emphasis added). Although Dr. Tolis's affirmation was executed in Massachusetts, his affirmation was not accompanied by the certificate of conformity required by CPLR 2309. The certificate of conformity required by that statute 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, or notarized in conformity with the laws of that state. The absence of the certificate of conformity, however, does not require the court to disregard the defendants' expert affirmations, 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]). The court thus directs the defendants to serve and file the necessary certificates of conformity on or before November 28, 2025.

In light of the foregoing, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted to the extent that they are awarded summary judgment dismissing the complaint insofar as asserted against the defendant Sanjay Parashar, M.D., and so much of the medical malpractice cause of action insofar as asserted against the defendants Craig R. Smith, M.D., and New York Presbyterian Hospital as was premised upon excessive retraction of the plaintiff's

chest cavity during the subject surgery, the complaint is dismissed insofar as asserted against the defendant Sanjay Parashar, M.D., the claim alleging excessive retraction of the chest cavity is dismissed insofar as asserted against the defendants Craig R. Smith, M.D., and New York Presbyterian Hospital, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendant Sanjay Parashar, M.D.; and it is further,

ORDERED that the Clerk of the court is directed to enter judgment dismissing the complaint insofar as asserted against the defendant Sanjay Parashar, 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 October 30, 2025, at 2:15 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.

This constitutes the Decision and Order of the court.

10/17/2025
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**