SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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VICTORIA KIM,

Plaintiff,

- v -

MADISON PLASTIC SURGERY, P.C. and ROBERT M. TORNAMBE, M.D., F.A.C.S.,

Defendants.

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INDEX NO. 805268/2023

MOTION DATE 10/14/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

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 denied.

The crux of the plaintiff's claim is that, on September 12, 2022, the defendant plastic surgeon Robert M. Tornambe, M.D., F.A.C.S., in the course of working for his professional corporation, the defendant Madison Plastic Surgery, P.C. (Madison), negligently performed a bilateral upper blepharoplasty and lower transconjunctival blepharoplasty upon her. In her complaint, the plaintiff alleged that Tornambe departed from the applicable standard of care in performing these procedures upon her. In her bill of particulars, she alleged that Tornambe departed from the applicable standards of care by failing properly to monitor and treat her preoperatively, and in failing to take proper measurements before performing cosmetic surgery on and around her eyes. The plaintiff also averred that Tornambe failed properly to perform the surgery, inasmuch as he was overaggressive in his resections of her skin, failed properly to treat and care for her during the surgery, and failed properly to monitor her after the surgery.

She further asserted that, subsequent to the surgery, although she continued to be treated by Tornambe until October 4, 2022, he failed properly to diagnose her resultant condition, failed to inform her of postoperative complications related to the surgery, and failed to treat those complications. She contended that, as a consequence of Tornambe's malpractice, she was caused to sustain levator injuries to her eyes, that is, damage to the muscles that lift her upper eyelids, thus causing her eyelids to droop, a condition known as ptosis. Specifically, the plaintiff alleged that her left eyelid descends and is not in proportion to her right eye, and that Tornambe's procedure left her with lack of symmetry in the size of both of her eyes, requiring her to undergo a left upper blepharoptosis repair through a conjunctival Muller muscle resection that was performed on February 27, 2023 by plastic surgeon Roman Shinder, M.D., at SUNY Downstate Eye Center in Brooklyn, New York.

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,* 44 NY3d 57, 62-63 [2025]; *Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie

showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). Nonetheless, the law does not require a health-care provider to guarantee a good result (*see Saliaris v D'Amelia*, 143 AD2d 996, 996 [2d Dept 1988]), and, although an outcome or result may truly be unfortunate, "'a bad result does not, ipso facto, support a claim for medical malpractice'" (*Saliaris v D'Amelia*, 143 AD2d at 996-997; quoting *Schoch v Dougherty*, 122 AD2d 467, 468 [3d Dept 1988]; *see Nestorowich v Ricotta,* 281 AD2d 870, 871 [4th Dept 2001], *affd* 97 NY2d

393 [2002]; *Bobek v Crystal*, 291 AD2d 521, 523 [2d Dept 2002]; *Nabozny v Cappelletti*, 267 AD2d 623, 628 [3d Dept 1999]; *Zito v Friedman*, 77 AD2d 514, 515 [1st Dept 1980] [jury must be instructed that a bad result by itself is not proof of malpractice]).

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]; *see generally Kristie M. v. Mercy Hosp. of Buffalo,* 240 AD3d 1228 [4th Dept 2025]; *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).

In support of their motion, the defendants submitted the pleadings, the plaintiff's bill of particulars, transcripts of the parties' deposition testimony, relevant medical records, photographs, a statement of allegedly undisputed material facts, a memorandum of law, an attorney's affirmation, and the expert affirmation of board-certified plastic and reconstructive surgeon Joseph Feinberg, M.D., F.A.C.S., who opined that Tornambe did not depart from good and accepted practice, and that "the injuries alleged by plaintiff, while seemingly related to the blepharoplasty performed by Dr. Tornambe on September 12, 2022, were not related to any departure from good and accepted plastic surgical practice on the part of the defendant."

Dr. Feinberg first described the plaintiff's relevant medical history, noting that she initially presented to the defendants on August 11, 2022, complaining of "redundant" skin in her upper eyelids bilaterally, and bulging fat in her lower lids bilaterally. After discussing the issue with the plaintiff and performing a physical evaluation, Tornambe recommended that the plaintiff undergo a bilateral blepharoplasty. As Dr. Feinberg described it, the plaintiff returned to Madison on September 12, 2022, Tornambe informed the plaintiff of the risks and benefits of, and alternatives to, the procedure, the plaintiff signed a consent form, and Tornambe performed a

bilateral upper blepharoplasty and lower transconjunctival blepharoplasty, with a peel of both lower lids. Dr. Feinberg asserted that the procedure was performed without problem or complication. He further noted that, on September 14, 2022, Madison employee Adriana Tapia contacted the plaintiff to follow up with her, and "confirmed" the absence of any unanticipated postoperative problem. Dr. Feinberg averred that the plaintiff returned to see Tornambe on September 20, 2022, at which time she complained of residual left-eye swelling, which she had purportedly reported as having slowly improved over several days prior to the visit. According to Dr. Feinberg, although Tornambe's physical examination did reveal increased swelling of the left upper eyelid, the plaintiff's eyelid function appeared to be normal, upon which Tornambe wrote that the swelling would resolve with time.

The plaintiff returned to see Tornambe on October 4, 2022, who examined her, and diagnosed her with 3 millimeters (mm) to 4 mm of ptosis in her left eye, that is, a left-eyelid droop of 3 mm to 4 mm, and suggested the that the levator muscle had been disinserted. Tornambe consulted with oculoplastic surgeon Henry M. Spinelli, M.D., and thereupon recommended conservative observation and prescribed the administration of phenylephrine eyedrops. That was the plaintiff's last visit with Tornambe.

As Dr. Feinberg interpreted the plaintiff's medical charts, on October 13, 2022, the plaintiff presented to Dr. Shinder, who diagnosed a severe ptosis of the left eyelid, and recommended that she allow additional time for the lid to fully heal so that he could assess its final position. Dr. Shinder spoke directly to Tornambe, after which Dr. Shinder wrote in his chart that the plaintiff had sustained a "likely levator injury" after having been subject to the overaggressive resection of skin. The plaintiff returned to Dr. Shinder on February 1, 2023, at which time he discussed a proposed revision procedure of the left eye with the plaintiff. Dr. Shinder's chart reflected that, on February 27, 2023, he performed a left upper blepharoptosis repair through the conjunctiva Muller muscle resection. According to Dr. Feinberg, however, Dr. Shinder's operative report made no mention that the levator muscle had been addressed during

the revision procedure. Dr. Shinder's note for March 9, 2023 indicated that that, during the revision procedure, he had observed an extensive adhesion between two layers of the conjunctiva, known as a symblepharon, which he attributed to Tornambe's procedure. According to Dr. Feinberg's reading of Dr. Shinder's chart, Dr. Shinder lysed the adhesion during his procedure, and Dr. Shinder concluded that, consequently, "the muscle resection was suboptimal." Dr. Feinberg noted, however, that the operative report itself made no reference to a symblepharon. As Dr. Feinberg explained it, the plaintiff returned to Dr. Shinder on July 5, 2023, complaining of asymmetry of her eyes and an incomplete closure of the upper and lower lid, a condition known as a lagophthalmos. Dr. Shinder's records reflected that he continued to recommend the administration of certain eyedrops, but did not recommend further surgery. Dr. Feinberg asserted that Tornambe's records contained no complaints by the plaintiff of any asymmetry, thus suggesting that this complaint only arose after Dr. Shinder's treatment.

Dr. Feinberg asserted that, on September 6, 2023, the plaintiff presented to ophthalmologist, Maureen A. Relland, M.D., who noted in her chart that the plaintiff's left-eyelid ptosis was "much improved" after Shinder's surgery, in comparison with Dr. Relland's previous examination of the plaintiff, which she had performed on December 5, 2022, that is, after Tornambe's surgery, but before Dr. Shinder's surgery. Nonetheless, Dr. Feinberg asserted that Dr. Relland reported that, as of September 6, 2023, the plaintiff now had an incomplete closure of her upper and lower lid on the left, a condition that she had not observed or reported in connection with the December 5, 2022 examination. According to Dr. Feinberg, Dr. Relland advised the patient to have no further surgery.

Dr. Feinberg opined that the initial blepharoplasty performed by Tornambe was an indicated procedure. He asserted that Tornambe appropriately obtained the plaintiff's medical history, properly assessed her complaints, properly evaluated and examined her in anticipation of performing his blepharoplasty, and properly obtained a medical clearance from the plaintiff's primary care physician. Dr. Feinberg further alleged that Tornambe allowed an appropriate

amount of time to transpire between the plaintiff's initial consultation and the procedure. He noted that the consent form that the plaintiff signed included the following language:

> "Although good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained . . . you may be disappointed with the results of surgery, asymmetry, unanticipated shape and size, loss of function, wound disruption. . . may occur after surgery,"

and that the form apprised the plaintiff that a second surgery or reoperation may be required because "it may not be possible to achieve optimal results with a single surgical procedure."

With respect to Tornambe's patient preparation immediately prior to surgery, Dr. Feinberg adverted to Tornambe's deposition testimony, in which the latter described his "practice" of preoperatively marking the patient, which Dr. Feinberg concluded did in fact comport with the standard of surgical care. At his deposition, Tornambe described the sequential steps that he always utilized to assess the amount of skin to be removed, specifically, that he employed a caliper. Tornambe further testified as to the subsequent steps that he always employed to ensure the removal of a safe amount of skin and avoid the removal of an excessive amount tissue. Dr. Feinberg opined that each of these aforementioned steps, along with the consent form, detailed a preoperative approach that "wholly comports with the standard [of] plastic surgical care." With regard to the procedure itself, Dr. Feinberg concluded that Tornambe's operative report described

> "the performance of a textbook blepharoplasty and his use of a cautery, specifically the Colorado tip of the electrocautery device to necessarily size and dissect portions of the fat pads is a safer and more appropriate practice than cross-clamping the fat in the patient's eyelids which is far less precise and conversely far more likely to result in over-resection."

Dr. Feinberg emphasized that the dissection of that fat while utilizing the electrocautery lip, as Tornambe described it, "is precise and very unlikely to injure the levator or its aponeurosis."

Dr. Feinberg rejected the plaintiff's contention that Tornambe provided insufficient postoperative care. He again adverted to Tornambe's deposition testimony, this time to the effect that Tornambe's practice was to have his assistant contact a patient two days after the

surgery to ascertain that patient's condition, which was actually done in the plaintiff's case. Dr. Feinberg concluded that this approach was completely appropriate, as was having the plaintiff visit him in person for a physical follow-up examination one week after the surgery, and remaining in contact with the plaintiff via telephone and text messaging in the interim, along with the exchange of photographs of the eyelid in question via text messaging, the latter of which he characterized as exceeding the standard of care. With respect to those photographs, Dr. Feinberg admitted that they clearly reflected a ptotic left eyelid.

Although Dr. Feinberg conceded that the plaintiff's ptotic left eyelid did not exist prior to Tornambe's procedure, he rejected the plaintiff's contentions that the Tornambe engaged in an overaggressive intraoperative resection of tissue, and that such an approach caused injury to the plaintiff's levator muscle. Referring to medical research, Dr. Feinberg concluded that it was far more likely that the outcome experienced by the plaintiff was secondary to a phenomenon known as postoperative blepharoplasty syndrome. He asserted that this syndrome is unrelated to an iatrogenic injury or disinsertion of a levator muscle caused by surgical trauma, but occurs when the levator aponeurosis becomes bound in the septal scar that necessarily had been created by the removal of the anterior orbital fat during the blepharoplasty procedure. Dr. Feinberg explained that, anatomically, the levator muscle is responsible for elevating the eyelid. He further stated that a particular 2019 peer-reviewed ophthalmology study established that the internal healing process can result in adhesion formation, which, in turn, exerts traction on the inferior remnant of the superior orbital septum fusing into the levator aponeurosis, thus causing an inability to properly elevate the eyelid. In this respect, Dr. Feinberg averred that the adhesion draws up the distal septum, thus placing traction on the levator aponeurosis, which may lead to disinsertion. According to Dr. Feinberg, this study had concluded that "excess tissue resection is by far the exception rather than the rule with regard to such levator injury." He thus concluded that postoperative blepharoplasty syndrome, which occurred in the absence of medical negligence, was far more likely to have caused the plaintiff's condition than

overaggressive resection. Dr. Feinberg also opined that the presence of this syndrome would explain why Dr. Shinder was unable to effectuate a complete repair during the revision surgery that employed the latter's Muller muscle resection approach to the problem.

Dr. Feinberg conceded that, although the plaintiff's cosmetic appearance was certainly improved by Dr. Shinder's revision procedure, as confirmed by Dr. Relland, the preferred surgical revision approach would have been to advance the levator and restore the anatomy, rather than to perform a Muller muscle resection, which he concluded essentially served to apply a patch to the problem rather than to restore the levator's natural anatomy and function. In this respect, Dr. Feinberg concluded that Muller muscle resections are more appropriate when a patient presents with near-normal levator function and an eyelid level that can elevate to a position close to normal with the use of phenylephrine drops. He asserted, however, that the plaintiff did not present with that condition, since her ptosis was described by Dr. Shinder as severe and significant. Dr. Feinberg asserted that the

> "surgical approach utilized by Dr. Shinder actually serves to shorten the Muller muscle utilizing it as an ancillary to elevate the eyelid rather than allowing the levator to do what it's anatomically supposed to do. The operative report by Dr. Shinder makes no mention of addressing the levator. It is essentially a blind procedure that does not even allow visualization of the levator. The restoration of the natural anatomy and the restoration of function to the levator aponeurosis may certainly have resulted in a more pleasing cosmetic appearance post revision surgery and have reduced or eliminated the asymmetry which forms the basis of plaintiff's present complaints. The most recent photographs exchanged by plaintiff were taken purportedly in September 2023 and do demonstrate notable improvement in the patient's appearance as confirmed by both plaintiff and Dr. Relland. However, the fact that the resolution is incomplete, allows me to conclude that it would have been optimal to address the levator muscle itself rather than alternatively addressing the Muller muscle in connection with the surgical repair as restoration of the natural anatomy is always preferable."

Dr. Feinberg ultimately concluded that suboptimal result of Tornambe's procedure could be attributed to a risk of the procedure and, thus, it was far more likely that postoperative blepharoplasty syndrome, rather than direct surgical disinsertion of the levator muscle was the cause of the plaintiff's initial ptosis.

In opposition to the motion, the plaintiff relied on many of the same documents that the defendants had submitted. She also submitted a counterstatement of material facts, an attorney's affirmation, and an expert affirmation from oculoplastic surgeon Dr. Shinder, who had performed the February 27, 2023 revision surgery upon the plaintiff. In his affirmation, Dr. Shinder opined that Tornambe did indeed depart from good and accepted practice, and that this departure caused or contributed to the plaintiff's claimed injuries.

Initially, Dr. Shinder asserted that, despite Tornambe's testimony that he measured and marked the plaintiff's eyelids prior to the subject surgery, Tornambe's operative report disclosed no mention of eyelid measurements or markings, which Dr. Shinder characterized as crucial steps in the surgery, and that the report did not describe the instrument that was used for the skin incision.

Dr. Shinder asserted that Tornambe performed an excision of the plaintiff's central and medial upper lid at pads, but that, since her preoperative photographs did not depict any evidence of an orbital fat prolapse, fat manipulation was not needed or warranted. He further concluded that, based on those photographs, Tornambe's excision of orbicularis oculi muscle was not needed or warranted, and that the plaintiff would have been better served with a simple skin-only blepharoplasty. In addition, Dr. Shinder criticized Tornambe for injecting 13 milliliters of local anesthetic during the surgery, inasmuch as he characterized it as a "very large volume" for the procedure that was performed

With respect to the plaintiff's September 20, 2022 postoperative visit with Tornambe, Dr. Shinder expressly rejected Tornambe's description of the plaintiff's left upper eyelid as evincing "normal lid function" and "without problems," since the postoperative photographs did not confirm those findings. Rather, he concluded that these photographs depicted a left upper eyelid that was, in fact, problematic. In this respect, Dr. Shinder asserted that the marked amount of ptosis present on those photographs was not a typical post-blepharoplasty condition, and that Tornambe should have considered the condition to be serious and addressed it in a

proper fashion. He also faulted Tornambe for the manner in which he assessed eyelid function. According to Dr. Shinder, upper eyelid function is typically tested by measuring levator function, but Tornambe did not perform any test for measuring that function. He thus concluded that Tornambe's postoperative diagnoses not only were erroneous, but detrimental to the ongoing care of the plaintiff, since a proper and timely diagnosis of her condition at that juncture could have led to more timely care of her ptosis, and, “most likely,” a better overall outcome.

Moreover, as Dr. Shinder interpreted Tornambe’s October 4, 2022 entry in the plaintiff’s chart, Tornambe measured 3 mm to 4 mm of ptosis, and conceded in writing that her ptosis could be the result of “blood or levator disinsertion during surgery.” According to Dr. Shinder, this was the first time that Tornambe contemplated a levator injury as the cause of the plaintiff’s ptosis, and he concluded that “this should have been in his thought process from the first postoperative visit,” since the extent of the plaintiff’s ptosis could not be explained by any alternate cause. As he framed the issue, the fact that Tornambe then sought advice from Dr. Spinelli, an oculoplastic surgeon, underscored Tornambe’s lack of ability to address this surgical complication in a proper fashion on his own, and contradicted Tornambe’s assessment that the plaintiff’s eyelids had a normal function and were without problems.

Dr. Shinder further opined that Tornambe’s prescription of phenylephrine eye drops to administer for “social occasions” as a way of temporarily lifting the plaintiff’s eyelids for cosmetic benefit is “not only absolutely contraindicated, but it represents a deviation from the good and accepted ophthalmological standards of medical care.” As he explained it, phenylephrine drops are a diagnostic tool for eye care professionals, and are not to be prescribed in the plaintiff’s situation, since they carry the potential for serious adverse effects. Dr. Shinder averred that Tornambe should have known that the eye drops that are prescribed for a lift of a ptotic lid must include the drugs iopidine or Upneeq, the latter of which contains oxymetazoline hydrochloride.

In addition, Dr. Shinder noted that Tornambe did not mention or consider levator repair to address the plaintiff's complications at the October 4, 2022 visit, which he asserted should have been done since it would have been prudent and in the plaintiff's best interest.

In describing his own initial consultation with the plaintiff on October 13, 2022, Dr. Shinder asserted that his examination identified several troubling findings, including a significant ptosis, with the ptotic lid completely covering the plaintiff's corneal light reflex, bilateral upper lid scars on both sides that were in suboptimal locations since they were not within the eyelid creases, and an 18 mm distance between the plaintiff's left eyebrow and the left eyelid margin. As he explained it, blepharoplasty scars should be within the eyelid crease, and their presence outside of the creases suggested improper preoperative measuring, marking, or both, as well as poor surgical technique or lack of knowledge of this phase of the surgery. Moreover, he concluded that the 18 mm distance from the left eyebrow to the left eyelid margin was evidence of an overaggressive skin excision during blepharoplasty, since the applicable standard requires a surgeon to leave behind at least 20 mm of lid skin during a blepharoplasty to prevent known complications, such as lagophthalmos and ocular surface/corneal dryness/dry eye, which the plaintiff was in fact experiencing as a result of Tornambe's surgery. Dr. Shinder further noted that, when he examined the plaintiff on October 13, 2022, she continued to experience lagophthalmos, a condition where the eyelid does not fully close, and he referred to clinical photographs taken at that visit to establish the presence of that condition. In addition, Dr. Shinder averred that this examination revealed that the plaintiff was experiencing subnormal levator function, which he concluded was due to an intraoperative levator injury that was inflicted during Tornambe's procedure.

Dr. Shinder asserted that, also on October 13, 2022, he called Tornambe to discuss the plaintiff's case, and that Tornambe stated during the conversation that he had never seen this type of complication before. According to Dr. Shinder, Tornambe also stated he always used a caliper to measure and mark the patient, and described his fat excision as "conservative."

Nonetheless, Dr. Shinder alleged that Tornambe's chart made no mention of Tornambe's employment of a caliper. He concluded that his own examination argued against the blepharoplasty being "conservative." Dr. Shinder then referred to Dr. Relland's December 5, 2022 examination, in which the latter assessed the plaintiff with severe left ptosis, with a margin reflex distance of 0 mm, and a subnormal levator muscle function of 10 mm. He also described his own February 1, 2023 examination of the plaintiff, in which he diagnosed the plaintiff with significant ptosis and lagophthalmos, at which time the plaintiff agreed to undergo revisional ptosis repair via a conjunctiva Muller muscle resection, as opposed to an anterior ptosis repair.

Dr. Shinder explained the reasons for his recommendation that the plaintiff undergo his suggested method for a revisional ptosis repair. He asserted that he performed that procedure upon the plaintiff on February 27, 2023, and that his key intraoperative finding was that the plaintiff evinced a significant superior symblepharon that spanned the entire width of the left upper lid, which he lysed during the procedure. Dr. Shinder averred that, had he performed an anterior ptosis repair technique, as Dr. Feinberg suggested, he never would have observed or repaired this symblepharon. Dr. Shinder stated that he last examined the plaintiff on July 5, 2023, and that, by that point, she had completely healed from her ptosis repair and symblepharon lysis. He noted that Dr. Relland again examined the plaintiff on September 6, 2023, and that Dr. Relland diagnosed the plaintiff with lagophthalmos, and recommended no further surgery.

Dr. Shinder expressly opined that Tornambe deviated from good and accepted medical and surgical care by performing improper preoperative measurement and making improper preoperative markings, and by performing overaggressive skin excision by delving too deep in his dissection during the plaintiff's blepharoplasty, thus injuring her levator muscle, and also injuring the plaintiff's conjunctiva, which could only happen with a full thickness lid wound. He further asserted that Tornambe committed malpractice by excising orbicularis oculi muscle, and by manipulating orbital fat prolapse, concluding that these procedures were unwarranted. As he

framed the issue, these deviations and departures pointed to Tornambe's "improper understanding of eyelid anatomy and surgical technique." Dr. Shinder further explicitly concluded that, as a consequence of these deviations and departures from accepted care, the plaintiff was compelled to undergo repair surgery, and caused or contributed to the plaintiff's chronic lagophthalmos, ocular surface/corneal dryness/dry eye, and subnormal levator function. Although Dr. Shinder conceded that blepharoplasty has known potential complications, he concluded that a levator injury-related ptosis and symblepharon "were substantially caused" by Tornambe's deviation from accepted standards of ophthalmological surgical care.

Dr. Shinder characterized Dr. Feinberg's theory that postoperative blepharoplasty syndrome had caused the plaintiff's ptosis as "a feeble attempt to cover up defendant's substandard surgery riddled with medical deviations." He asserted that "this theorized syndrome is incorrect and not relevant to the case herein, as it cannot explain the deficient skin left behind, the lagophthalmos, or the symblepharon." Finally, Dr. Shinder asserted that Dr. Feinberg's comments regarding the conjunctiva Muller muscle resection evinced "an outdated fund of knowledge and a lack of understanding of the mechanism by which it produces a lift in the eyelid position." In this respect, he explained that it is now well understood that "the lift is due to a splinting and advancement of the levator muscle rather than from a shortening of the muller muscle or conjunctiva."

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that Dr. Shinder's opinions were conclusory, speculative, and not supported by the medical records, and that Dr. Shinder made unsupported assumptions, thus offering a "defensive" opinion. He further contended that Dr. Shinder conclusion that the plaintiff's lagophthalmos was caused by Tornambe's procedure would "seem to be counterintuitive given the photographs that show . . . the lowered upper lid with resulting incomplete opening rather than deficient closing of the lids," and because Dr. Relland's records did not document the existence of lagophthalmos or incomplete closure of the lids.

The court concludes that the defendants made a prima facie showing of their entitlement to judgment as a matter of law. In this respect, the court gives the defendants the benefit of the doubt, inasmuch as Tornambe's records did not reflect the manner in which he measured and marked the plaintiff preoperatively, and he did not testify that he remembered how he actually measured and marked the plaintiff's eyelids, but only that his custom and habit was that he employed a caliper (*see Guido v Fielding*, 190 AD3d 49, 53-54 [1st Dept 2020] *see also Galetta v Galetta*, 21 NY3d 186, 197 [2013]; *Rivera v Anilesh*, 8 NY3d 627, 634 [2007]). Nonetheless, the court concludes that the opinions of the plaintiff's expert 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 (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to alleged departures from accepted practice in preoperative marking and measuring, surgical technique, postoperative diagnoses, and postoperative care, and whether those departures caused or contributed to the plaintiff's injuries. 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).

Hence, that branch of the defendants' motion seeking summary judgment dismissing the complaint insofar as asserted against Tornambe must be denied.

Where a healthcare professional working for his or her own professional corporation, limited liability company, or limited liability partnership renders health care to a patient "within the scope of his or her employment" for that corporation, company, or partnership, that entity may be held vicariously liable for the negligence of that healthcare provider (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]; *Yaniv v Taub*, 256 AD2d 273, 274 [1st Dept 1998]; *Connell v Hayden*, 83 AD2d 30, 46 [2d Dept 1981]; Business Corporation Law § 1505[a][i]; Limited Liability Company Law § 1205[a]; Partnership Law § 121-1500[q] *see also Galpern v De Vos & Co., PLLC,* 10-CV-1952 (CBA) (JMA), 2011 US Dist LEXIS 117095 *39 , 2011 WL

4597491, *13 [ED NY, Sep. 30, 2011] [Limited Liability Company Law is simply a reflection of the common-law rule that a member of a professional limited liability company is liable for those torts of the company in which he or she is a participant]; *see generally Brown-Jodoin v Pirrotti,* 2011 NY Slip Op 34223[U], 2011 NY Misc LEXIS 7307 [Sup Ct, Westchester County Aug. 17, 2011] [denying motion to dismiss in legal malpractice action made by attorney and his professional limited liability partnership]). Inasmuch as Madison is a professional corporation, it may be held vicariously liable for Tornambe's conduct to the extent that he is found to have committed malpractice. Hence, to the extent that summary judgment is being denied to Tornambe, summary judgment also must be denied to Madison as well.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is denied; and it is further,

ORDERED that, on the court's own motion, the attorneys for all of the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on December 18, 2025, at 2:45 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.

11/25/2025
DATE

JOHN J. KELLEY, J.S.C.

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