

Matos v Lee

2025 NY Slip Op 34628(U)

October 6, 2025

Supreme Court, Bronx County

Docket Number: Index No. 34133/2019E

Judge: Michael A. Frishman

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NEW YORK SUPREME COURT – COUNTY OF BRONX

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: PART 34

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POLIVIO PEREZ MATOS,

Index No. 34133/2019E

Plaintiff(s),
- against -

Hon. Michael A. Frishman
Justice of the Supreme Court

JIMMY K. LEE, M.D., MONTEFIORE MEDICAL
CENTER, GENE KIM, M.D., and ALEX
THEVENTHIRAN, M.D.,

Defendant(s).

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The following papers numbered 79-108 and 110-112 were read on this motion (**Seq. No. 3**) for
SUMARY JUDGMENT

Sequence No. 3	NYSCEF Doc. Nos.
Notice of Motion – Exhibits and Affidavits Annexed	79-96
Cross Motion – Exhibits and Affidavits Annexed	
Answering Affidavit and Exhibits, Memorandum of Law	97-108
Reply Affidavit	110-112

Upon deliberation of the application duly made by defendants, JIMMY K. LEE, M.D., MONTEFIORE MEDICAL CENTER, GENE KIM, M.D., and ALEX THEVENTHIRAN, M.D., by **NOTICE OF MOTION** and all the papers attached thereto, for an Order granting summary judgment in favor of defendants pursuant to CPLR §3212, is heretofore granted.

Plaintiff commenced this medical malpractice action to recover damages for injuries he alleges he sustained as a result of Dr. Lee negligently performing right eye cataract and pterygium surgery on April 11, 2018 and defendants’ failure to timely and properly treat increased eye pressure (intraocular pressure). Plaintiff asserts that these departures resulted in his loss of vision. Plaintiff also alleges claims for lack of informed consent and negligent hiring.

The court’s function on a motion for summary judgment is issue finding rather than issue determination (*Sillman v Twentieth Century Fox Film Corp.*, 3 NY2d 395 [1957]). In a medical malpractice action, a defendant establishes prima facie entitlement to summary judgment by showing either (i) that in treating the plaintiff there was no departure from good and accepted medical practice, or (ii) that any departure was not the proximate cause of the injuries alleged (*Bahnyuk v Reed*, 174 AD3d 481, 482 [1st Dept 2019]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff’s complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law (*roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]).

Once a defendant meets his or her burden, the plaintiff must rebut defendant's *prima facie* showing (*Scalisi v Oberlander*, 96 AD3d 106, 120 [1st Dept 2012]). A plaintiff is only required to raise a triable issue of fact as to causation where the defendant makes a *prima facie* showing that a claimed departure was not a proximate cause of the plaintiff's injuries (*Barry v Lee*, 180 AD3d 103, 106 [1st Dept 2019], *affd* 35 NY3d 1050 [2020]). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation ... the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]). Further, the plaintiff's expert must address the specific assertions of the defendant's expert with respect to negligence and causation (*Foster-Sturup v Long*, 95 AD3d 726, 728-729 [1st Dept 2012]).

Since summary judgment is a drastic remedy, it should not be granted where there is any doubt as to the existence of a triable issue (*Rotuba Extruders v Ceppos*, 46 NY2d 223 [1978]). The burden on the movant is a heavy one, and the facts must be viewed in the light most favorable to the non-moving party (*Jacobsen v New York City Health & Hosps. Corp.*, 22 NY3d 824 [2014]).

Proximate cause is almost invariably a factual issue (*Turturro v City of New York*, 28 NYd 469, 485 [2016]). Ordinarily, is it for the trier of fact to determine the issue of proximate cause (*Howard v Poseidon Pools*, 72 NY2d 972, 974 [1988]). However, the issue of proximate cause may be decided as a matter of law "where only one conclusion may be drawn from the established facts" (*id.* at 974, quoting *Derdiarian v Felix Contr. Corp.*, 51 NY2d 308, 315 [1980]). Additionally, it is the jury's function to assess conflicting evidence and determine the credibility of the witnesses and the weight to be accorded expert testimony (*Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 180 [1st Dept 1974], *affd* 37 NY2d 719 [1975]).

Defendants seek summary judgment dismissing the Complaint against them arguing, *inter alia*, that the care and treatment rendered to plaintiff did not depart from good and accepted standards of care and nothing defendant did or failed to do caused or contributed to plaintiff's claimed injuries. Defendants assert plaintiff's right eye vision problems date back to at least 2013. Defendants further assert plaintiff had already been diagnosed with the following conditions in his right eye prior to moving to New York: age-related macular degeneration, optic nerve head elevation, optic nerve head drusen, and a pterygium. Their motion is supported, among other things, by the affirmation of Nathan Radcliffe, M.D., who is Board Certified in Ophthalmology. The affirmation of defendants' expert satisfy a *prima facie* showing of their entitlement to summary judgment.

Specifically, Dr. Radcliffe opines the initial cataract and pterygium excision surgery performed by Dr. Lee on April 11, 2018 was indicated because plaintiff's best corrected visual acuity (hereinafter "VA") was only 20/60-2 which interfered with his activities of daily living. Moreover, the surgery was indicated not only to address plaintiff's poor vision but to also understand the underlying pathology for plaintiff's long-standing visual complaints and visual loss since the cataract prevented Dr. Lee from optimally visualizing the back of plaintiff's eye and diagnosing the other causes of his vision loss. Plaintiff alleges defendants failed to take a proper medical history, however, the record indicates that a medical, surgical, and ophthalmological history was taken and plaintiff failed to disclose past ophthalmological history regarding his right eye. Dr. Radcliffe states the cataract extraction and pterygium excision surgery was performed properly, and without any issues or complications. A post-operative slit-lamp examination was performed and there were no issues; plaintiff's IOP was 12 mmHG and his uncorrected VA was 20/150, which is normal for post-operative day one according to Dr. Radcliffe. He states it was within the standard of care to instruct plaintiff to

return in one month as there were no complications or issues on post-operative day one, according to The American Academy of Ophthalmology Preferred Practice Pattern.

Dr. Radcliffe explains plaintiff's elevated IOP of 55mmHG does not indicate anything went wrong during surgery since post-operative elevated IOP and glaucoma are both known risks of cataract surgery which Dr. Lee informed plaintiff of. He states Dr. Lee properly administered topical drops and Diamox, successfully reducing the IOP by almost 50%; there is no "normal" range of IOP for a person experiencing elevated pressure/glaucoma. He further states Dr. Lee properly adjusted plaintiff's medications, prescribing Combigan and lowering the steroid, and scheduled plaintiff for follow up the next day to check his IOP. Although plaintiff had not filled his prescription and was not taking the steroid drop as prescribed, his IOP was still lower at 26 mmHG; Dr. Kim noted the haptic of the intraocular lens (IOL) was out of place. Dr. Radcliffe opines it was appropriate to refer plaintiff to Dr. Lee to reposition the IOL in a few days to allow plaintiff to obtain his medications and for further improvement in his IOP. He highlights that there is no indication anywhere in the chart or subsequent records that the dislocated IOL caused any damage to the structures of plaintiff's eye. Dr. Radcliffe explains the lens becoming dislocated subsequent to surgery is a known complication of cataract extraction surgery and was addressed by Dr. Lee in his informed consent. Dr. Radcliffe further explains plaintiff's previous undisclosed trauma to the right eye could have caused weakened zonules and zonular instability which led to the lens becoming dislocated.

Dr. Radcliffe states Dr. Lee properly re-positioned the IOL on May 16, 2018 without complication. On post-op day one, plaintiff still was not taking the pressure-reducing medications as prescribed and his pressure was initially 33 mmHg then 26mmHg. Dr. Radcliffe highlights plaintiff's VA had improved to 20/40 without correction which was a substantial improvement from pre-op. He also highlights plaintiff's IOP was reduced to 23 mmHg and his VA was 20/0-2 on May 24, 2018 after plaintiff began taking his prescriptions. Dr. Radcliffe states it was appropriate for Dr. Lee to further stress compliance with medications when plaintiff returned on July 5, 2018 with an IOP of 34 mmHG. He further states it was proper for Dr. Lee to examine the lens under anesthesia and ensure it was properly centered when the IOL appeared dislocated again on September 26, 2018. Dr. Radcliffe explains it was the standard of care to prescribe drops, including prednisolone, and instruct plaintiff to return in two weeks on post operative day one. He further explains once plaintiff began complying with his medications, his IOP immediately decreased and his VA improved. Dr. Radcliffe opines plaintiff's glaucoma was highly aggressive and either did not respond well to treatment or treatment was not working due to plaintiff's repeated non-compliance which can make it difficult to control their IOPs. Despite this, he further opines Dr. Lee was appropriate and within the standard of care given the circumstances and information known to him at the time.

Dr. Radcliffe states plaintiff's dislocated IOL was not an emergent situation as plaintiff's IOP had already decreased to 26 mmHg from 55 mmHg the day before and would presumably decrease further upon plaintiff starting the prescribed medications. He further states there is no indication that this temporary lens dislocation caused any permanent damage to plaintiff's eye or vision. Furthermore, after the IOL was repositioned, and plaintiff started taking his medications, his IOP dropped to 23 mmHg by May 24, 2018, and his VA improved to 20/40-2 without correction. When plaintiff returned to Dr. Kim on July 13, 2018 with an IOP of 42 mmHg, Dr. Radcliffe opines it is the standard to increase patients to maximum medication therapy before resorting to more invasive surgical intervention as the overwhelming majority of patients will respond to maximum medication

¹ Dr. Radcliffe states a range of 12-21 mmHg is sometimes considered statistically "normal," but this is only in non-operative eyes and does not apply to post-operative IOP values (Dr. Radcliffe aff para 77).

therapy.² He further opines Dr. Kim followed the standard of care by promptly coordinating with Dr. Theventhiran to perform Ahmed Valve surgery when plaintiff did not respond to maximum medication therapy. Moreover, it would have been within the standard of care to perform the surgery within one week after maximum medication therapy had failed.

Dr. Radcliffe explains an Ahmed Valve was the correct surgery to perform on plaintiff since it is well-documented that plaintiff did not comply with topical therapy which would pose a problem having a trabeculectomy as that requires pristine compliance with prednisolone for a period of three to six months. Plaintiff also had several prior ocular surgeries which reduced the success rate of trabeculectomies. He states the Ahmed Valve surgery successful reduced plaintiff's IOP and plaintiff's claim that the increased IOP caused his vision loss was not caused by anything Dr. Theventhiran did or failed to do. Dr. Radcliffe further states the anterior chamber reformations and choroidals resolved and did not cause any long-term issues or visual loss. In addition, plaintiff denied any complaints and reported feeling "much better in terms of vision" on August 2, 2018 and his VA without correction was 20/40-1. He explains plaintiff's IOP drastically improved the following day once Dr. Theventhiran instructed him to restart his medications when his IOP was elevated after the second lens repositioning. Dr. Radcliffe opines any delay in referring plaintiff to Lighthouse did not cause or contribute to plaintiff's alleged vision loss because it is inappropriate to refer someone to Lighthouse until post-operative issues are resolved as Lighthouse does not treat glaucoma. He further opines the doctors at Montefiore acted with the standard of care at all times in their treatment of plaintiff.

Dr. Radcliffe highlights plaintiff's central VA is significantly better than it was prior to Montefiore's treatment. He also highlights plaintiff had complaints about his vision since Puerto Rico and there is no baseline of comparison in terms of his peripheral vision since the first visual field test was performed at Montefiore. Furthermore, plaintiff had borderline IOPs on his previous undisclosed visits at Lincoln Ophthalmology; he had complaints about chronic decreased vision; and he used a cane for right eye vision loss for years prior to his treatment at Montefiore. Dr. Radcliffe references the Ocular Hypertension Treatment Study which states more than 90% of patients with ocular hypertension (defined in the study as elevated IOP of 24 to 32 mmHg) did not progress to glaucoma over 5 years even when left untreated. He states nothing that the Montefiore physicians did or did not do could have prevented his alleged vision loss and plaintiff's woeful non-compliance contributed to any purported vision loss.

As for plaintiff's informed consent claim, Dr. Radcliffe states it is well-documented that the risks, benefits, and alternatives of each procedure were discussed with plaintiff and he signed at least one detailed written informed consent prior to each procedure. He opines the informed consent discussions were within the standard of care, and that plaintiff gave fully informed consent prior to each procedure. Furthermore, plaintiff signed detailed written informed consents, sometimes multiple consent forms in both Spanish and English. He further opines a reasonably prudent person in plaintiff's position would have elected to undergo these procedures, even if fully informed of the risks, benefits, and alternatives because there is no alternative to treating a cataract besides surgical extraction; if the cataract were not removed, it would continue to worsen, eventually leading to blindness. In addition, Dr. Radcliffe states there is nothing to suggest that the named physicians lacked the necessary training and experience to serve as attending ophthalmologists.

² Plaintiff's IOP decreased to 35 mmHg after Dr. Kim administered a round of pressure-reducing drops.

In opposition to defendants' motion for summary judgment, plaintiff asserts that defendants have failed to meet their burden, and they departed from the standard of care by failing to timely and properly treat increased eye pressure (intraocular pressure). In support, plaintiff relies on the affirmation of an undisclosed physician, who specializes and practices in the field of ophthalmology.³

Defendants argue plaintiff's expert is not qualified to render an opinion in this case as she does not have the requisite skill, training, education, knowledge, or experience. Defendants also highlight that plaintiff's expert is a pediatric general ophthalmologist.⁴ It is well recognized that, "[a] physician need not be a specialist in a particular field if he nevertheless possesses the requisite knowledge necessary to make a determination on the issues presented. Once the expert professes such knowledge, the issue of the expert's qualifications to render such an opinion must be left to the trial" (*Almeyda v Concourse Rehabilitation & Nursing Ctr., Inc.*, 195 AD3d 437, 437 [1st Dept 2021]). Although plaintiff failed to provide the Court with an unredacted affirmation, in light of judicial economy, the Court will consider the papers submitted.

Plaintiff's expert opines Dr. Lee deviated from the standard of care in failing to properly position the intraocular lens during Mr. Matos' April 11, 2018 cataract extraction and lens implantation. His expert further opines had Dr. Lee properly positioned the lens and then repositioned the lens, Mr. Matos would not have lost his vision. The expert states Mr. Matos would not have been diagnosed with Uveitis Glaucoma Hyphema (UGH) syndrome if Dr. Lee had properly placed the lens. Plaintiff's expert highlights that Dr. Kim testified that the increased IOP was caused by UGH due to the malposition of the intraocular lens. Plaintiff's expert states Dr. Kim deviated from the standard of care when he failed to order timely and immediate treatment of the cause of the UGH and increased IOP and in not treating the etiology of the increased IOP. It is plaintiff's expert position that the failure to reposition the lens immediately caused further injury to plaintiff's eye which is confirmed by the May 15, 2018 note that Mr. Matos had decreased VA. Plaintiff's expert further states the failure to act and have a closer follow up was a substantial contributing factor to prolonged increased IOP, which damaged the structures in Mr. Matos' eye including, but not limited to the optic nerve and macula. His expert explains the standard of care required a Trabeculectomy instead of an Ahmed Valve since the lens became displaced again which caused further damage to the eye.

Plaintiff's expert opines the defendants acknowledged that the damage done to plaintiff's right eye happened when they were treating him: Dr. Thevrenthiran admitted that the optic nerve had been damaged by August 6, 2018; he further confirmed that increased IOP was at the top of differential diagnosis as the cause of the optic nerve damage and this damage correlated with the visual field that showed peripheral vision loss; and Dr. Kim confirmed that the most likely cause of the thinning of the disc and optic nerve was the increased intraocular pressure. Plaintiff's expert further opines the variations in Mr. Matos' VA does not mean that he did not sustain significant injuries due to defendants' malpractice; the etiology of the optic nerve and disc damage was not the [result of the] assault that occurred back in the 1980s because plaintiff would have had many problems sooner than 2018; Mr. Matos' vision loss was not due to an aggressive and treatment resistant glaucoma, but was due to defendants' failure to timely and/or properly treat the malpositioned IOL and increased IOP; and Mr. Matos should have been warned that he could go blind.

³ The affirmation is silent as to whether the physician is board certified in Ophthalmology.

⁴ The Court is reiterating defendants' argument; the Court is unaware if this is true as an unredacted physician affirmation has not been provided to the Court.

However, an expert's affirmation that sets forth general conclusions, misstatements of evidence, and unsupported assertions, and which fails to address the opinions of defendant's expert, is insufficient to defeat summary judgment (*Cabrera v Golden*, 231 AD3d 149, 155 [1st Dept 2024]). Plaintiff's expert fails to refute defendant's expert on plaintiff's pre-existing vision loss and to acknowledge that plaintiff did have vision problems prior to 2018. It was documented in the Puerto Rico Medical Center records as early as 2013 that plaintiff had a pterygium in his right eye. Additionally, it is documented in the Lincoln Ophthalmology Records (p. 18), plaintiff had trauma in his right eye and a pterygium excision in his right eye in Puerto Rico. Plaintiff presented to Lincoln Hospital on July 23, 2014 for an eye clinic appointment; it was determined he had chronic decrease of vision in his right eye. It is further documented in the Lutheran HealthCare records that plaintiff requested a cane on August 8, 2014 to assist with walking and for safety due to right eye vision loss and a left eye prosthetic. Plaintiff's expert misstates the record that plaintiff did not have visual acuity readings of 20/150, 20/200, 20/300 and 20/400 before being treated by defendant, however, in the Lincoln Ophthalmology Clinic Records, plaintiff is documented to have VA of 20/200 on August 1, 2014.

Plaintiff's expert failed to take into account the previous eye injuries suffered by plaintiff prior to his treatment with defendant. Plaintiff's expert further states Dr. Kim admitted Mr. Matos did not have a chorioretinal scar of the macula prior to Dr. Lee's surgery but he had macula damage following his Ahmed Valve surgery with Dr. Theventhiran, however, the scar is documented in the Lincoln Ophthalmology records on August 3, 2015, a few years prior to Dr. Lee's surgery. Notably, it was also documented that plaintiff had decreased VA in the right eye secondary to the macula. Plaintiff's expert also states he did not have an inferior paracentral 1 millimeter circular anterior stromal scar on his cornea on May 10, 2018, but that scar was documented in the Lincoln Ophthalmology Medical records (p. 19) as early as August 1, 2014. Plaintiff's expert states the Lighthouse Guild records dated November 12, 2018⁵ documented plaintiff's best corrected vision at 20/200, however, the records state plaintiff's uncorrected VA was 20/60 and 20/40 with subjective refraction. Furthermore, plaintiff's corrected VA of 20/40 was measured at Montefiore a day before. As of August 13, 2024, plaintiff's corrected VA was 20/40. Additionally, plaintiff's expert opines defendant's failure to treat the malpositioned IOL led to plaintiff's increased IOP, however, even after correction plaintiff's expert fails to acknowledge his IOP remained high.

Plaintiff's expert also misquotes the testimony given by Dr. Kim and Dr. Theventhiran. His expert states matter of factly Dr. Theventhiran testified that plaintiff was legally blind on October 5, 2018, however, he further testified that plaintiff's vision improved since treating him but he inferred he was likely legally blind before although he was unable to definitively state when that happened. Plaintiff has failed to raise a triable issue of fact that would warrant denial of defendant's motion for summary judgment.

As to plaintiff's informed consent claim, plaintiff's expert only mentions the April 11, 2018 procedure performed by Dr. Lee and his failure to warn plaintiff that he could go blind. Conversely, the Montefiore Medical Records states "the risks were explained to the patient including but not limited to the risks of pain, visual loss, infection, bleeding, corneal decompensation, glaucoma, retinal changes, ptosis, and need for subsequent surgery ... the patient understands these risks and consents to surgery. (p. 804) Furthermore, despite alleging he is unable to see, plaintiff identified his signature on the consent form at his deposition. Since it is stated in the records that plaintiff consented to the

⁵ Plaintiff states November 12, 2018, however, upon reviewing the records the date is November 9, 2018.

surgery, was notified of the risks, and he identified his signature on the form, plaintiff's lack of informed consent claim is dismissed.

Plaintiff's expert failed to rebut defendants' expert regarding the negligent hiring claim; therefore the claim is dismissed as abandoned (*Saidin v Negron*, 136 AD3d 458 [1st Dept 2016]).

Accordingly, it is hereby

ORDERED that the motion by defendants, JIMMY K. LEE, M.D., MONTEFIORE MEDICAL CENTER, GENE KIM, M.D., and ALEX THEVENTHIRAN, M.D., for summary judgment pursuant to CPLR §3212, is heretofore granted; and it is further

ORDERED that the Clerk of the Court is directed to enter judgment in favor of the defendants herein, dismissing the Complaint; and it is further

ORDERED that counsel for defendants shall serve a copy of this Decision with Notice of Entry by first class mail within thirty (30) days of its entry.

This constitutes the Decision and Order of the Court.

Dated: 10/6/25

Hon. 
MICHAEL A. FRISHMAN, J.S.C.

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- 1. CHECK ONE..... CASE DISPOSED IN ITS ENTIRETY CASE STILL ACTIVE
 - 2. MOTION IS..... GRANTED DENIED GRANTED IN PART OTHER
 - 3. CHECK IF APPROPRIATE..... SETTLE ORDER SUBMIT ORDER