Sheiffer v Fox

2023 NY Slip Op 30936(U)

March 27, 2023

Supreme Court, New York County

Docket Number: Index No. 162180/2015

Judge: John J. Kelley

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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JAIME SHEIFFER,

Plaintiff,

- v -

NATHAN FOX, M.D., ADRIENNE BARASCH, M.D., SUSAN PESCI, M.D., SAMUEL BENDER, M.D., MICHAEL SILVERSTEIN, M.D., STEPHANIE MELKA, M.D., NEIL GRAFSTEIN, M.D., CIARA MARLEY, M.D., PAUL CHOI M.D., JERRY BLAIVAS, M.D., MATERNAL FETAL MEDICINE ASSOCIATES, PLLC, THE MOUNT SINAI HOSPITAL, NEW YORK UROLOGICAL ASSOCIATES, P.C., EAST RIVER MEDICAL IMAGING, P.C., and UROCENTER OF NEW YORK,

Defendants.

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INDEX NO. 162180/2015

MOTION DATE 11/16/2022

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 222, 226, 227, 228, and 231

were read on this motion to/for JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, vicarious liability, and negligent hiring and retention of medical employees, the defendants Nathan Fox, M.D., Adrienne Barasch, M.D., Susan Pesci, M.D., Samuel Bender, M.D., Michael Silverstein, M.D., Stephanie Melka, M.D., Maternal Fetal Medicine Associates, PLLC (MFMA), and The Mount Sinai Hospital (collectively the obstetrical defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted to the extent that summary judgment is awarded to Barasch, Pesci, Bender, Silverstein, Melka, and The Mount Sinai Hospital (Mount Sinai) dismissing the

complaint in its entirety insofar as asserted against them, and dismissing the lack of informed consent and negligent hiring and retention causes of action against Fox and MFMA. The motion is otherwise denied, as there are triable issues of fact as to whether Fox departed from good and accepted practice in performing a cesarean section procedure upon the plaintiff, whether that departure caused and contributed to her claimed injuries, and whether MFMA is vicariously liable therefor.

II. FACTUAL BACKGROUND

The crux of the plaintiff's medical malpractice claims against the obstetrical defendants is that, during a cesarean section procedure, Fox, an obstetrician/gynecologist employed by MFMA, while assisted by Mount Sinai intern Barasch and Mount Sinai resident Pesci, transected the plaintiff's bladder, causing bleeding, infection, incontinence, and pain, as well as the need to repair the transection. The plaintiff also averred that the repair of the transected bladder caused a fistula to develop that necessitated an additional surgery to repair it. She asserted that the other individually named obstetricians/gynecologists failed properly to recognize, diagnose, and treat the fistula in a timely fashion. In addition, the plaintiff alleged that MFMA, which employed these other physicians, as well as Mount Sinai, which employed Barasch and Pesci, were vicariously liable for their employees' malpractice.

In 2013, plaintiff, who was then 35 years old, began receiving prenatal care at the defendant MFMA. While treating at MFMA, the plaintiff was seen and examined by the defendants Fox, Bender, Silverstein, and Melka, all of whom were employed by MFMA and had admitting privileges at Mount Sinai. At her initial prenatal appointment, the plaintiff reported that she was experiencing her first pregnancy. Her past medical history was significant for an atrial septal defect repair due to a mitral valve prolapse in 1996 and a laparoscopic right cystectomy for an ovarian dermoid cyst in 2008. She also had a history of abnormal pap smears, although they had been normal since 2009. At the time of her first visit to MFMA, she was told that her estimated due date was April 7, 2014. MFMA formulated a plan for genetic counseling due to

advanced maternal age, biophysical profiles weekly beginning at 36 weeks gestation, and a delivery at 41 weeks of gestation. The plaintiff's prenatal course was routine, until approximately March 13, 2014, when she was at 36 weeks and 3 days gestation, at which time she evinced increased blood pressure, edema, and weight gain. MFMA physicians directed the plaintiff to the Mount Sinai labor and delivery department to evaluate her for preeclampsia. The plaintiff was admitted overnight for prolonged monitoring.

According to the obstetrical defendants, her fetal well-being upon admission was reassured during that admission, after which she was diagnosed with gestational diabetes due to elevated blood pressure readings. The plaintiff was directed to collect her own urine samples over the next 24-hour period, and was discharged from the hospital on March 14, 2014, with instructions to complete the urine collection at home and return the full sample the next day. The urine test results revealed an elevated protein level of 243 mg in the 24-hour sample, as the obstetrical defendants contended that the normal range was 30 mg to 150 mg in a 24-hour urine sample.

On March 17, 2014, when the plaintiff was at 37 weeks and one day of her gestation period, obstetrician/gynecologist Silverstein saw her at MFMA, at which time she underwent a biophysical profile conducted by Fox, resulting in a score of 8/8. According to the obstetrical defendants, MFMA physicians discussed the signs and symptoms of labor and delivery with the plaintiff, and arranged for the induction of labor for later that week. At 7:35 pm on March 19, 2014, the plaintiff presented to the labor and delivery triage unit at Mount Sinai, at which time she was at 37 weeks and 3 days gestation, complaining of strong, regular contractions since 4:00 p.m. that afternoon. As of that time, the plaintiff was scheduled for induced labor for the following day. A cervical examination revealed that she was 4 cm dilated and 90% effaced, and that the fetus was at the -3 station. Fox was the attending physician on call at MFMA when the plaintiff was admitted, and he examined the plaintiff at 9:01 p.m. Notwithstanding the results of the 24-hour urine test conducted between March 13, 2014 to March 14, 2014, Fox documented

that the plaintiff's 24-hour urine protein levels had been "normal" the week before and that her blood pressure readings had been in the normal range, although contemporaneous laboratory testing indicated an elevated protein level. The plaintiff denied that she was suffering from headaches, visual changes, shortness of breath, or chest pain. She was admitted for early labor and, notwithstanding the prior plan for induced labor, the plan formulated on March 19, 2014 was for an anticipated normal spontaneous vaginal delivery.

The plaintiff's labor proceeded normally until approximately 1:45 a.m. on March 20, 2014, when Mount Sinai medical staff observed severe, repetitive fetal heart decelerations. Physicians at Mount Sinai determined to bring the plaintiff to the operating room (OR) for what the obstetrical defendants characterized as an emergent cesarean section procedure, and the plaintiff thus was brought to the OR at 1:54 a.m. on March 20, 2014. When she arrived at the OR, the plaintiff executed a consent form in connection with the procedure and, according to Fox, it was his custom and practice to advise patients of the risks of the procedure, including bleeding, infection, and damage to adjacent organs.

Fox commenced the procedure at 2:01 a.m. on March 20, 2014, and completed it at 4:44 a.m., when the plaintiff's child was delivered. In his operative report, Fox wrote that the pre- and post-operative diagnosis was a non-reassuring fetal heart rate tracing and arrest of fetal descent. He documented that the plaintiff was in spontaneous labor and fully dilated when he noted recurrent fetal heart rate decelerations. As Fox described it, the vertex had not descended below the -2 station, and he thereupon decided to deliver the fetus by cesarean section. Barasch, who was then an intern employed by Mount Sinai, assisted Fox during the procedure. Fox documented that a Foley catheter that previously had been placed had been removed due to the plaintiff's discomfort just prior her commencement of pushing. He further noted that there was a small amount of blood, but no urine, draining from the catheter. According to the operative report, a Pfannenstiel incision---an abdominal incision that allowed him access to the plaintiff's abdomen---was made in the "usual fashion." A transverse incision

was made in the lower uterine segment, employing a scalpel. The operative report indicated that the plaintiff's uterus was entered bluntly, and that the uterine incision was extended. The infant was delivered without difficulty, with Apgar scores of 7 and 8, and the placenta thereafter was delivered intact.

According to Fox's operative report, the plaintiff's uterus was cleared of all clots and debris. Upon his inspection of the uterine incision, Fox noted an additional "vertical defect" in the posterior wall of the plaintiff's bladder, and concluded that the defect was not contiguous with the prior ovarian cystectomy, and was several centimeters inferior to the site of that cystectomy. He noted no uterine incision extensions.

Fox thereupon requested a urology consultation, at which point fourth-year Mount Sinai resident Pesci arrived to relieve Barasch. According to the obstetrical defendants, the care and treatment that Barasch rendered to the plaintiff was at all times supervised by Fox, while Pesci's involvement was limited to assisting Fox with the cesarean section after the bladder laceration was identified, and consisted solely of the closure of the cesarean section incisions after the delivery of the infant. After the uterine incision was closed, the urology team, including the defendant urologist Neil Grafstein, M.D., scrubbed in and repaired the bladder defect in layers. Fox concluded that the etiology of the defect was unknown, that is, he could not determine whether it occurred during labor or during the time of delivery, but he did note that it "did not have the appearance of a 'surgical' incision as it was vertical and not straight." Fox testified at his deposition that, after the infant was delivered, he observed a "bladder defect" that could have been caused either spontaneously during labor, by virtue of the placement and movement of the Foley catheter, or during the cesarean section as a consequence of the employment of retractors or the scalpel. Grafstein's operative report noted that he was called emergently for an intraoperative consult after the finding of a possible cystotomy, that is, a surgical incision of the plaintiff's bladder. In contrast to Fox's uncertainty as to the etiology or characterization of the bladder "defect," Grafstein characterized the defect as an approximately 6 cm-7 cm cystotomy

at the dome of the bladder, extending towards the posterior wall. Grafstein reported that the trigone was visualized through the cystotomy and seen to be a safe distance away from the site of the cystotomy, without any evidence of injury to the trigone or ureteral orifices. He further reported that the bladder was repaired in multiple layers in a running fashion, and recommended that a Foley catheter remain in place for one to two weeks.

After the surgery, the plaintiff remained hospitalized until March 26, 2014. During her admission, she was followed by pulmonologists due to her history of asthma during her first trimester, as well as because of her complaints of coughing, wheezing, and shortness of breath since the delivery. The plaintiff was diagnosed with an upper respiratory infection and placed on the systemic steroid Prednisone, the bronchodilator Albuterol, and the corticosteroid inhalant Budesonide, after which her respiratory condition improved. Urologists also followed the plaintiff during her hospital stay, with the urology team documenting that she had good urinary output. The plaintiff complained of pain from the surgery throughout her admission, rating the pain as an 8 on a scale of 10. On March 22, 2014, the plaintiff complained of "retching, burping large amounts of air," for which an X-ray of the abdomen was ordered. The x-ray revealed an air-filled distention of small and large bowel loops throughout the plaintiff's abdomen, many of which demonstrated air-fluid level on upright imaging. The defendants Melka and Bender, both of whom are obstetrician/gynecologists, concluded that, based upon their examinations of the plaintiff, these findings were consistent with a post-operative ileus, that is, a prolonged absence of bowel function after a surgical procedure.

Subsequent to March 22, 2014, the plaintiff's condition reportedly improved with conservative treatment. On March 26, 2014, Fox discharged the plaintiff, with a referral to Visiting Nurse Services of New York, and recommended that she return to his office two to three weeks later. The plaintiff also was scheduled to see Grafstein in one week. Fox prescribed her ibuprofen, the painkiller Percocet, Budesonide, Albuterol, and a three-day course of Prednisone.

On March 28, 2014, after contacting Fox, the plaintiff presented to the Mount Sinai emergency room with complaints of chills and discolored urine. Fox examined her at 2:11 a.m. on that date, and documented an elevated blood pressure, but noted that her other vital signs were normal. Fox noted that it did not appear that she was suffering from a urinary tract infection, pyelonephritis, or sepsis, and performed cultures and blood testing. Fox paged the Mount Sinai urology department, and urology staff agreed with his plan to discharge her to her home.

On April 1, 2014, the plaintiff had her first office visit with Fox since the delivery of her child, and she met with Grafstein as well. Grafstein emailed Fox and informed the latter that the plaintiff's cystogram looked good and that he removed the catheter. On April 4, 2014, the plaintiff called MFMA's offices, complaining of pain on her right side, and she returned to the MFMA office on April 7, 2014 for a follow-up visit with Silverstein, who recommended and documented that the plaintiff should call the office if her abdominal pain did not improve with the use of the analgesics that she was then already taking. Silverstein further recommend an abdominal computed tomography (CT) scan if there were no improvement in her pain. On April 10, 2014, an MFMA staff employee spoke with the plaintiff, who reported continued complaints of right-sided pain and constant cramping, and called back later that day, reporting continued pain. MFMA ordered an abdominal/pelvic CT scan at that time, but the plaintiff did not undergo that study. On April 17, 2014, the plaintiff returned to Grafstein's office for her final visit, reporting mild dysuria, but improving incisional pain. The plaintiff then underwent a sonogram, which showed her post-voiding residual was at 50 cubic centimeters (cc) of urine. According to the obstetrical defendants, the burning upon urination of which the plaintiff had complained had improved since the catheter was removed and that, although she also reported small amounts of blood in her urine, she was advised that this was normal for the first six weeks following childbirth. At that time, the plaintiff was only urinating twice daily and, in fact, a urine dipstick was positive for leukocytes, indicating the presence of white blood cells and, hence, an

infection. Grafstein prescribed the antibiotic Bactrim and ordered a urine culture, which was, however, negative for infection. The obstetrical defendants contended that a cystogram confirmed that the bladder defect had been repaired, and that the repair was holding as of April 17, 2014.

On May 1, 2014, the plaintiff was seen by Bender, who documented her complaints of continuing abdominal pain. At that time, the plaintiff also reported a "funny feeling" when she urinated, but also told MFMA physicians that her urologist performed a culture that was negative for infection. Bender purportedly discussed the timetable for recovery with the plaintiff, prescribed Pyridium for urinary discomfort, and ordered an ultrasound to assess the causes of her abdominal pain. The plaintiff underwent ultrasound testing at Carnegie South Imaging for Women on May 2, 2014, after which Fox saw her at MFMA. The plaintiff continued to report abdominal pain to the right of, and superior to, her incision, despite having taken non-steroidal anti-inflammatory drugs to treat the symptoms, and notwithstanding slow improvement of the pain. In addition, the plaintiff reported weakness and occasional dizziness when standing up, as well as occasional dysuria that nonetheless was improving overall. Fox formulated an opinion that the plaintiff's abdominal pain was related to fibroids, and concluded at the time that her urinary symptoms were a normal occurrence and probably would resolve over time.

On May 9, 2014, the plaintiff presented to the defendant urologist Ciara Marley, M.D. Marley's differential diagnosis included a ureterovaginal or vesicovaginal fistula as a potential cause of urinary tract problems, and thus ordered a CT urogram. Marley also performed a blue dye test, which involves the insertion of a Foley catheter into the bladder and injecting normal saline solution containing blue dye, after which a tampon is inserted into the vagina. As the obstetrical defendants described it, if there is a "communication" between the vagina and bladder, the tampon would have blue dye on it. The blue dye test was negative and, hence, there was no apparent communication between the vagina and bladder.

On May 10, 2014, the plaintiff presented to East River Medical Imaging, P.C., for a CT scan of the abdomen and pelvis, which was interpreted by the defendant radiologist Paul Choi, M.D. Upon examining the scan of the plaintiff's ureters, including the left distal ureter from the S1 sacral level to a point immediately proximal to the ureterovesical junction, Dr. Choi concluded that the anatomical features were "not opacified after multiple attempts at scanning, which may be due to phase of ureteral contraction," while the remainder of the area showed normal opacification, and there was no evidence of extra luminal contrast surrounding the ureters or bladder. According to Choi, there was a small amount of free fluid noted in the right anterior pelvis that may have been post-surgical in nature, and no evidence of excreted contrast in the endometrial canal or vaginal vault. Dr. Choi further concluded that the plaintiff's uterus was prominent and multilobular in appearance, with multiple hypodense foci, likely representing fibroids measuring 4.1 cm by 3.9 cm along the posterior corpus, as well as multiple additional exophytic appearing fibroids measuring 4.2 cm by 3.6 cm in the right anterior corpus of the uterus. Dr. Choi also noted the presence of additional smaller hypodense foci. He further concluded that the urinary bladder evinced the presence of a moderate amount of nondependent air anteriorly within the lumen, and he had the impression that there was no evidence of extraluminal contrast adjacent to the uterus or bladder or within the vaginal vault. Dr. Choi characterized the plaintiff's kidneys and urinary tracts as unremarkable, and determined that any air within the bladder lumen was presumably related to the cystoscopy. He thus opined that the multiple hypodense foci in the uterus likely represented multiple fibroids.

The plaintiff returned to see Marley on May 14, 2014, at which time Marley performed a cystogram, with results that were negative. To conduct the cystogram, the plaintiff's bladder was filled with 250 cc of urine, and all images were negative for a leak. Marley still thought that vesicovaginal fistula was a possibility, and thus suggested that the plaintiff reduce her intake of bladder irritants, including alcohol and caffeine, recommending that the plaintiff come back if her complaints continued. The plaintiff thereafter presented to the defendant urologist Jerry Blaivas

M.D., on May 21, 2014, complaining of post-partum incontinence and leaking of urine when standing up, including urination down her leg, despite the absence of feeling as if she needed to evacuate her bladder. The plaintiff reported to Blaivas that she developed these symptoms approximately five weeks after delivering her child. Blaivas noted that the plaintiff's ureters and her post-operative cystogram were "OK," that her CT scan was unremarkable, and that a repeat cystogram showed complete bladder evacuation. Nonetheless, one film depicted the presence of contrast above the plaintiff's bladder. Upon Blaivas's physical examination of the plaintiff, he noted that her pelvic muscle pressure was strong, that a neurological examination was within normal limits, and that a bladder "stress test" undertaken when her bladder was full caused no leakage. Blaivas also performed a lower urinary tract symptom (LUTS) test, yielding a score a 21 out of 56 points, indicating moderate to severe symptoms. The plaintiff's voiding score was 3 out of 16, storage score was 14 out of 36, overactive bladder symptom score was 6 out of 28, and incontinence score was 8 out of 12. Blaivas recommended that the plaintiff maintain a diary of her voiding, prescribed Vesicare to treat the symptoms of an overactive bladder, and recommended that she return to see him in one month if she were doing well or one week if she were not. The plaintiff did not visit with Blaivas after that one appointment

Between May 21, 2014 and May 30, 2014, the plaintiff and Fox exchanged several email messages concerning her urinary complaints. On May 29, 2014, the plaintiff met with urologist Jaspreet Sandhu, M.D., at Memorial Sloan Kettering Cancer Center (MSKCC) to evaluate her for a potential vesicovaginal fistula. Dr. Sandhu prescribed the placement of a Foley catheter for two weeks to see if her leakage and other symptoms resolved on their own, and suggested surgical repair if that did not help. Upon examination, Dr. Sandhu noted there was pooled urine in the vaginal vault. He also recommended a CT cystography thereafter to evaluate whether the fistula had resolved. On May 30, 2014, the plaintiff emailed Fox, informing him that she had a "new complication and medical update," and wanted to speak with him. In response, he called the plaintiff, who reported that Dr. Sandhu diagnosed her with a vesicovaginal fistula. She

reported to Fox that this was the first time that a specialist was able to visualize a fistula. On June 19, 2014, Dr. Sandhu performed a CT cystography, which showed a vesicovaginal fistula extending from the left of midline bladder dome to the left anterior vaginal vault. On June 28, 2014, the plaintiff presented to MSKCC for a repair of the vesicovaginal fistula. Dr. Sandhu performed the procedure, which involved closing the fistula and the placement of a urethral stent. A July 15, 2014 CT cystography revealed that the fistula had resolved.

III. THE PLAINTIFF'S ALLEGATIONS

In her complaint, the plaintiff made general allegations against the obstetrical defendants to the effect that they failed to provide her with adequate medical care and departed from good and accepted practice during the course of her treatment with them. She further alleged that they failed to obtain her fully informed consent to a cesarean section procedure because they failed to disclose all of the risks associated with it, and that a reasonable person would not have consented to the procedure had all of those risks been disclosed. In addition, she asserted a cause of action, denominated as one to recover for vicarious liability against MFMA and Mount Sinai, that also sought recovery against MFMA for negligently hiring or retaining several individual physicians as employees and against Mount Sinai for maintaining those physicians' admitting and operating privileges at Mount Sinai's facilities.

In her bill of particulars as to MFMA, the plaintiff asserted that it ommitted malpractice because one or more of its employees departed from good and accepted practice in the performance of the cesarean section by, among other things, negligently performing fascial and uterine incisions, negligently applying retractors, and negligently failing to order and perform a cystogram. The plaintiff further asserted that MFMA failed to review the plaintiff's prior radiological studies. In addition, she alleged that MFMA failed to consider vesicovaginal fistula as part of its differential diagnosis for the plaintiff's signs and symptoms, delayed the ultimate diagnosis of that condition, and, thus, delayed the necessary treatment for that condition. The plaintiff further claimed that MFMA negligently directed interns, residents, fellows, and other

surgical staff present during the performance of the cesarean section. In addition, she averred that MFMA failed fully to apprise her of the risks of undergoing a cesarean section and, thus, failed to obtain her fully informed consent to the procedure. The plaintiff asserted that, as a consequence of those departures from good and accepted practice, she was caused to sustain a 6 cm to 7 cm long cystotomy at the dome of her bladder, extending toward the posterior wall of the bladder, necessitating the closure of the cystotomy with bladder repair. She further alleged that she suffered from dysuria, urinary tract infection, urinary tract pain, urinary incontinence, lower back pain, and additional pain while walking, sitting, and standing. In addition, the plaintiff averred that, due to MFMA's malpractice, she sustained a vesicovaginal fistula extending the left of the midline of the dome of her bladder to the left anterior vaginal vault, necessitating the surgical closure of the fistula.

With respect to Mount Sinai, the plaintiff reiterated the allegations of negligence that she asserted against MFMA, but specified that Mount Sinai also was negligent because its own hospital staff, including interns, residents, nurses, and other health-care professionals, engaged in the same negligent conduct that MFMA's employees allegedly had engaged in, and failed to obtain her fully informed consent to the procedure in the same manner as MFMA's employees.

In her bills of particulars addressed to Fox, Barasch, and Pesci, the plaintiff alleged that they departed from good and accepted practice by negligently performing the cesarean section and, with respect to Barasch and Pesci, negligently assisting in the performance of the procedure. She alleged that all three of these defendants departed from good practice by failing to diagnose her post-operative vesicovaginal fistula, thus delaying treatment therefor. With respect to Fox in particular, the plaintiff averred that he also departed from good and accepted practice in negligently directing interns, residents, fellows, and other surgical staff present during the procedure, in negligently performing fascial and uterine incisions, and in negligently applying retractors. In addition, the plaintiff asserted that these three defendants failed to obtain her fully informed consent to the procedure.

In her bills of particulars addressed to Silverstein, Melka, and Bender, the plaintiff alleged that they departed from good and accepted practice by failing to observe and diagnose a vesicovaginal fistula, failing to refer her to a urologist, failing to recommend, order, perform, or refer her for a cystogram, failing to review her prior radiological studies, and failing to consider vesicovaginal fistula as part of a differential diagnosis based on her signs, symptoms, and complaints, thus delaying her treatment for that condition. Although these three physicians did not undertake any invasive procedure, and the allegations against them were premised solely on failures to perform proper testing, failure to diagnose, and failure to refer to other specialists, the plaintiff nonetheless asserted that they failed to obtain her fully informed consent to the treatment that they rendered.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the obstetrical defendants submitted the pleadings, the plaintiffs' bills of particulars, relevant medical and hospital records, the transcripts of the parties' deposition testimony, a statement of material facts, an attorney's affirmation, a memorandum of law, and the expert affidavit of Dwight Rouse, M.D., who is board certified in obstetrics and gynecology and maternal-fetal medicine. They argued that none of them departed from good and accepted practice, that their conduct did not cause or contribute to the plaintiff's injuries, and that the bladder laceration and fistula were known risks of a cesarean section procedure. They further contended that Barasch and Pesci could not be held liable because they were respectively an intern and a resident who simply followed Fox's directives, and exercised no independent judgment. In addition, the obstetrical defendants asserted that Mount Sinai could not be held liable for Fox's negligence in any event, as he was not its employee, but a private attending surgeon. They also argued that the consent obtained by those directly involved in the surgical procedure was qualitatively sufficient, that the procedure constituted an emergency in any event, and that the lack of informed consent claim did not lie against physicians who only were accused of failing to diagnose the fistula or refer her to other specialists.

In his affidavit, Rouse asserted that he found "no merit" to the plaintiff's contention that Fox, Barasch, and Pesci failed to utilize appropriate surgical technique in the performance of the cesarean section or that they failed to diagnose and treat a vesicovaginal fistula in a timely fashion. He opined that that the cesarean section constituted an emergency procedure that was "performed in an acceptable manner," while the plaintiff unfortunately "experienced an incidental cystotomy or bladder injury despite receiving excellent care." Dr. Rouse asserted that a cystotomy is a recognized complication of an emergency cesarean section and is not, of itself, evidence of a departure from accepted standards of care. He further pointed out that the bladder injury was immediately diagnosed and timely treated by a urologist called by Fox, and that the plaintiff continued under the care of several urologists, who subsequently diagnosed and treated a vesicovaginal fistula, which, in turn, is a "recognized complication" of the bladder repair procedure.

Dr. Rouse went on to explain that

> "Cesarean sections, like all surgeries, carry inherent risks of intraoperative complications. Urologic injury is the most common injury at the time of either obstetric or gynecologic surgery, with the bladder being the most frequent organ damaged. The risk of bladder laceration (cystotomy) is one out of every two hundred Cesarean sections. Risk factors for bladder injury during Cesarean section include previous Cesarean delivery, adhesions, emergent Cesarean delivery, and Cesarean section performed at the time of the second stage of labor."

He asserted that most bladder injuries are recognized at the time of surgery, and that timely recognition and repair are associated with a significant reduction in patient mortality. Dr. Rouse noted that potential complications of bladder injury include prolonged operative time, urinary tract infection, prolonged indwelling catheter time, and the formation of vesicouterine or vesicovaginal fistula. He explained that the recognition of bladder injury is "imperative," that the plaintiff's bladder injury was timely diagnosed and properly treated in this case.

According to Dr. Rouse, the operative report and deposition testimony established that the cesarean section was performed according to the standard of care. Specifically, he opined

that the appropriate surgical technique was utilized during the performance of the procedure and that there was "absolutely no support" for the plaintiff's claim that Fox, Barasch, or Pesci negligently performed the fascial incision or the uterine incision, or that they negligently utilized retractors during the cesarean section so as to cause the laceration. He explained that bladder laceration is a known complication of a caesarean section procedure because the procedure involves an incision in the lower part of the uterus through which the baby is delivered, while the bladder lies in front of the uterus. Dr. Rouse continued that one of the first steps in performing a cesarean section is to push the bladder down in order to expose the part of the uterus to be incised. According to Dr. Rouse, during the mobilization of the bladder, the bladder may sustain some form of injury and, hence, it can be lacerated despite appropriate surgical technique. He opined that "[a]ny claim that the bladder laceration was caused by negligent surgical technique is unsupported by the data presented in the contemporaneous medical records and the deposition testimony of Dr. Fox and his assistants." Dr. Rouse asserted that, after the bladder laceration was visualized, Fox appropriately called in Grafstein, a urologist, who immediately sutured the laceration, and Dr. Rouse concluded that Fox timely and appropriately identified the laceration, and called in the appropriate specialist.

Dr. Rouse went on to explain that a vesicovaginal fistula is an opening that forms between the bladder and the wall of the vagina that can occur after a bladder laceration is repaired. He stated that, typically, surgery is required to close the opening. Dr Rouse concluded from his review of the records that the urologists who saw the plaintiff after Grafstein repaired the laceration monitored her very closely for a fistula. He noted, however, that fistulas can take several weeks before they become apparent on radiologic imaging and that, in the plaintiff's case, it was approximately two months after the cesarean section was performed that a vesicovaginal fistula ultimately was diagnosed through imaging. He also stated that, after the fistula was repaired, the plaintiff "recovered well with return of normal urologic function."

Dr. Rouse expressly opined that Fox, Silverstein, Bender, and Melka appropriately relied on the urologists to follow the plaintiff's urologic complaints, as these MFMA obstetricians were entitled to rely on their colleagues in other specialties, such as urology, who are trained to treat bladder injuries and complications of those injuries. Dr Rouse thus rejected any claim that any of the obstetrical defendants failed to diagnose and treat a vesicovaginal fistula in a timely fashion, or failed to order appropriate studies to rule out vesicovaginal fistula.

Dr. Rouse further took issue with the plaintiff's claim that Fox negligently supervised or directed Barasch and Pesci. As he explained it, Pesci was not involved in the cesarean delivery prior to the identification of the laceration, while Barasch "was an intern acting under Dr. Fox's supervision who assisted the team and made no decisions as to the modality of the delivery." Dr. Rouse concluded that "[t]he decisions regarding surgical technique during the Cesarean section were entirely the responsibility of the attending Dr. Fox who met his obligation to this patient and comported with the standard of care."

With respect to the lack of informed consent claim, Dr. Rouse noted that the plaintiff signed an informed consent form upon admission to Mount Sinai, and adverted to Fox's deposition testimony that, based on his custom and practice, "he would have advised Ms. Sheiffer of the risks associated with Cesarean section including a potential injury to a nearby organ," and that, in any event, the procedure was "emergently performed due to appropriate concern for fetal well-being, and it resulted in the birth of a healthy baby."

Dr. Rouse pointed out that the plaintiff was a private patient of MFMA, and only Fox---an MFMA employee---was in charge of her care during labor and delivery. Hence, he concluded that Mount Sinai was not responsible for Fox's conduct. He further noted that, other than the claims against Barasch and Pesci, the plaintiff asserted no separate claims against members of the Mount Sinai staff. Upon concluding that Fox, Melka, Bender, and Silverstein committed no acts of malpractice, or were responsible for omissions that would constitute malpractice, Dr. Rouse concluded that MFMA should not be held liable.

Ultimately, Dr. Rouse concluded that the damages that the plaintiff claimed to have sustained were "attributable to complications of the treatment she and the fetus required and these were not caused by any allegedly negligent acts or omissions by the moving defendants"

In opposition to the obstetrical defendants' motion, the plaintiff relied upon the same documentation that they submitted, and also submitted the expert affirmation of John Garofalo, M.D., a physician who is board certified in obstetrics and gynecology. He opined that Fox departed from good and accepted practice in performing the cesarean section, and that his departures caused and contributed to the plaintiff's injuries.

Dr. Garofalo explained that a laparotomy is accomplished via an incision through the abdominal wall and into the peritoneal cavity, and is most commonly accomplished through a Pfannenstiel incision, a transverse incision through the lower abdomen curving slightly in the direction of the patient's head at the level of the pubic hair, and extending slightly beyond the lateral borders of the rectus muscle bilaterally. As he described it, the incision is carried to the tissue separating the patient's muscles from the peritoneal tissue, also known as the fascia, at which time the rectus muscle is then separated from the fascia in the midline and the peritoneal cavity is entered. Dr. Garofalo opined that

> "[c]are must be taken to avoid lacerating the bladder during the laparotomy. The bladder extends from the cervix to the edge of the uterine wall, and proper surgical technique requires identifying the bladder's size and location. The peritoneal lining should be carefully cut until loss of translucency is noted in order to avoid accidental cystotomy (bladder aceration- an incision through the wall of the bladder)."

Although he conceded that bladder lacerations are a known complication of cesarean delivery, he concluded that they should only occur when scar tissue from a prior cesarean section or bladder operation impairs visualization or when the surgeon must proceed with excessive speed in response to fetal distress.

Dr. Garofalo explained that the "original description of the Munro Kerr Cesarean section specified that immediately prior to the hysterotomy, the bladder should be mobilized away from

the lower segment of the uterus by transversely incising the loose uterovesical peritoneum." He continued that, in this manner, a "bladder flap" was created so that the bladder could be moved inferiorly away from the lower uterine segment. As Dr. Garofalo explained it, the historical justification for the creation of a bladder flap dated back to the pre-antibiotic era, when puerperal fever associated with cesarean section was a major cause of maternal mortality and morbidity, and the closure of the vesicouterine peritoneal incision was felt to provide a barrier to the spread of infection from the hysterotomy into the peritoneal cavity. He nonetheless further explained that prospective studies since 2000 indicated that the creation of a bladder flap is unnecessary and not the best practice, and that "omitting the bladder flap provides reduction of operating time and incision-delivery interval, reduced blood loss, lower requirements for analgesics, and fewer postoperative urinary track symptoms." Based on anatomical considerations, Dr. Garofalo opined that the omission of the development of the vesicouterine space during cesarean section is considered by many obstetricians to be an effective measure for the prevention of bladder injury during this procedure. He conceded that, notwithstanding this logic, omission of this step has not been definitively linked to decreased likelihood of bladder trauma. Hence, he concluded that the creation of the flap, in and of itself, is not a departure from accepted standards. Nonetheless, he concluded that, if a bladder flap were to be created, if at all, it should be accomplished employing a sharp dissection under direct visualization, and that the bladder should never be separated from the lower uterus bluntly because excessive force during blunt separation can lead to bladder trauma.

Dr. Garofalo explained that, in the course of a cesarean section, upon accessing the lower uterus, an incision is made and the fetus is delivered through the uterine and abdominal incisions, after which the uterus is repaired and the abdominal incision is closed. He opined that Fox departed from good and accepted standards of medical care when performing the cesarean section procedure on the plaintiff, and that the bladder laceration was not incidental, but occurred because Fox or a member of his surgical team either applied excess blunt force to the

bladder during creation of the bladder flap or failed properly to determine the bladder's size and location during creation of the Pfannenstiel incision. Dr. Garofalo came to this conclusion based on the bladder laceration's irregular vertical characteristic and Fox's failure to observe the laceration prior to completion of the delivery, particularly because Fox's operative report did not indicate how the bladder was mobilized. He explained that the shape and location of the injury were consistent with blunt dissection of the bladder flap, and pointed out that Dr. Rouse's observation that this laceration was "several centimeters inferior to the hysterotomy" also was consistent with blunt force injury to the bladder. In this case, Dr. Garofalo also concluded that the creation of a bladder flap was unnecessary in the first instance.

Dr. Garofalo further noted that, while the location of the bladder laceration on the posterior wall of the bladder dome was consistent with an injury sustained during negligent creation of the Pfannenstiel incision, he unambiguously opined that the "injury was more likely than not the result of excessive force applied to the bladder" during the creation of the bladder flap "because lacerations during creation of the Pfannenstiel incision are usually detected upon incision but Dr. Fox did not observe this laceration until after delivery, and the irregular character of this laceration is more consistent with blunt force trauma." He explained that a laceration during creation of the Pfannenstiel incision is avoidable, provided the surgeon identified the size and location of the bladder prior to entering the peritoneal cavity. As he further described it, laceration should only occur incident to surgery when scar tissue from prior cesarean deliveries or bladder surgeries prevents visualization through the peritoneal lining or when the surgeon is operating with excessive speed in response to fetal distress. Since the plaintiff had no prior cesarean deliveries or bladder surgeries, no scar tissue was noted in the operative report, and the fetal heart rate tracing was not characterized as a category 3 tracing, which would have indicated fetal distress, Dr. Garofalo concluded that there was no justification for a "rapid" entry.

Notwithstanding the plaintiff's allegations in her bills of particulars, Dr. Garofalo conceded that there was no indication that the bladder laceration was caused by retractors, the

insertion or removal of a Foley catheter, pressure on the lower uterine segment during delivery, or means other than the application of excessive pressure while bluntly dissecting the bladder flap or the failure to visualize the bladder's size and location prior to creation of the Pfannenstiel incision.

The plaintiff's expert went on to opine that the bladder laceration was the triggering event that caused the plaintiff's vesicovaginal fistula, resulting in pain, incontinence, and the necessity of surgical repair of the fistula itself.

Dr. Garofalo nonetheless also concluded that the bladder laceration was properly repaired prior to the closure of the cesarean section, and that none of the obstetrical defendants was negligent in the provision of post-surgical treatment and care to the plaintiff. He noted that the development of a vesicovaginal fistula requiring surgical repair remained a foreseeable complication that in fact developed here. He did not fault any of the other obstetrical defendants for causing the fistula or failing to recognize or diagnose it. Dr. Garofalo did not address the issue of whether any of the plaintiff's subsequent treating urologists departed from good and accepted care in failing to diagnose the fistula several months after the delivery. Nor did he address the plaintiff's claims concerning the qualitative sufficiency of the consent that she gave to the cesarean section procedure, or whether Barasch or Pesci exercised any independent judgment in the course of the procedure.

In reply, the obstetrical defendants submitted an attorney's affirmation, in which they argued that, inasmuch as the plaintiff did not submit a counter statement of material facts, all of the facts set forth in their own statement of material facts must be deemed admitted. They also contended that Dr. Garofalo, who is not licensed to practice medicine in New York, was not permitted to submit an affirmation pursuant to CPLR 2106(a), but was required to submit an affidavit accompanied by a certificate of conformity, as required by CPLR 2309(c). They noted that, in any event, Garofalo did not address any claims of negligence or vicarious liability against the obstetrical defendants other than Fox and MFMA. In addition, they asserted that, even if Dr.

Garofalo's hypothesis that employment of excessive pressure during the dissection of the bladder flap caused the bladder injury were true, his opinion did not raise a triable issue of fact as to whether Fox departed from the applicable standard of care.

V. SUMMARY JUDGMENT STANDARDS

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 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]). Once the movant meets his or her 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 his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she 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]).

The obstetrical defendants contend that Dr. Garofalo's affirmation does not constitute admissible evidence to oppose their summary judgment motion because he is not licensed to practice medicine in New York and, thus, may not avail himself of the option to submit an unnotarized affirmation in lieu of a notarized affidavit. The court notes that a medical expert need not be licensed to practice medicine in New York for his or her affidavit to be considered by a court in connection with a summary judgment motion (*see Grey v Garcia-Fusco*, 2020 NY Slip Op 32280[U], *20 n 19, 2020 NY Misc LEXIS 3270, *30 n 19 [Sup Ct, N.Y. County, Jun. 16, 2020]; *Solano v Ronak Med. Care*, 2013 NY Slip Op 30837[U], *7, 2013 NY Misc LEXIS 170, *8-9 [Sup Ct, N.Y. County, Apr. 22, 2013]). Moreover, although Dr. Garofalo is a physician who is not licensed to practice medicine in New York, and thus cannot opt to submit an unnotarized affirmation in lieu of a notarized affidavit (*see* CPLR 2106[a] [limiting the option to employ an affirmation to a "physician . . . authorized by law to practice in the state"]), the court exercises its discretion and directs the plaintiff to submit the content of Dr. Garofalo's affirmation in the form of an affidavit (*see* CPLR 2001; *Matos v Schwartz,* 104 AD3d 650, 653 [2d Dept 2013]; *Winslow v Syed*, 2021 NY Slip Op 33230[U], *5-6, 2021 NY Misc LEXIS 9432, *13 [Sup Ct, Dutchess County, Apr. 20, 2021]), accompanied by a certificate of conformity, as required by CPLR 2309, which may be filed nunc pro tunc (*see 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 rejects the obstetrical defendants' contention that the plaintiff's failure to serve a counter statement of material facts constituted an admission that all of the facts alleged in their statement of material facts were true. The obstetrical defendants made the instant motion

on July 14, 2022 (*see* CPLR 2211), and scheduled a return date of August 19, 2022. They stipulated to adjourn the motion until October 31, 2022, after which the court adjourned the motion until November 16, 2022. On August 31, 2022, however, the court rule cited by the obstetrical 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]). Since the court is obligated to apply the law in effect when it decides a motion and issues the resultant order (*see Landgraf v USI Film Products*, 511 US 244, 264 [1994]; *US Bank N.A. v Nelson*, 36 NY3d 998, 1000 [2020]; *see also McCandless v. McCandless*, 38 AD2d 171, 172 [4th Dept 1972]), and this court did not expressly require the submission of a statement of material facts in this action, the obstetrical defendants' contention in this regard is unavailing. Even were the court to conclude that the "facts" set forth in their statement are deemed admitted, the opinions set forth in that statement would not be deemed admitted in any event (*see Whitesides v Randolph*, 2022 NY Slip Op 30841[U], *15, 2022 NY Misc LEXIS 1283, *25-26 [Sup Ct, N.Y. County, Mar. 10, 2022] [Kelley, J.]).

A. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"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 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]). 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 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 Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing 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]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, to satisfy his or her burden on a motion for summary judgment, a defendant must address and

rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see 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 connection with the medical malpractice claims, the obstetrical defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including Dr. Rouse's expert affidavit, by demonstrating that none of them departed from good and accepted practice.

With respect to Fox, the obstetrical defendants established that he did not deviate from good practice in the manner in which he executed the Pfannenstiel incision, in visualizing and separating the bladder from the surgical track, in the manner in which he placed and removed Foley catheters, in the manner in which he employed retractors, and in the pressure and force that he applied to the bladder flap. They further demonstrated, prima facie, that bladder

laceration is a known risk of a cesarean section procedure. In opposition, however, the plaintiff's raised a triable issue of fact with the opinions expressed in Dr. Garofalo's affirmation that, despite the fact that a lacerated bladder is a known risk of the surgery, the nature and appearance of the laceration on the plantiff's bladder indicated that Fox employed excessive pressure and force, that this constituted a departure from good and accepted practice, and that this departure caused the laceration and all sequellae, including pain, incontinence, and the development of a fistula that required additional surgery. 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 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]; *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"]). Consequently, the court must deny that branch of the motion seeking summary judgment dismissing the medical malpractice cause of action against Fox.

With respect to the plaintiff's claims against Barasch and Pesci, however,

> "[a] resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene"

(*Soto v Andaz*, 8 AD3d 470, 471 [2d Dept 2004]; *see Murphy v Drosinos,*179 AD3d 461, 462 [1st Dept 2020] [resident did not exercise her own medical judgment or otherwise operate outside the realm of ordinary prudence so as to trigger individual liability]; *Lorenzo v Kahn*, 74 AD3d 1711, 1713 [4th Dept 2010]; *Buchheim v Sanghavi*, 299 AD2d 229, 230 [1st Dept 2002];

see also Murphy v Drosinos, 179 AD3d 461, 462 [1st Dept 2020]; *Irizarry v St. Barnabas Hosp.*, 145 AD3d 529, 530 [1st Dept 2016]). The obstetrical defendants established that neither Barasch nor Pesci exercised any judgment independent of Fox, that Fox supervised each task that they performed, and that his directions did not so greatly deviate from normal practice that they should be held liable for failing to intervene. Since Dr. Garofalo did not address this issue, and actually conceded that they committed no malpractice in connection with their post-surgical care or any failure to observe or diagnose the fistula that later developed, the plaintiff failed to raise a triable issue of fact as to the purported negligence of Barasch and Pesci. Hence, those defendants are entitled to summary judgment dismissing the medical malpractice cause of action insofar as asserted against them.

In connection with the plaintiff's claims against Bender, Silverstein, Melka, the obstetrical defendants established, prima facie, that none of these three obstetrician/gynecologists deviated from good and accepted practice in the post-operative treatment and care that they rendered to the plaintiff. Since Dr. Garofalo conceded that they were not negligent, they, too, are entitled to summary judgment dismissing the medical malpractice cause of action insofar as asserted against them.

The obstetrical defendants further established, prima facie, that no Mount Sinai employee, including Barasch and Pesci, committed any act of malpractice. Since the plaintiff did not address this issue in her opposition papers, she failed to raise a triable issue of fact with respect to this issue, and Mount Sinai is thus entitled to summary judgment dismissing the medical malpractice cause of action insofar as asserted against it. With respect to MFMA, it may, as discussed in more detail hereafter, be held vicariously liable for Fox's negligence.

B. LACK OF INFORMED CONSENT

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

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable

> medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst*., 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

Nonetheless, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]).

The obstetrical defendants established, prima facie, that the consent that they obtained from the plaintiff in connection with the surgical procedure was qualitatively sufficient, and that the cesarean section procedure was an emergency procedure in any event. Since Dr. Garofalo did not render an opinion in this regard, the plaintiff failed to raise a triable issue of fact in opposition to the obstetrical defendants' showing, and all of the obstetrical defendants are entitled to summary judgment dismissing that cause of action insofar as asserted against them. In addition, summary dismissal of the plaintiff's lack of informed claims against Bender,

Silverstein, and Melka is warranted for the additional reason that the claim was based solely on their alleged failure to diagnose the fistula in a timely fashion, and thereupon refer her for treatment of that fistula.

C. VICARIOUS LIABILITY

Where a physician working for a professional corporation renders medical care to a patient "within the scope of his or her employment" for that corporation, the corporation may be held vicariously liable for the negligence of the physician (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]). Inasmuch as this court has concluded that there are triable issues of fact as to whether Fox committed malpractice, it also concludes that MFMA, as his employer, may be held vicariously liable for that malpractice.

"'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]). It is well established that a hospital is not vicariously liable for the negligent acts of a private attending physician such as Fox (*see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Filippone v St. Vincent's Hosp. & Med. Ctr*., 253 AD2d 616, 618 [1st Dept 1998]; *Georges v Swift*, 194 AD2d 517, 518 [2d Dept 1993]).

Nonetheless, "'vicarious liability for the medical malpractice of an independent physician may be imposed under a theory of apparent or ostensible agency'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949, quoting *Keesler v Small*, 140 AD3d 1021, 1022 [2d Dept 2016]; *see Hill v St. Clare's Hosp*., 67 NY2d at 79).

> "'In order to create such apparent agency, there must be words or conduct of the principal, communicated to a third party, which give rise to the appearance and belief that the agent possesses the authority to act on behalf of the principal. The

> third party must reasonably rely on the appearance of authority, based on some misleading words or conduct by the principal, not the agent. Moreover, the third party must accept the services of the agent in reliance upon the perceived relationship between the agent and the principal, and not in reliance on the agent's skill'"

(*Keesler v Small*, 140 AD3d at 1022, quoting *Dragotta v Southampton Hos*p., 39 AD3d 697, 698 [2d Dept 2007]; *see Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949; *Loaiza v Lam*, 107 AD3d 951, 952 [2d Dept 2013]). "'In evaluating whether a doctor is the apparent agent of a hospital, a court should consider all attendant circumstances to determine whether the patient could properly have believed that the physician was provided by the hospital'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949, quoting *Loaiza v Lam*, 107 AD3d at 952-953).

In this case, the plaintiff was a private patient of MFMA and Fox, and agreed to admission for a cesarean section that she anticipated that Fox himself would perform and that he, in fact, performed. Hence, even if Fox ultimately is found to have committed malpractice, Mount Sinai cannot be held liable solely on account of Fox's negligence, as there is no evidence that would support the theory of apparent or ostensible agency in this action.

Further,

> "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]; *cf. 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 obstetrical defendants established that Barasch and Pesci, in their capacities as an intern and a resident, respectively, exercised no independent judgment and did not implement any directives issued by Fox that so greatly deviated from normal practice that they should have intervened. The plaintiff, by declining to address that issue, failed to raise a triable issue of fact in opposition to that showing, and the vicarious liability claim against Mount Sinai may be summarily dismissed on that ground alone. Inasmuch as the court already has concluded that Barasch and Pesci are entitled to summary judgment dismissing the complaint insofar as asserted against them, the plaintiff's claim that Mount Sinai must be held vicariously liable for the conduct of those two physicians must be summarily dismissed on that ground as well.

D. NEGLIGENT HIRING, TRAINING, AND RETENTION

Both MFMA and Mount Sinai demonstrated that they neither "knew, [n]or should have known," of their employees' "propensity for the sort of conduct which caused the injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v. New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). Inasmuch as the plaintiff did not address this issue in her opposition papers, she failed to raise a triable issue of fact in opposition to the obstetrical defendants' prima facie showing in this regard. Hence, that branch of the obstetrical defendants' motion seeking summary judgment dismissing the negligent training and retention cause of action as against them must be granted.

VI. CONCLUSION

In light of the foregoing it is

ORDERED that the motion is granted only to the extent that summary judgment is awarded to the defendants Adrienne Barasch, M.D., Susan Pesci, M.D., Samuel Bender, M.D., Michael Silverstein, M.D., Stephanie Melka, M.D., and The Mount Sinai Hospital dismissing the complaint in its entirety insofar as asserted against them, and to the defendants Nathan Fox, M.D., and Maternal Fetal Medicine Associates, PLLC, dismissing the lack of informed consent

and negligent hiring and retention causes of action insofar as asserted against them, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the plaintiff is directed, within 45 days of the entry of this order, to submit an affidavit from John Garofalo, M.D., duly sworn to and notarized, setting forth or incorporating by reference the contents of the affirmation that he already has submitted in this action, which affidavit shall be accompanied by a certificate of conformity if it is sworn to outside of the State of New York; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendants Adrienne Barasch, M.D., Susan Pesci, M.D., Samuel Bender, M.D., Michael Silverstein, M.D., Stephanie Melka, M.D., and The Mount Sinai Hospital; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendants Adrienne Barasch, M.D., Susan Pesci, M.D., Samuel Bender, M.D., Michael Silverstein, M.D., Stephanie Melka, M.D., and The Mount Sinai Hospital.

This constitutes the Decision and Order of the court.

3/27/2023
DATE

JOANNA 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

162180/2015 SHEIFFER, JAIME vs. FOX MD, NATHAN
Motion No. 004