

**Sheiffer v Fox**

2023 NY Slip Op 30959(U)

March 28, 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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The following e-filed documents, listed by NYSCEF document number (Motion 006) 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 221, 224, 229, 230, 231, 232

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, vicarious liability, and negligent hiring and retention of medical personnel, the defendant urologist Jerry Blaivas, M.D., and his practice, Urocenter of New York (together the Urocenter 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, and the complaint is dismissed insofar as asserted against the Urocenter defendants.

The facts of this dispute, as well as an analysis of the law applicable to summary judgment motions in medical malpractice actions, are set forth in great detail in this court's March 27, 2023 order deciding motion sequence 004. The plaintiff alleged that, on March 20, 2014, the defendant obstetrician/gynecologist Nathan Fox, M.D., negligently transected her

urinary bladder during a cesarean section procedure, necessitating intraoperative repair surgery. She further alleged that, as a consequence of the bladder repair surgery, she later developed a vesicovaginal fistula that also required surgical repair, and that, as relevant here, all of the urologists named as defendants in this action failed to appreciate the presence of the fistula in a timely fashion, causing her to suffer from pain and discomfort until the fistula was repaired.

As the court explained in the order determining motion sequence 004, after Fox recognized that there was a bladder defect, he called in the defendant urologist Neil Grafstein, M.D., to perform the bladder repair, Grafstein thereupon repaired the bladder laceration, and Grafstein thereafter followed up with the plaintiff by, among other things, performing a cystogram and prescribing antibiotics to treat an apparent urinary tract infection. The plaintiff's expert obstetrician/gynecologist, John Garofalo, M.D., conceded that Grafstein's surgery did not depart from good and accepted medical practice, and that none of the defendant obstetrician/gynecologists who provided follow-up examinations, testing, treatment, and care to the plaintiff between March 20, 2014 and May 2, 2014 departed from good and accepted practice in failing to observe or diagnose the fistula.

The crux of the plaintiff's claim against the Urocenter defendants is that, although the fistula had in fact developed by the time that they examined her on May 21, 2014, they failed to observe it on May 14, 2014 and May 21, 2014 cystograms, or diagnose it, despite the facts that the urologist who had seen her only one week earlier had included vesicovaginal fistula in her differential diagnoses, and the urologist who saw her only eight days later actually diagnosed the presence of the fistula, surgically repairing it on June 28, 2014. The plaintiff thus claims that the Urocenter defendants' failure to diagnose the fistula delayed treatment for at least one month, during which she suffered from pain that could have been remedied earlier.

As described in the order deciding motion sequence 004, the plaintiff, on May 9, 2014, presented to the defendant urologist Ciara Marley, M.D., at the office of her former practice, the

defendant New York Urological Associates, P.C. 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 several 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 Marley characterized as negative. To conduct the cystogram, the plaintiff's bladder was filled with 250 cc of dye, and all images were negative for a leakage. Marley, however, 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.

On May 21, 2014, the plaintiff instead presented to the Blaivas at the office of his practice, New York City Urology, PLLC, doing business as Urocenter of New York, 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---the third urologist she had seen---that she developed these symptoms approximately five weeks after delivering her child, or in late April 2014. 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. Blaivas further reported 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, although she had a telephone conversation with him on May 2, 7 2014.

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---the fourth urologist to see the plaintiff---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 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.

In support of their motion, the Urocenter defendants submitted the pleadings, the plaintiff's bill of particulars as to them, the parties' deposition transcripts, relevant medical and hospital records, a statement of material facts, an attorney's affirmation, and the affirmation of their expert, Franklin Lowe, M.D., who is board certified in urology and a professor of urology. Lowe averred that the Urocenter defendants did not depart from good and accepted medical practice in examining, diagnosing, and recommending a course of treatment to the plaintiff, and that nothing that they did or did not do caused or contributed to the plaintiff's injuries.

As Dr. Lowe described it,

"Blaivas performed a thorough pelvic examination of the plaintiff in both the lithotomy (lying down) and standing positions, which included examination with a full bladder, and asking the patient to cough, which were normal. The examination did not reveal any leakage of urine, nor any urine in the vagina. A stress test demonstrated no urinary leakage. An examination of pelvic muscle

pressure yielded a strong rating. Evaluation of the plaintiff's neurological function, deep tendon reflexes, extremities and rectum were also normal."

According to Dr. Lowe, Blaivas testified at his deposition that, based on the content of his May 21, 2014 notes, he likely reviewed the cystogram images, and that "a fistula is the first thing he would have considered." Dr. Lowe noted that Blaivas's plan was for the plaintiff to complete a bladder diary and pad test, urinalysis, and culture. He further noted that, although the plaintiff never returned to the Urocenter defendants' office, she did return the bladder diary, after which Blaivas documented a telephone conversation with the plaintiff on May 27, 2014. As Dr. Lowe described it, the bladder diary indicated that the plaintiff voided 14 times, twice at night, had 5 urgency voids and 3 episodes of incontinence. Dr. Lowe noted that Blaivas prescribed Vesicare for an overactive bladder, and instructed the plaintiff to return in one month if she was doing well, or in one week if not, but that the plaintiff never returned to see him.

As Dr. Lowe framed it,

"Blaivas took a thorough history and performed an appropriate and thorough physical examination. Dr. Blaivas' assessment of overactive bladder was appropriate based on the plaintiff's history of bladder leakage when standing from a sitting or lying down position and washing her hands, and physical examination findings including of no urinary leakage with a full bladder, and upon asking the patient to cough. Significantly, the examination and a stress test did not reveal any urine in the vagina, which would be seen in the presence of a fistula."

Dr. Lowe characterized, as "baseless," the plaintiff's claim that Blaivas failed to review her prior radiological studies, inasmuch as his office note indicated that "CAT scan unremarkable.

Repeat cystogram showed complete bladder emptying, but on one film it looked like there was contrast above bladder that could be in a tic," that is, a diverticulum, which is a small pouch in the bladder wall that was likely a result of the bladder repair. Dr. Lowe opined that, contrary to the plaintiff's contention, Blaivas's note was specific and thorough in addressing and describing the plaintiff's signs and symptoms, as were his pelvic, neurological, rectal, deep tendon reflex, and extremity examinations. He concluded that Blaivas's performance of a stress test, his provision of instructions to the plaintiff to keep a bladder diary, the prescription of Vesicare, and

his recommendation that she return in one week if her symptoms persisted, all supported his conclusion that Blaivas properly addressed the plaintiff's signs and symptoms.

Dr. Lowe also took issue with the plaintiff's contention that Blaivas's failure to perform a CT cystogram on May 21, 2014 constituted a departure from good practice, concluding that it was not indicated, inasmuch as the plaintiff already had a negative cystogram only seven days earlier. Nonetheless, Blaivas's testimony suggested that there was indeed a "repeat" cystogram that was performed and reviewed on May 21, 2014. The Urocenter defendants never fully explained whether Blaivas did not perform a cystogram on that date. In any event, Dr. Lowe asserted that, had the plaintiff returned to Blaivas after her May 27, 2014 telephone conference with him, "he would have performed a cystoscopy," but that she never returned to Blaivas, and instead followed-up with another urologist, Dr. Sandhu, just two days after that phone call.

According to Dr. Lowe, Blaivas did indeed consider a vesicovaginal fistula as part of his differential diagnosis because such a fistula "is always to be considered as part of a differential diagnosis after bladder perforation and with complaints of incontinence," but that Blaivas's findings on examination and testing were inconsistent with a vesicovaginal fistula because, in both lying and standing positions, the plaintiff had nearly 500 ml of fluid in her bladder with no leakage. He further opined that it was "quite unusual" for this type of fistula to develop where, as here, a bladder perforation was timely recognized and repaired. Dr. Lowe reiterated that the CT scan and prior cystoscopy were negative. Dr. Lowe further opined that Blaivas did not depart from good and accepted practice in failing to diagnose a vesicovaginal fistula since the plaintiff never returned to Blaivas for care and treatment after the initial visit of May 21, 2014, thus depriving him of the opportunity to conduct further tests and make the diagnosis. As he asserted it, "[h]ad the plaintiff returned, Dr. Blaivas would have performed a cystoscopy and urodynamic studies, which would likely have revealed a vesicovaginal fistula." For the same reason, Dr. Lowe concluded that Blaivas could not be deemed negligent

for delaying plaintiff's treatment for a vesicovaginal fistula, inasmuch as Dr. Sandhu suspected the presence of a vesicovaginal fistula on May 29, 2014, only eight days after her only visit with Blaivas and a scant two days after he phone call with Blaivas. Dr. Lowe thus opined that "there was no delay, and . . . the treatment and successful outcome would have been the same had it been instituted days earlier," compelling the conclusion that care and treatment rendered by the Urocenter defendants was not the proximate cause of any pain or discomfort that plaintiff endured between May 27, 2014 and June 28, 2014, when Dr. Sandhu repaired the Fistula.

Dr. Lowe further asserted that the Urocenter defendants informed the plaintiff of the risks and benefits of, and alternatives to, the testing and treatment they conducted and rendered.

In opposition to the Urocenter defendants' motion, the plaintiff relied on the same submissions as they did, and also submitted the affirmation of expert urologist Jerry J. Weinberg, M.D. Dr. Weinberg opined that the Urocenter defendants did indeed depart from good and accepted medical practice, inasmuch as Blaivas misread the May 14, 2014 cystogram imaging, which Dr. Weinberg concluded did show the presence of a vesicovaginal fistula. Dr. Weinberg asserted that this departure delayed treatment and repair of the fistula for approximately one month, thus causing and contributing to the plaintiff's continued suffering.

Dr. Weinberg first explained that a fistula is an abnormal passage between an organ and body surface or between two organs, and that a vesicovaginal fistula is an abnormal passage between the bladder and the vagina. As he described it, the formation of this passage is accompanied by significant abdominal pain, as urine destroys the peritoneal tissue, and the presence of this passage leads to continuous leakage of urine from the bladder into the vagina, resulting in urinary incontinence. Dr. Weinberg noted that

"[t]he first step to diagnosing a VVF is to conduct a pelvic examination. Dye may also be inserted into the bladder and the patient asked to cough or bear down, causing dye-stained urine to travel through the fistula and appear in the vagina or on a tampon. A computerized tomography ('CT') urogram, a specialized CT scan utilizing dye to obtain detailed cross-section images of the area between the bladder and the vagina, may also be performed. A cystoscope examination, in which a small camera used to visualize the inside of the bladder and locate the

fistula is the most powerful and important diagnostic tool. A CT scan and/or voiding cystourethrogram can be used to confirm the diagnosis and ensure that there are no other fistulas. Sometimes, a retrograde pyelogram is used to see if there are any leaks between the ureters and the vagina.”

He opined that the treatment of a vesicovaginal fistula depends on the size, location, and age of the fistula, explaining that a small vesicovaginal fistula that recently had developed may spontaneously close with continuous Foley catheterization, but that the majority of patients are treated surgically for the condition.

Dr. Weinberg expressly concluded that Blaivas departed from good and accepted standards of medical care during his care in failing to diagnose vesicovaginal fistula at the May 21, 2014 visit in light of the plaintiff’s urinary complaints and the May 14, 2021 cystogram scans generated by Marley. According to Dr. Weinberg, “Blaivas erroneously found the May 14, 2014, cystogram performed by Dr. Marley to be negative,” while, upon his own review of 16 images related to the May 14, 2014 cystogram, including images number 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 17, and 19, Dr. Weinberg concluded that “the images from the cystogram show a VVF.” He further noted that the postvoid films showed pooled urine in the vaginal vault, which is consistent with a vesicovaginal fistula.

Dr. Weinberg opined that the bladder laceration generated during the cesarean section procedure directly caused the vesicovaginal fistula to develop, and caused the plaintiff to suffer severe abdominal pain and incontinence, including the discomfort and embarrassment of uncontrolled urination and repeated medical examinations and tests, which were often uncomfortable and personally invasive. He further opined that the bladder laceration and concomitant repair of the bladder ultimately necessitated a second surgery to repair the vesicovaginal fistula, thus causing additional physical pain and further extending her recovery. As pertinent to the plaintiff’s claims against Blaivas, Dr. Weinberg opined that that Blaivas’s “negligent failure to diagnose Ms. Sheiffer’s VVF and treat her with Foley catheterization on May 21, 2014, was a substantial factor in continuing Ms. Sheiffer’s pain, discomfort, and

embarrassment, extending the length of her recovery, and necessitating additional medical tests.”

Blaivas established, prima facie, that he did not depart from good and accepted medical practice in reading the May 14, 2014 cystogram imaging, in failing to observe the presence of a vesicovaginal fistula, and in failing to recommend further treatment. In opposition to that showing, however, the plaintiff raised a triable issue of fact with respect Blaivas’s alleged departure, as her retained expert unambiguously concluded that Blaivas should have recognized the May 14, 2014 cystogram imaging as positive for vesicovaginal fistula, and treated the plaintiff accordingly.

Conversely, in opposition to the Urocenter defendants’ prima facie showing that any such departure from accepted practice did not cause or contribute to the plaintiff’s injuries, the plaintiff failed to raise a triable issue of fact. Specifically, the Urocenter defendants demonstrated that the plaintiff’s outcome and course of treatment would have been the same regardless of whether Blaivas diagnosed the fistula on May 21, 2014. Where a plaintiff alleges that a defendant negligently failed or delayed in diagnosing and treating a condition, a finding that the negligence was a proximate cause of an injury may be predicated on the theory that the defendant thereby diminished the plaintiff’s chance of a better outcome (*Majid v Cheon-Lee*, 147 AD3d 66, 71 [3d Dept 2016]; *Clune v Moore*, 142 AD3d 1330, 1331 [4th Dept 2016]; *Wolf v Persaud*, 130 AD3d 1523, 1525 [4th Dept 2015]; *Goldberg v Horowitz*, 73 AD3d 691, 694 [2d Dept 2010]; *Borawski v Huang*, 34 AD3d 409, 410 [2d Dept 2006]). Here, the lapse of time between Blaivas’s one appointment with the plaintiff and the plaintiff’s first appointment with Dr. Sandhu was only eight days. Dr. Weinberg did not render an opinion that the de minimis delay diminished the plaintiff’s chance of a better outcome. Indeed, he

“failed to articulate how the treatment would have been different had the defendant made a timely diagnosis. Furthermore, he failed to articulate, in a nonconclusory fashion, that the injured plaintiff’s condition would not have deteriorated had there been a timely diagnosis. The affirmation of the plaintiff[’s] expert was, therefore, insufficient to raise a triable issue of fact as to causation”

(*Goldsmith v Taverni*, 90 AD3d 704, 705 [2d Dept 2011]). In this respect, the plaintiff adduced no proof that she would have obtained a better outcome had Blaivas noted the presence of vesicovaginal fistula eight days before Dr. Sandhu first suspected it, and weeks before Dr. Sandhu actually diagnosed and treated it. In fact, Dr. Weinberg did not respond to Dr. Lowe's conclusion that, had Blaivas immediately diagnosed vesicovaginal fistula on May 21, 2014, the course of the plaintiff's treatment would have been identical to that ultimately provided by Dr. Sandhu, and the nature of her condition would not have been different. Moreover, to establish that a failure to diagnose proximately led to a deteriorating condition, a plaintiff must show that the delay attendant to that failure was undue or unreasonable (see *Marchione v State of New York*, 194 AD2d 851, 854-855 [3d Dept 1993]; *Stanback v State of New York*, 163 AD3d 298, 298 [2d Dept 1990]), a conclusion that simply is not supported by the record here. Stated another way, the plaintiff "presented no evidence that [her] physical condition would have been any different had there been no delay in the diagnosis" (see *Bossio v Fiorillo*, 210 AD2d 836, 838 [2d Dept 1994]), and no evidence that the de minimis delay "diminished plaintiff's chance of a better outcome or increased the injuries she ultimately sustained" (*Simko v Rochester Gen. Hosp.*, 199 AD3d 1408, 1412 [4th Dept 2021]). Instead, by seeking an appointment with her fourth urologist in two months, only two days after her last communication with Blaivas, the plaintiff did not even provide Blaivas with the opportunity to take another look at the cystogram, revise his diagnosis, or proceed with the treatment that Dr. Sandhu ultimately and successfully rendered several weeks later. Nor was there any evidence that the severity of her condition or injuries "increased" between May 21, 2014, when she first presented to Blaivas, and May 29, 2014, when she first presented to Dr. Sandhu.

In addition, as explained in this court's March 27, 2014 order deciding motion sequence 004, a claim alleging a failure to diagnose cannot serve as the predicate for a lack of informed

consent cause of action where, as here, it did not involve the invasion of the plaintiff's bodily integrity (see *Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007])

Consequently, the Urocenter defendants' motion must be granted.

In light of the foregoing, it is

ORDERED that the motion is granted, the defendants Jerry Blaivas, M.D., and Urocenter of New York are awarded summary judgment dismissing the complaint insofar as asserted against them, and the complaint is dismissed insofar as asserted against the defendants Jerry Blaivas, M.D., and Urocenter of New York; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendants Jerry Blaivas, M.D., and Urocenter of New York; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against defendants the Jerry Blaivas, M.D., and Urocenter of New York.

This constitutes the Decision and Order of the court.

3/28/2023

DATE

  
JOHN J. KELLEY, J.S.C.

CHECK ONE:

CASE DISPOSED

NON-FINAL DISPOSITION

GRANTED

DENIED

GRANTED IN PART

OTHER

APPLICATION:

SETTLE ORDER

SUBMIT ORDER

CHECK IF APPROPRIATE:

INCLUDES TRANSFER/REASSIGN

FIDUCIARY APPOINTMENT

REFERENCE