Barbagallo v Dinnal
2025 NY Slip Op 34140(U)
October 24, 2025
Supreme Court, New York County
Docket Number: Index No. 104418/2010
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY**, ***Justice*** — PART **56M**

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TERRI BARBAGALLO,

Plaintiff,

- v -

VANESSA N. DINNAL, M.D., and COLUMBUS CIRCLE OB/GYN,

Defendants.

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INDEX NO. 104418/2010

MOTION DATE 10/17/2025

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44

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, and negligent hiring, training, supervision, retention, and credentialing of healthcare personnel, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the negligent hiring, training, supervision, retention, and credentialing cause of action, and so much of the medical malpractice cause of action as was premised upon their alleged failure to take a proper medical history and their determination to perform a contraindicated pap smear test. The motion is otherwise denied.

The crux of the plaintiff's claim is that, on May 28, 2008, the defendant obstetrician/gynecologist (OB/GYN) Vanessa N. Dinnal, M.D.,[1] while working for the defendant practice Columbus Circle OB/GYN (Columbus Circle), negligently performed a vaginal examination upon

[1] The proper spelling of that defendant's name is Vanessa N. Dinnall, M.D., but no party has moved to amend the caption to correct the spelling.

the plaintiff with a metal speculum, thus causing lesions and burns to the plaintiff's labia. In her complaint, the plaintiff made general allegations that the defendants departed from good and accepted practice, that they failed to obtain her fully informed consent to an examination with a metal speculum, and that they were negligent in vetting, training, and supervising healthcare personnel, including Dinnall and her assistants. In her bill of particulars, the plaintiff alleged that the defendants negligently examined her with a speculum. In this regard, she alleged that they heated the speculum for an unreasonable length of time before initially inserting it into her vagina. She further asserted that they failed properly to test the speculum before insertion to ascertain whether it was too hot. In addition, the plaintiff averred that the defendants employed defective equipment and an improper technique in the course of warming the speculum, and that they negligently continued her examination even after burning her with the speculum and while her pelvic and/or vaginal muscles were in spasm. She further faulted the defendants for failing to employ proper technique while reinserting the speculum into her vagina, applying unreasonable force during the reinsertion, and negligently opening the “bills” of the speculum prior to full reinsertion. In addition, the plaintiff contended that the defendants performed contraindicated procedures upon her, including a contraindicated pap smear, and failed properly to diagnose and treat her. The plaintiff also alleged that the defendants failed to take her complete medical history. Moreover, she reiterated that the defendants failed to obtain her fully informed consent to the examination via speculum.

The plaintiff further alleged in her bill of particulars that, as a consequence of the aforementioned departures from good and accepted care, she was caused to sustain two small whitish lesions with brownish edges at the 5 o'clock position of her inner labia at introitus, that arose from the burns, with minimal surrounding erythema, along with vulvar pain and muscle spasm. She further asserted that she suffered from neuropathic pain process of the vulva, known as dysesthetic vulvodynia, involving a branch of the pudendal nerve, that resulted in stinging, aching, burning, and swelling of the left labia minora and vagina. In this respect, she

specified that her left interlabial sulci and left labia minora were tender to light touch and were slightly swollen, while her vestibule was tender from the 3 o'clock position to the 7 o'clock position, and was mildly erythematous, while her levator ani muscles were mildly tight and tender from left to right. The plaintiff asserted that her left obturator internus became especially tender, thus causing pain to "shoot out" from the focal area of pain, with additional pain to her right posterior thigh, pelvis, and left inner groin/outer vaginal area, and pain and swelling in her perineum and over her right ischium. As of consequence of these conditions, she alleged that she also sustained a right thigh sprain, a right-sided hamstring/adductor strain, pelvic floor spasm and dysfunction, pelvic misalignment, and tightness in her buttocks and inner thighs, as well as the development or exacerbation of a Bartholin gland cyst. Moreover, she asserted that she is no longer able to engage in sexual activity, including intercourse and masturbation, and suffers from a fear of intimacy, depression, anxiety, and humiliation.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr*., 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Flanders v Goodfellow,* _____NY3d_____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at

503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]). Moreover, where a party's submission itself reveals the existence of a triable issue of fact, that party is deemed to have failed to establish its prima facie entitlement to judgment as a matter of law (*see Reading v Fabiano,* 137 AD3d 1686, 1687 [4th Dept 2016]; *Kimber Mfg., Inc. v Hanzus*, 56 AD3d 615, 617 [2d Dept 2008]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Moreover, where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190

AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

In support of their motion, the defendants submitted the pleadings, the plaintiff's bills of particulars, transcripts of the parties' deposition testimony, relevant medical records, correspondence between the plaintiff and at least one of her examining physicians, an attorney's affirmation, and the expert affirmations of board-certified OB/GYN Monique de Four Jones, M.D., and board-certified neurologist and pain management specialist Grace Forde, M.D., both of whom opined that the defendants did not depart from good practice, and that nothing that the defendants did or did not do caused or contributed to the plaintiff's injuries.

Dr. Jones first recounted the relevant history of the plaintiff's encounter with the defendants, explaining that, on May 28, 2008, the plaintiff, who was then 46 years old, presented to the offices of Columbus Circle, now known as a division of St. Luke's Roosevelt Hospital Center, for a new patient visit and an annual gynecological examination. Dr. Jones agreed with Dinnall's deposition testimony that a new patient review and annual examination entail a review of systems, a discussion of the patient's complete medical/surgical history, and a physical examination. According to Dr. Jones, the plaintiff presented to Dinnall with a history of adenomyosis, which she explained is a condition in which endometrial tissue that lines the uterus grows outside of the muscle wall of the uterus, along with menorrhagia/dysmenorrhea. Dr. Jones asserted that these conditions had been resolved with the administration of the medication Desogen. As Dr. Jones described it, Dinnall's physical examination of the plaintiff revealed that the plaintiff then weighed 136 pounds, and that the plaintiff's blood pressure was 110/76, while there were no significant or concerning findings in the plaintiff's body systems outside of the genitourinary tract. Dr. Jones explained that, during the visit, the plaintiff

completed a “Menstrual History” sheet, which generally inquired into her gynecological and obstetrical history, on which the plaintiff disclosed a history of human papilloma virus (HPV) and genital warts dating back to 2003, as well as prior abnormal pap smear test, which was positive for HPV, squamous metaplasia, and inflammation.

Dr. Jones noted that Dinnall had testified at her deposition that she had planned to perform pap smear and gonorrhea-chlamydia tests upon the plaintiff. Dr. Jones asserted that the performance of a pap smear test entails the use of a speculum, and noted that Dinnall testified at her deposition that she “customarily” used plastic speculums for such tests, and would only use metal speculums under certain circumstances, such as when the patient was severely overweight, if there was a redundancy of vaginal tissue, or when examining a pediatric patient, since pediatric-sized speculums are only made out of metal. Dinnall also testified that, if a plastic speculum were not available, she might employ a metal speculum, but that it was her custom and practice always to have plastic speculums available, and that all speculums always were sterilized. Columbus Circle medical assistant Annamaria Santiago, who worked with Dinnall, testified that plastic speculums were “generally” employed, except in the instances described by Dinnall, adding that metal speculums were also employed in procedures such as a loop electrosurgical excision procedure or a colposcopy.

As relevant to the plaintiff’s claims here, Dinnall testified that, to the extent that any speculums that she employed were cleaned using an autoclave, those speculums were cooled down after they were autoclaved, and that it was her practice to check the temperature of the speculum before use, since, among other things, she needed to use her hands to grab the instrument. Dinnall further testified that there was never an instance when she felt that the speculum was “too hot” to use on a patient. According to Dr. Jones’s interpretation of Dinnall’s custom and habit testimony, during such examinations, but before the pap smear was performed, a pelvic examination “would have been conducted,” in which Dinnall “would have” a medical assistant enter the room for assistance and observation. Dr. Jones further described

Dinnall's general custom and practice, asserting that, once everyone was present, the patient "would be asked to place her feet in the stirrups on the examination table," after which Dinnall "would then" sit in front of the patient and remove a speculum from a drawer in the examination table, and, while performing the examination, Dinnall "would speak" to the patient, informing her that she "would place" a hand on the patient's leg and place a finger at the vaginal opening to insert the speculum, and, while inserting the speculum, "would use" one hand to part the vaginal labia while rotating the speculum ninety degrees, ensuring that the smallest portion of the speculum was introduced first. Dinnall's custom and practice then involved "gently" advancing the speculum approximately 1 centimeter (cm) to 2 cm, until it was fully inserted into the patient's vagina, after which Dinnall "would open" the speculum to allow visualization of the cervix, and then "would speak" to the patient during the entirety of the procedure. As Dr. Jones further described Dinnall's custom and practice, the latter would assure that the cervix was visualized satisfactorily, swab the cervix for a tissue sample, and withdraw the speculum, employing the tissue samples for the pap smear and gonorrhea-chlamydia tests.

In connection with her examination of the plaintiff, Dinnall testified that the pelvic examination and pap smear tests were uneventful, and that the plaintiff made no complaints during the procedure, but that, if something untoward had happened during the examination, she "would have" discussed the issue with the plaintiff and "would have" reported it in the relevant chart. Dr. Jones asserted that, inasmuch as there was no indication in the record that the plaintiff made any complaints during or at the conclusion of the visit, and because Dinnall's impression was that the visit involved a "routine annual exam," Dinnall formulated a plan to have the plaintiff follow up in connection with the results of the pap smear and gonorrhea-chlamydia tests and to return to the office as needed. Dr. Jones explained that the results of the May 28, 2008 pap smear test were positive for atypical squamous cells, and that, although Dinnall called the plaintiff to discuss those results, the plaintiff did not respond, after which Dinnall wrote a letter to the plaintiff on July 22, 2008. According to Dr. Jones, medical assistant Santiago

testified at her deposition that, after use, speculums would be soaked in a cleaning solution, cleaned off and placed in a special bag to be sterilized in an autoclave, that Columbus Circle was stocked with many backup speculums, and that “there was never a speculum used coming straight out of the autoclave onto the patient. That would never happen.”

As Dr. Jones explained it, on June 5, 2008, which was after Dinnall’s office had attempted to call the plaintiff with the test results, but before the office had sent the letter described above, the plaintiff herself wrote to Dinnall, complaining that the exam “was the most painful GYN exam” she had experience “in over 30 years of exams with at least ten different doctors due to insurance and address changes.” The plaintiff also purportedly called the Columbus Circle office to complain about the painful nature of the examination, and of “irritation and swelling for a number of days after, that has still not subsided.” She further asserted at her deposition that the Columbus Circle office did not return her call for three days. The plaintiff also averred that she felt rushed during the encounter, and expressed her fear that she had developed a Bartholin cyst, a problem she had not had “in years.” She contended that Dinnall overheated the speculum and “shoved” it into her vagina when the muscles were tight.

On June 6, 2008, the plaintiff presented to OB/GYN Deborah Ottenheimer, M.D., complaining of vulvar pain, and reporting a history of a Bartholin’s gland from several years earlier, which had been catheterized and drained, without subsequent problems. As set forth in Dr. Ottenheimer’s chart, the plaintiff also explained that she had recently undergone a vaginal examination in which “a very hot metal speculum was used and was very painful to patient during and after,” complained of vulvar swelling, and asserted that she had become concerned about a recurrent Bartholin cyst. The chart indicated that the plaintiff sat in a warm bath on the evening of June 5, 2008, with mild improvement. Dr. Ottenheimer further reported that, at the 5 o’clock position on the inner labia at the introitus, she observed “two small whitish lesions with brownish edges *appearing to be burns*” with “minimal surrounding erythema” (emphasis added). Dr. Ottenheimer told the plaintiff to clean the lesions with mild soaps, keep them dry, and watch

for signs of infection, and discussed with her "the nature of the burn and the healing, stages." Dr. Jones asserted that the plaintiff then presented numerous subsequent providers with complaints of ongoing pelvic pain after the "so-called burn incident." She conceded that many of these subsequent providers would reference Dinnall's examination as having triggered the "alleged" chronic pelvic pain syndrome, but stated that none of these providers documented having observed a lesion consistent with a "burn," but, instead, "merely parroted the patient's own recollection of an alleged 'burn' in their notes while attempting to determine the cause of the patient's ongoing pelvic pain, which has now persisted for eighteen years."

Dr. Jones opined that the subject vaginal examination and pap smear were performed within good and accepted standards of care, and that it was proper for Dinnall to use a speculum to dilate the vagina, as it enabled a visual inspection of the cervix and access for tissue sample collection. She explicitly concluded that, although a plastic speculum was "in all likelihood" employed during that examination, the examination was proper regardless of whether the speculum was plastic or metal. Dr. Jones reiterated Dinnall's description of the custom and practice that the latter employed while performing that type of examination, and concluded that each step of that examination, as described by Dinnall and reported in Dinnall's chart, was proper, entirely appropriate, and complied with the relevant standard of care. She opined that the steps taken by Dinnall were, and continue to be, the standard method for performing a vaginal examination and pap smear test, and that no alternative methods could have been employed to conduct these procedures.

In addition, Dr. Jones concluded that no action or inaction on Dinnall's part caused the injuries claimed by the plaintiff. In this respect, she opined that it is impossible to burn a patient with a speculum during a nonsurgical examination, regardless of whether a plastic or metal speculum is employed, and that, consequently, the plaintiff was not burned by the speculum during the subject examination. Dr. Jones reiterated that both Dinnall and Santiago, who assisted Dinnall during that examination, testified that they probably employed a plastic

speculum, and that it was taken from a drawer in the examination table. As she framed the issue, "[i]n 2008 and today, I am unaware of a gynecological examination table with a storage drawer for speculums capable of heating a device to the point that it would burn skin," and, despite employing drawers to store speculums for more than 30 years, she had never observed a plastic or metal speculum that was stored in an examination table drawer as being so hot that it would have the capacity to burn human skin. She further asserted that, had Dinnall employed a speculum hot enough to burn skin, Dinnall would have felt it when she prepared to use the instrument on the plaintiff, even if Dinnall had worn protective medical gloves. Dr. Jones alleged that it was "plausible and likely that Dr. Dinnall or any other provider would not have used a speculum that was so hot that they could feel the heat through such gloves."

Dr. Jones stated that, after conducting a medical literature review, she learned of "absolutely no reported cases of burns from a speculum, plastic or metal, during a routine gynecological exam," while the only reported case of a speculum-related burn was a case involving a metal speculum employed during a hysterectomy. She explained that, in that case, contact between the metal speculum and a cautery device that also was employed during the hysterectomy led to the transfer of heat through the speculum to the walls of the vagina, resulting in a burn, that is, the surgeon inadvertently heated the metal speculum by applying the cautery device to it. Dr. Jones asserted that such an occurrence simply did apply in the plaintiff's, case since her care did not involve electrocautery for a surgical procedure or a similar surgical technique. Rather, she stated that the subject examination was a nonsurgical examination, with respect to which Dinnall "very likely" used a plastic speculum.

Dr. Jones opined that, while the subject examination might have been uncomfortable for the plaintiff, "it is unlikely, to impossible," that the plaintiff would have suffered a burn. She opined that the two whitish lesions with brown edges on the left outer labia that Dr. Ottenheimer observed on June 6, 2008 "most likely" were not burns, since an instrument hot enough to cause burns after being inserted into the vagina would likely not burn the inner labia, which is

external tissue, but instead would likely result in length-wise burns within the vaginal walls. She repeated that neither Dr. Ottenheimer nor any other subsequent healthcare provider described lesions that would fit the description of a burn. Dr. Jones opined that, most likely, the lesions that Dr. Ottenheimer observed were either Herpes/HSV-2 lesions or manifestations of lesions from the patient's known history, such as HPV or a Bartholin cyst, since these conditions have the capacity to produce whitish lesions with brown edges on the outer labia at various stages. Consequently, she concluded that these explanations were far more plausible than a purported "burn" from a hot speculum. In this respect, Dr. Jones noted that Dr. Ottenheimer did not take a tissue culture of the lesions that she found and, hence, information about possible bacterial or viral processes could not be ascertained, while she further noted that the plaintiff's extant medical records did not indicate whether she had ever been tested for herpes/HSV-2, which would have explained both the plaintiff's complaints to Dr. Ottenheimer and the latter's findings. Dr. Jones also asserted that, in addition to the type of lesions that Dr. Ottenheimer observed, herpes can produce pelvic pain, as well as pain in other body systems.

In connection with the plaintiff's history of a Bartholin cyst, and a recurrence of that condition in September 2009, Dr. Jones explained that such a cyst is a lesion that develops when a gland on either side of the vaginal opening becomes blocked or infected, which can result in swollen lesions in the vaginal opening in addition to pain. She averred that a vaginal examination with a speculum while a patient has a developing or incipient Bartholin cyst can cause significant pain, but explained that it would be impossible to know if a cyst is developing if it has not reached the point where it can be appreciated through visual inspection.

Dr. Jones concluded that any pain associated with a reasonable effort to complete a vaginal examination utilizing a speculum should resolve within a few days with conservative care. She noted that, even with the gentlest approach by an examining OB/GYN, some pain can occur upon examination. Nonetheless, she opined that, from an OB/GYN standpoint, there

was nothing in the plaintiff's records or the parties' deposition testimony regarding the May 28, 2008 vaginal examination that could be linked to a chronic pain syndrome.

Dr. Forde reiterated some of Dr. Jones's descriptions of the plaintiff's medical history, up to and including the plaintiff's visit with Dr. Ottenheimer. She noted that, subsequent to her visit with Dr. Ottenheimer, the plaintiff, on three occasions in 2014, saw neurologist Aaron Filler, M.D., who was, at the time, associated with The Institute for Nerve Medicine and the Center for Advanced Spinal Neurosurgery in Santa Monica, California. According to Dr. Forde, Dr. Filler reviewed the plaintiff's prior imaging studies, including a 2009 pelvic magnetic resonance imaging (MRI) scan and a 2012 pelvic MRI scan, at which time he reported no clear evidence of an abnormality, aside from a Bartholin cyst and some tissue abnormality on the left, and proceeded to order another pelvic MRI scan, which was completed on January 21, 2014, after which he compared it to the 2009 and 2012 scans. According to Dr. Forde, the January 21, 2014 soft tissue MRI pelvic neurography revealed an abnormality in the distal coccyx, which measured approximately 2.9 cm in width and 2.4 cm in vertical extent. Dr. Filler described the abnormality as hyperintense and partly extended through the bone of the coccyx, and suspected either chordoma or a completely benign process. Dr. Forde explained that a chordoma is a slow-growing, malignant spine or skull-base lesion, and that the lesion observed on the January 21, 2014 scan was 30% larger than the image seen on the 2012 scan and about 50% larger than the image seen on the 2009 scan.

As Dr. Forde explained it, because the 2009 scan was taken approximately one year after Dinnall's examination, Dr. Filler essentially told the plaintiff that she might have a malignant mass in her coccyx, but that, even if the mass were benign, from a pain standpoint, it was concerning that it extended through the coccyx bone and was growing, and, thus, had the capacity to inflict great pain. Dr. Forde asserted that the January 21, 2014 scan also revealed evidence of pudendal nerve hyperintensity, consistent with a nerve irritation syndrome on the left, greater than the right, and spasms affecting the left pelvic floor muscles, causing

asymmetry of the pelvic floor, while a Bartholin cyst and urethral diverticulum were also noted. She further explained that Dr. Filler undertook a three-dimensional reconstruction and analysis, revealing a bilateral abnormality affecting the pudendal nerves at the level of the ischial spine and proximal portion of the nerve. Dr. Filler reported that this was consistent with a left-greater-than-right pudendal entrapment syndrome, which he concluded was strongly suggestive of a clinically significant pudendal nerve disorder. Dr. Filler recommended a further workup and treatment geared toward ruling out a malignancy, since he wanted the plaintiff to undergo further testing to determine whether the lesion required a biopsy. According to Dr. Forde, the plaintiff declined to undergo such a workup. Dr. Filler last saw the plaintiff on January 24, 2014.

On April 1, 2016, the plaintiff presented to OB/GYN and integrative medicine specialist Betsey Greenleaf, M.D., at the New Jersey Urological Institute in Eatontown, New Jersey. Dr. Greenleaf ordered a pelvic MRI neurography, without contrast, to evaluate the plaintiff's pudendal neuralgia and severe pelvic pain. The plaintiff told Dr. Greenleaf that she had sustained a "vaginal burn," which was included in the plaintiff's medical history. On June 6, 2016, the plaintiff underwent a pelvic MRI neurography, which was performed by radiologist Hollis G. Potter, M.D., at the Hospital for Special Surgery (HSS) in Manhattan. Dr. Potter interpreted the scan as showing no scar entrapment of the pudendal nerves, although varices, that is, varicose veins, which have the capacity to cause chronic pain, were noted in the vessels of the vaginal area. Dr. Potter further reported the presence of a soft tissue mass in the area of the plaintiff's urethra, which she attributed to periurethral diverticulum, a left-sided Bartholin gland cyst, and Nabothian gland cysts, which also can cause chronic pain, as well as a signal abnormality within the sacrococcygeal junction, in other words, a mass in the coccyx, which Dr. Forde explained was most likely calcified blood clots, known as a phlebolith, and a large intraosseous hemangioma, that is, a blood vessel tumor that passes through bone.

Dr. Forde explicitly criticized the plaintiff for writing to Dr. Potter to change her findings, incorrectly claiming support for that request from Drs. Greenleaf and Filler, as well as from

surgeon Alexander E. Poor, M.D., and radiologist Johannes M. Roedl, M.D., of Vincera Institute in Philadelphia, Pennsylvania. As Dr. Forde described the plaintiff's letter, the plaintiff requested that Dr. Potter rewrite her report to say that:

> "(1) there is a tear in the left obturator internus muscles; (2) her left psoas muscle is greatly atrophied; (3) that the hemangioma is a 'nonaggressive osseus benign lesion' and 'all doctors note that it cannot be the cause of any of my symptoms,' adding 'are you able to write that in your report it is not pertinent to my pain?'; (4) there is no osteoarthritis in the hip, and (5) the aforementioned pelvic varices are entrapping her pudendal nerve, or basically that she has entrapment of her pudendal nerve."

Dr. Forde explained that the plaintiff continued to receive care from Dr. Greenleaf until June 2016. She asserted that, on October 4, 2017, another healthcare provider took a pelvic MRI scan and, thus, immediately before Dr. Poor began treating the plaintiff. Dr. Forde explained that the indications for that study were "lumbar pain" and to "evaluate for mass," and that this MRI scan revealed, among other things, an area of signal abnormality seen in the lower sacrum and upper coccyx, which could be related to a "severe bone bruise," but was also concerning for a "marrow replacement process (such as metastatic disease or myeloma)." Further evaluation via a bone scan and further workup for an "unknown primary" were also recommended.

The plaintiff first saw Dr. Poor on October 30, 2017, at which time she told him that a prior healthcare provider had "burned" her vagina "with a too hot speculum, withdrew it and reinserted it against spasming muscles at a weird angle and with blades partially open, resulting in pudendal nerve damage/entrapment, obturator internus muscle gap, and burned left vaginal wall deep in the tissue." The plaintiff purportedly also told Dr. Poor that the burn led to years of pain and declining stability, which she attempted to manage with yoga and acupuncture. Dr. Forde, however, asserted that the pain did not prevent the plaintiff from going to yoga sessions twice per week, walking along the beach almost daily, dancing socially, attending church, and driving a car for up to two hours per day. Dr. Forde asserted that the plaintiff purportedly stopped working in 2013, but nonetheless could maintain a social life, while, in 2015, the plaintiff purportedly "resumed" physical therapy, but complained that the exercises caused intense

pudendal flare-ups, back pain, pubic pain, changes in clitoral sensation, and pain in the lower abdomen. Dr. Forde asserted that these conditions "could not possibly be caused by a burn."

Dr. Forde stated that Dr. Poor has continued to treat the plaintiff for her pelvic pain and related complaints with nonsurgical options, such as pelvic floor physical therapy, medications, and other modalities. She asserted that Dr. Poor had ordered and reviewed multiple MRI scans of the plaintiff's pelvis during the course of his care, including his first one, which was ordered and completed on October 30, 2017. According to Dr. Forde, the indication for the scan was left groin pain extending into the vulva and pubic symphysis and "prior vaginal injury." The scan allegedly revealed the presence of a rounded cystic structure encircling portions of the urethra measuring 1.4 cm by 1.5 cm by 2 cm that was most consistent with a urethral diverticulum, another structure measuring 8 cm by 8 cm by 4 cm that was consistent with a Bartholin cyst, and a structure in the upper portion of the coccyx without surrounding soft tissue edema that was consistent with a nonaggressive osseous lesion, which Dr. Forde characterized as likely a benign chondroid lesion or fibrous dysplasia, that is, essentially a mass. Dr. Forde further asserted that an MRI of the plaintiff's pelvis, taken without contrast, was ordered by Dr. Poor, was completed on June 22, 2021, and was read as revealing the presence of an osseous lesion in the upper coccyx that was unchanged since October 30, 2017, a nonaggressive chondroid lesion of the bone, a Bartholin cyst lesion in the vagina, a cystic lesion on the urethra, and other findings. She noted that, on May 4, 2022, a follow-up MRI scan of the pelvis without contrast was taken, after which the radiologist reading the scan concluded that the urethral cystic structure, which was thought to be the urethral diverticulum, the Bartholin gland cyst, and the bony mass/lesion in the upper portion of the coccyx, had not changed since 2017.

Dr. Forde concluded that the plaintiff has experienced numerous chronic, pain-related conditions "that cannot possibly result from the alleged burns on the exterior of the vagina." She asserted that these conditions included the plaintiff's generalized complaints of weakness,

abductor issues, pudendal neuralgia, pudendal flare-ups, back pain, pubic pain, hip pain, changes in clitoral sensation, pain in the lower abdomen, and an obturator nerve injury. She opined that the cause of any ongoing complaints of pelvic pain, pelvic/genital hypersensitivity, radiating pelvic pain, back pain, radiating back pain, and chronic pain syndrome were not caused by the vaginal examination and pap smear performed by Dinnall in 2008. Rather, Dr. Forde came to the conclusion that the conditions reported in the medical records explained the plaintiff's symptomatology, such as the mass in her distal coccyx that extended through the bone and was growing for approximately seven years, as well as Bartholin and Nabothian cysts, phleboliths, genital warts, and a tense levator ani muscle. She further asserted that an alleged obturator nerve injury cannot result from a burn, inasmuch as the obturator nerve is located very deeply, rendering it impossible to damage it by a burn, particularly because Dinnall did not employ an electrocautery device during her nonsurgical examination. Dr. Forde further asserted that the sacral-coccyx mass that Dr. Greenleaf had identified was "clearly present and causing symptoms," along with the vaginal varices, the urethral diverticulum, and Bartholin/Nabothian cysts. She opined that the pelvic floor issues and muscle spasms that had been documented in Dr. Greenleaf's records were the result of pelvic floor dysfunction, not a burn. As she explained it, as a woman ages, her pelvic floor can dry out if, like the plaintiff, she is not sexually active, and that such dryness can cause pain, which explained why the plaintiff cannot insert anything into the vagina.

Dr. Forde went on to explain that a noncancerous bony sacral coccyx tumor is capable of producing all of the symptoms of which the plaintiff complained, including pelvic pain, chronic vaginal pain, pelvic hypersensitivity, pain during sexual intercourse, back pain, and weakness, while genital pain and numbness and painful intercourse symptoms also are associated with a tumor of the sacral coccyx. She asserted that a tumor in the tailbone, which is within the area of the sacral coccyx, can also cause pain while sitting, pain with movement, and positional pain, while abnormal gait and muscle weakness can all result from a sacral coccyx tumor, but not

from a burn. Dr. Forde noted that, in this respect, the tumor started growing rapidly, just when the plaintiff began to complain of pelvic pain not long after her encounter with Dinnall. Hence, she concluded that, "[i]n all likelihood, Ms. Barbagallo's continued complaints of pelvic pain, back pain, muscle weakness, pelvic hypersensitivity and dysfunction, gait problems, and other related complaints are most likely due to growth related to the well-documented tumor." Dr. Forde opined that the plaintiff's test results reflected conditions that also were "capable of" producing her complaints, such as the pelvic varices that Dr. Greenleaf had noted, which Dr. Forde explained were indicative of pelvic congestion syndrome, a condition in which large, irregular, varicosed veins in the pelvic area impair blood flow and cause pooling that can, in turn, lead to chronic pelvic pain, with the pain greater on the left than on the right. Similarly, she stated that tumors in the coccyx/tailbone area can cause pelvic congestion as the tumor grows and compresses nearby nerves and organs. Dr. Forde concluded that the documentation of pelvic congestion coincided with the growth of the coccyx tumor, which, "in all likelihood," caused impingement of adjacent nerves, organs, and tissues leading to chronic pelvic pain.

Dr. Forde characterized as "implausible" the plaintiff's theory that a "burn" was caused by a hot speculum during Dinnall's vaginal examination. She reiterated Dinnall's and Santiago's deposition testimony, in which they averred that Dinnall generally employed plastic speculum, as well as Dr. Jones's opinion that it was implausible that a metal speculum could have caused a vaginal burn, since it would have burned Dinnall or Santiago "long before" it could have burned the plaintiff. She noted that, had the speculum been metal, the entire instrument, including the handle, would have been heated to a dangerous extent, which did not occur here. Moreover, she asserted that,

> "[a]ssuming for argument's sake that even if it were possible to burn them with a hot metal speculum, the burn itself would have been present everywhere that the speculum touched (i.e., internal and external parts of the vagina), not just two external spots. I am unaware of any medical literature documenting an instance of a vaginal burn in a case that did not involve a surgical/operative procedure. This patient, Ms. Barbagallo, was not undergoing a procedure utilizing

> electrocautery that could have potentially caused a burn if the cautery device made contact with a metal speculum."

Dr. Forde concluded that the two lesions on the plaintiff's inner labia, as described in Dr. Ottenheimer's chart, "could not themselves subsequently cause Plaintiff's chronic pelvic pain, weakness, and altered function" regardless of their etiology. Inasmuch as the plaintiff had a history of Bartholin cyst and HPV, Dr. Forde opined that the lesions documented by Dr. Ottenheimer cannot be automatically explained as "burns," particularly because Dinnall merely performed standard pelvic examination and pap smear utilizing a plastic speculum. She further concluded that Dr. Ottenheimer and other healthcare providers did not independently determine that the lesions were caused by a burn, but appeared merely to have accepted the plaintiff's "historical narrative of a burn from a hot speculum based upon the Plaintiff's 'say so.'" Dr. Forde supported this conclusion with her opinion that the goal of all physicians who examined the plaintiff subsequent to Dinnall's examination was not to disprove or confirm whether the plaintiff indeed had sustained a burn, but was to investigate the source of her complaints, diagnose her problem, and prescribe a course of therapy to create improvement.

Based on her review of the charts maintained by Drs. Filler, Greenleaf, and Poor, Dr. Forde explained that all of them had documented the presence of a fairly large and apparently symptomatic sacral coccyx tumor, that grew significantly between 2009 to 2014, and, thus, not long after Dinnall's examination and concomitantly with the period of the plaintiff's increasing complaints of pelvic pain and diminished function. Thus, she explicitly opined that it was the sacral coccyx tumor that caused the conditions leading to the plaintiff's complaints, including chronic pelvic pain, pelvic hypersensitivity, pain during intercourse, radiating pain to the back, impaired gait, weakness, and a host of other complaints. Dr. Forde thus concluded that the discomfort experienced during Dinnall's vaginal examination, and over the days immediately thereafter, likely was caused when nerves and tissues already affected by the coccyx tumor and a dormant Bartholin cyst had been stimulated and provoked.

In opposition to the defendants' motion, the plaintiff relied on many of the same documents that the defendants had submitted, and also submitted Dinnall's billing records, medical insurance records, an attorney's affirmation, and the expert affirmation of board-certified OB/GYN Andrew Goldstein, M.D., who opined that Dinnall departed from good and accepted medical practice during while treating the plaintiff by improperly employing a hot speculum without adequate temperature testing, resulting in significant thermal injury to the plaintiff's vulvovaginal tissues, as well causing vulvar pain with muscle spasm, pudendal neuralgia, and chronic pelvic pain syndrome.

In the first instance, a July 30, 2008 letter from United HealthCare/Oxford, written in response to the plaintiff's inquiry, indicated that investigators from that insurer had contacted Dinnall, who had left her practice with Columbus Circle on June 30, 2008, and spoke with her. According to the letter, Dinnall informed the Oxford representative that, contrary to her deposition testimony, her general custom and practice was that she "tests the speculum on the patient's skin prior to insertion to make sure the temperature is not too warm." In addition, the letter indicated that an Oxford representative also had spoken with a Ms. Crique at Columbus Circle, "who has conducted an investigation and has submitted a corrective action plan regarding the warming of speculums."

Dr. Goldstein first reiterated much of the plaintiff's medical history that had been described by Drs. Jones and Forde in their affirmations. He also adverted to the plaintiff's deposition testimony, in which testified that the speculum felt "way too hot," and that, as soon as the instrument touched her, it felt like "everything was on fire." Dr. Goldstein additionally referred to the plaintiff's testimony that, immediately after the examination, she experienced instability when walking. Dr. Goldstein recapitulated the plaintiff's testimony, in which she asserted that the Columbus Circle healthcare provider who was assisting Dinnall told the plaintiff that "Dr. Dinnall likes a warm speculum," to which the plaintiff responded that "warm is okay, but not hot." He further noted that the plaintiff testified that she experienced significant

resistance and pain during the insertion of the speculum, which was not fully inserted, and she felt a big shove that, along with the heat of the instrument, caused her to scream in pain.

Dr. Goldstein opined that, contrary to the defendants' experts' assertions, Dinnall's insertion of a hot speculum could indeed cause damage to the plaintiff's vaginal tissues that are lateral to the vagina, including the pudendal nerve, which is one of the main nerves of the anogential region that provides both sensory and motor function to the anus, vulva, vagina, urethra, and clitoris. Dr. Goldstein explicitly rejected the opinions of the defendants' experts that it was "impossible" for a metal speculum to cause a burn. Moreover, he stated that, if such tissue is damaged, and lesions develop, a patient may experience sensory loss, chronic pelvic pain, and pain which can be exacerbated by activities such as sex, prolonged sitting on hard surfaces, climbing stairs, and exercises such as dancing and Pilates, which he concluded that the plaintiff in fact experienced "as a result of Dr. Dinnall's examination on May 28, 2008."

According to Dr. Goldstein,

> "[o]nly a metal speculum could be hot at any point because it is re-used after it is sterilized with heat in an autoclave, whereas a plastic speculum would be discarded after use. An autoclave is a machine that uses steam under pressure to kill harmful bacteria, viruses, fungi, and spores on items that are placed inside a pressure vessel. The items are heated to an appropriate sterilization temperature for a given amount of time. The two common steam-sterilizing temperatures are 121°C (250°F) and 132°C (270°F). These temperatures must be maintained to kill microorganisms."

In connection with the use of an autoclave, Dr. Goldstein noted that Dinnall's assistant, Santiago, testified at her deposition that the autoclave was employed to sterilize metal speculums at Columbus Circle after business hours. Since Dinnall treated the plaintiff after Columbus Circle's "usual working hours," Dr. Goldstein concluded that there was an increased likelihood that Dinnall employed a hot metal speculum during the plaintiff's examination. He noted the inconsistency between Dinnall's testimony that it was not her usual practice to test the heat of a speculum before employing it, with the Oxford letter in which the Oxford representative recounted Dinnall's purported statement that she did, in fact, test a speculum on skin before

use. Moreover, he noted that, although Dinnall testified that she employed metal speculums only for examining obese patients and when performing a colposcopy, and that neither of those circumstances applied to the plaintiff, Dinnall's billing records reflected that, she did, in fact, conduct a colposcopy upon the plaintiff, thus suggesting that she did indeed employ a metal, rather than a plastic, speculum during her examination and treatment of the plaintiff.

Dr. Goldstein explained that, when a speculum is removed from an autoclave, it is hot, and that when the subject speculum was handed to Dinnall, she was wearing regular examination gloves. He stated that, although Dinnall testified that she could feel the heat through the gloves, Santiago testified that, unlike Dinnall, she could not feel the heat of a recently autoclaved speculum through her gloves. He explicitly opined that standard medical gloves do not reliably allow practitioners to feel the heat of such instruments. In this respect, he asserted that the standard of care requires that the temperature of the speculum be tested against a sensitive area, such as the practitioner's wrist, to confirm it is safe for use. Dr. Goldstein concluded that the defendants departed from good and accepted medical practice when they failed to ensure thermal safety of the surgical tools utilized on May 28, 2008, and that this departure was a substantial factor in causing the plaintiff's injuries. Based on the plaintiff's testimony that she had experienced severe burning pain upon insertion of the speculum, as well as the fact that, despite her visible discomfort and involuntary vaginal muscle tension, Dinnall forcefully reinserted the speculum into the plaintiff's vaginal canal, Dr. Goldstein concluded that the defendants further departed from the applicable standard of care in the manner in which they reinserted the speculum. In addition, Dr. Goldstein expressly rejected the opinion of the defendants' experts that a burn caused by a heated speculum would appear as lengthwise lesions on the vaginal walls, and that the absence of such burns disproves the plaintiff's claims. In reaching this conclusion, he explained that such an opinion neglected the variability of thermal injury presentation based on tissue type and location. Dr. Goldstein asserted, in this regard, that vaginal walls and external vulvar tissues have distinct structures, sensitivities, and

exposure to thermal sources, in that vulvar tissues, including the labia and perineum, are more exposed and have a thinner epithelial layer compared to the vaginal walls, while discharges within the vagina might protect the vaginal mucosa from thermal injury. As such, he concluded that the labia and perineum would be more susceptible to injury from an overly hot speculum, and that the perineal branch and posterior branch of the pudendal nerve can indeed be affected by a burn on the perineum or labia, which he asserted was what occurred to the plaintiff.

According to Dr. Goldstein, when the plaintiff presented to Dr. Ottenheimer on June 6, 2008, both Dr. Ottenheimer and a nurse practitioner at Dr. Ottenheimer's office told the plaintiff that the presence of two small burns was a result of an overheated speculum that Dinnall had employed during the subject examination. The plaintiff testified that the nurse practitioner advised her to keep the area clean and dry and to avoid wearing panties while sleeping, and thereupon prescribed an ointment containing a steroid and atopical anesthetic to treat the significant pain and swelling in the area, which she graded at a level of 10 on scale of 10.

Dr. Goldstein averred that he personally examined and treated the plaintiff on April 30, 2010 and again in 2012. He asserted that, at the April 30, 2010 visit, the plaintiff reported severe vulvar pain characterized by intense burning, stinging, aching, and swelling in the left labia minora and vaginal area, and that these symptoms began immediately following Dinnall's May 28, 2008 examination. Dr. Goldstein also examined the plaintiff at the April 30, 2010 appointment, when she was then 48 years old. He asserted that the lesions that had been reported were consistent with burns on the plaintiff's vulva, and that, although the plaintiff's initial treatment with topical steroids and lidocaine resolved the lesions, the pain persisted, requiring physical therapy to address muscle spasms, as well as medical therapy to treat neuralgia, with acupuncture having provided the most significant relief.

Dr. Goldstein asserted that his examination findings revealed mild swelling and tenderness of the left interlabial sulci and labia minora, with mild erythema in the vulvar vestibule, but no masses, lesions, or ulcerations. He stated that the plaintiff's levator ani

muscles, particularly in the left obturator internus, were tight and tender, causing radiating vulvar pain. Based on these findings and a thorough discussion with the plaintiff with respect to her medical history, Dr. Goldstein formed the impression that the plaintiff likely was suffering from a neuropathic pain condition of the vulva, specifically dysesthetic vulvodynia, involving a branch of the pudendal nerve, a condition also known as pudendal neuralgia. He asserted that a vulvoscopy ruled out HPV, vulvar intraepithelial neoplasia, vulvar dermatoses, recent acute bums, or scar tissue, and that a wet-mount analysis showed no infections or abnormalities. Dr. Goldstein reported that, although he had administered an injection of marcaine to the affected area, it provided only minimal immediate pain relief. He asserted that he extensively discussed treatment options with the plaintiff, including tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, gabapentin, pregabalin, and capsaicin. Dr. Goldstein asserted that, on May 10, 2010, he had a follow-up conversation with the plaintiff, during which she reported experiencing relief due to nerve block therapy, which he concluded supported his diagnosis of a neuropathic pain process.

Dr. Goldstein reiterated the defendants' experts' description of the plaintiff's January 20, 2014 visit with Dr. Filler in California, noting that she presented to Dr. Filler complaining of persistent pain in her vaginal area, and that Dr. Filler's impression included pudendal nerve irritation and entrapment syndrome, greater on the left than the right, neuropathic pain involving the left obturator internus muscle and pelvic floor spasm, and asymmetric vaginal/labial wall changes. Dr. Goldstein concluded that these symptoms correlated with a burn caused by an overheated speculum. He further noted that the magnetic resonance neurography (MRN) test that Dr. Filler had ordered revealed evidence of pudendal nerve hypersensitivity, consistent with nerve irritation syndrome, which was greater on the left than the right, with spasm affecting the left pelvic floor muscles, which Dr. Goldstein concluded were also consistent with left-greater-than-right pudendal entrapment syndrome.

Dr. Goldstein opined that the plaintiff's injuries have significantly affected her life in numerous adverse aspects, including her ability to sit, walk, and engage in activities she once enjoyed, such as swimming and Pilates, and limited her career options, and decreased her social activities and sexual relationships. He asserted that she now requires various medical treatments and therapies, including physical therapy, nerve-block injections, and psychotherapy, which have, in turn, caused compensatory injuries and affected her autonomic nervous system, leading to additional health issues. As the plaintiff's treating physician in 2010 and 2012, Dr. Goldstein documented injuries "directly related to the speculum burn she sustained during a gynecological examination on May 28, 2008," and concluded that the burn caused immediate and severe pain, with visible lesions consistent with burns, and initiated a cascade of chronic symptoms, including burning, stinging, swelling, and debilitating vulvar pain. He asserted that his examinations revealed tenderness and swelling in the affected areas, tightness in the pelvic muscles, and symptoms consistent with pudendal neuralgia and dysesthetic vulvodynia, a neuropathic pain condition directly attributable to nerve damage from the burn. Dr. Goldstein opined that the conditions that he observed "were proximately caused by the burn injury to Ms. Barbagallo's vulva on May 28, 2008," as were the conditions diagnosed in 2014 by Dr. Filler. In this respect, he opined that a burn to the vulva can cause pudendal nerve damage due to the nerve's close association with the structures of the vulvar region, since that nerve, which provides sensory and motor innervation to the external genitalia, perineum, and surrounding areas, is highly susceptible to injury when the skin and underlying tissues are exposed to significant thermal trauma. In other words, he averred that a burn injury to the vulva can damage the sensory nerve endings connected to the pudendal nerve, leading to inflammation and disruption of normal nerve function, as well as an inflammatory response that causes swelling, tissue scarring, and irritation of the pudendal nerve or its branches, which, over time, can result in nerve entrapment, where scar tissue compresses the nerve, impairing its function. He stated that this cascade of events can lead to hypersensitivity, chronic pain, and neuropathic

conditions such as pudendal neuralgia and dysesthetic vulvodynia. Dr. Goldstein thus expressly contested the opinion of the defendants' experts that the burn injury could not and did not cause the injuries to the plaintiff's pudendal nerve.

Dr. Goldstein opined that the defendants' experts wrongly attributed the plaintiff's symptoms to undiagnosed HSV-2 or a Bartholin cyst, rather than thermal trauma, characterizing this opinion as speculative, unsupported by evidence, and inconsistent with the clinical timeline and presentation, specifically because the plaintiff experienced severe pain, swelling, and lesions immediately following the use of the speculum, which he described as "characteristic" of thermal injury. He further noted that the plaintiff evinced no signs or symptoms of an HSV-2 infection, which he explained are characterized by an obvious cutaneous lesion, and that there was no evidence in her medical history or records to support a diagnosis of HSV-2. Dr. Goldstein asserted that, despite the fact that millions of women have been diagnosed with HSV-2, "there are no substantial cases in the medical literature of HSV-2 causing persistent post-herpetic neuralgia of the pudendal nerve."

Similarly, Dr. Goldstein asserted that the defendants' suggestion that the plaintiff's symptoms were caused by an infected Bartholin cyst, rather than thermal trauma, was inconsistent with her clinical presentation and the documented evidence. Dr. Goldstein conceded that, while the plaintiff had a history of Bartholin cysts, such cysts typically present as localized swellings near the vaginal opening, caused by a blocked duct in the Bartholin gland, and that they generally are painless unless they become infected, at which point they may develop into an abscess characterized by a tender, reddened, swollen lump, confined to the area of the gland. He explained that an abscess may also present with localized warmth, pain, and, occasionally, drainage if ruptured, but that, in the plaintiff's case, there was no evidence of a preexisting cyst or abscess during the May 28, 2008 examination, let alone any clinical findings suggesting an active infection at the time. Dr. Goldstein stated that, had such a cyst been present, Dinnall "would have easily recognized such cyst or abscess at the time of the

appointment." Moreover, he explained that the plaintiff's symptoms, which included widespread vulvar lesions, swelling, and immediate severe pain following the use of the speculum, "are inconsistent with an infected Bartholin cyst," since lesions caused by thermal trauma tend to be irregularly shaped, diffuse, and accompanied by immediate pain and swelling at the site of contact, while an infected Bartholin cyst would produce localized tenderness and swelling near the gland and evolve over time, potentially with systemic signs such as fever.

In reply to the plaintiff's opposition papers, the defendants submitted an attorney's affirmation, in which counsel argued that Dr. Goldstein's opinions were conclusory, speculative, and unsupported by the medical records. He further reiterated the defendants' deposition testimony that Dinnall's custom and practice was to employ a plastic speculum, and that it was impossible to heat a plastic speculum for use during an examination.

The court notes that the defendants premised their summary judgment motion not on Dinnall's or Santiago's personal recollection of whether Dinnall employed a plastic speculum, rather than metal speculum, in performing her May 28, 2008 vaginal examination of the plaintiff. Rather, they premised their motion on Dinnall's and Santiago's deposition testimony that it was Dinnall's habit, custom, and routine to use plastic speculums on patients, such as the plaintiff, who were not severely overweight, did not present with a redundancy of vaginal tissue, were not pediatric patients, were not undergoing a colposcopy, and were not undergoing a loop electrosurgical excision procedure. Importantly, rather than testifying, or establishing via other evidence, that Dinnall *invariably* employed a plastic speculum when conducting a regular vaginal examination upon a patient who did not fall within any of those categories, Dinnall, Santiago, and the defendants' experts repeatedly used the words "customarily" and "generally" to describe the frequency with which, and situations in which, Dinnall employed plastic speculums for regular vaginal examinations in non-overweight patients.

As the Appellate Division, First Department, explained,

> "[i]n order for an expert's opinion based on habit testimony to be considered by a court on a doctor's motion for summary judgment in a medical malpractice action, a foundation must be laid for the admissibility of the underlying habit testimony. In general, evidence of conduct on other occasions is irrelevant to prove that a person performed a particular act on a different, unrelated occasion. Evidence of habit is, however, admissible to show that someone acted in conformity with that habit on a particular occasion. In order to qualify as a habit or routine practice, the proponent must show that it is a deliberative and repetitive practice by a person in complete control of the circumstances. Habit evidence is distinguishable from conduct, no matter how frequent, that is likely to vary from time to time depending on the circumstances . . . Habit or repetitive routine is admissible to fill in any 'evidentiary gaps' involving that person in similar circumstances to infer they were handled the same way
>
> "Where medical procedures are concerned, habit evidence is admissible to establish that routine or mundane procedures were followed"

(*Guido v Fielding*, 190 AD3d 49, 53-54 [1st Dept 2020] [citations omitted]; *see Galetta v Galetta*, 21 NY3d 186, 197 [2013]; *Rivera v Anilesh*, 8 NY3d 627, 634 [2007]; *Halloran v Virginia Chems*., 41 NY2d 386, 389, 392, 393 [1977] [admissibility of habit evidence is limited to cases where the proof demonstrates "a deliberate and repetitive practice" by a person "in complete control of the circumstances," as opposed to "conduct however frequent yet likely to vary from time to time depending upon the surrounding circumstances"]; *Goldson v Mann*, 173 AD3d 410, 411 [1st Dept 2019] ["Defendant's testimony did not establish a deliberate and repetitive practice sufficient to show evidence of his behavior during plaintiff's examination, as he testified that his examination varied depending on the examinee"]; *cf. Mazella v Beals*, 27 NY3d 694, 710 [2016] [evidence of propensity to commit tortious acts is prejudicial and inadmissible]).

"[E]vidence of 'conduct however frequent yet likely to vary from time to time depending upon the surrounding circumstances' is not admissible as custom and practice evidence" (*Martin v Timmins*, 178 AD3d 107, 110 [2d Dept 2019], quoting *Rivera v Anilesh*, 8 NY3d at 634 [some internal quotation marks omitted]). In *Martin v Timmins,* the Appellate Division concluded that a surgeon's testimony that he generally employed a particular method for suturing a specific mesh patch during hernia repairs was inadmissible to establish that he employed that method during the plaintiff's surgery. As it explained, "[a]lthough habit evidence may be admissible in a

medical malpractice action where the defendant physician makes the requisite showing, here, the evidence did not demonstrate that the defendant's suturing of the . . . . mesh patch represented a deliberate and repetitive practice by a person in complete control of the circumstances The defendant's procedure for suturing mesh patches during hernia repairs lacked unvarying uniformity and was likely to vary from time to time depending upon the surrounding circumstances" (*id*. [citation and internal quotation mark omitted]). "'Custom and practice evidence draws its probative value from the repetition and unvarying uniformity of the procedure involved as it depends on the inference that a person who regularly follows a strict routine in relation to a particular repetitive practice is likely to have followed that same strict routine at a specific date or time relevant to the litigation'" (*Huertas v Town of Smithtown*, 226 AD3d 656, 658 [2d Dept 2024], quoting *Galetta v Galetta*, 21 NY3d at 197-198; *Rivera v Stand Up MRI of Elmhurst, P.C.*, 235 AD3d 918, 920 [2d Dept 2025]).

The court concludes that neither Dinnall's nor Santiago's testimony was sufficient to establish that Dinnall invariably employed a plastic speculum while performing the type of vaginal examination that she performed upon the plaintiff. Hence, the defendants failed to establish, prima facie, that Dinnall employed a plastic speculum when she examined the plaintiff on May 28, 2008, or that it would have been impossible to have burned the plaintiff because Dinnall did not employ a speculum capable of causing a burn.

In addition, by submitting the transcript of the plaintiff's deposition testimony, in which she averred that Santiago, who was testifying on behalf of Columbus Circle, had told the plaintiff that "Dr. Dinnall likes a warm speculum," to which the plaintiff responded that "warm is okay, but not hot," the defendants have placed before the court a party admission that reflects the existence of a triable issue of fact as to whether Dinnall employed a speculum upon the plaintiff that was capable of being heated in the first instance (*see Vendette v Feinberg* , 125 AD2d 960, 960 [4th Dept 1986] [a party admission "constitutes evidence in admissible form necessary to defeat a motion for summary judgment"]; *see also Angiolillo v Christie's, Inc.*, 85 AD3d 442, 443

[1st Dept 2020] [party admission is admissible where declaration is made by corporate employee to a person other than the declarant's principal]; *Delgado v Martinez Family Auto*, 113 AD3d 426, 426 [1st Dept 2014]; *Jackson v Trust*, 103 AD3d 851, 852 [2d Dept 2013]; *Ramos v Rojas*, 37 AD3d 291, 292 [1st Dept 2007]; *Batista v New York City Tr. Auth.,* 2023 NY Slip Op 31580[U], * 4, 2023 NY Misc LEXIS 2354, *6 [Sup Ct, N.Y. County, May 10, 2023] [Kelley, J.] ["A party admission is admissible in evidence notwithstanding the rule against the admissibility of hearsay . . . even where the admission is made by the party's agent"]). Moreover, by adverting to Dr. Ottenheimer's records, which attributed the plaintiff's lesions to a burn injury, the defendants' submissions reflected the existence of triable issues of fact as to whether the plaintiff's injuries could have been, or were, caused by an overheated metal speculum.

Additionally, the absence from the defendants' chart of any contemporaneous complaints of pain and discomfort made by the plaintiff during the subject examination does not "conclusively establish" that she did not make any such complaints (*see Cabrera v Golden,* 231 AD3d 149, 156 [1st Dept 2024] [absence of notation in chart indicating that decedent was questioned about a headache is not proof that he was not questioned]; *E.K. v Tovar*, 185 AD3d 803, 805 [2d Dept 2020] [lack of entry in medical chart that defendant physician was present in delivery room during the plaintiff's intubation does not conclusively establish his absence]; *Melendez v Parkchester Med. Servs., P.C.*, 76 AD3d 927, 928 [1st Dept 2010] ["the absence of a notation in the hospital records indicating that the decedent was questioned about her pertinent prior medical history is not proof that she was not so questioned"]; *Cerny v Williams*, 32 AD3d 881, 884 [2d Dept 2006] [same as *E.K.*]; *Krapivka v Maimonides Med. Ctr.*, 119 AD2d 801, 801-802 [2d Dept 1986] [same as *Melendez*]).

The defendants did, however, make a prima facie showing that Dinnall took a proper medical history of the plaintiff, and that a pap smear test was not contraindicated. Inasmuch as Dr. Goldstein did not address those claims, the defendants must be awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon

those claims. Nonetheless, since the court concludes that the defendants failed to establish their prima facie entitlement to judgment as a matter of law in connection with the remainder of the claims underpinning the medical malpractice cause of action, the remainder of that branch of their motion seeking summary judgment dismissing the medical malpractice cause of action must be denied, regardless of the sufficiency of the plaintiff's opposition papers. In any event, even had the defendants made the necessary prima facie showing, the plaintiff would have raised triable issues of fact in opposition thereto with their submissions, including Dr. Goldstein's affirmation, whose opinions the court concludes were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the plaintiff (*Wiands v Albany Med. Ctr*., 29 AD3d 982, 984 [2d Dept 2006]), as well as a copy of Dinnall's invoice to the plaintiff for the services that were rendered, which billed the plaintiff for "Colpo w/Biopsy and ECC." This document established that Dinnall invoiced the plaintiff for performing a colposcopy, one of the very procedures with respect to which Dinnall conceded that she employed a metal speculum. Hence, there clearly is a triable issue of fact as to whether Dinnall employed a metal speculum. Moreover, Dr. Goldstein's affirmation also raised triable issues of fact as to whether an overheated metal speculum caused the lesions on the plaintiff's labia, whether those lesions were caused by burns, and whether the burns caused or contributed to all of the sequellae of which the plaintiff now complains. Consequently, that branch of the defendants' motion addressed to the remainder of the medical malpractice cause of action would have been denied on that ground as well.

The elements of a cause of action to recover 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]). 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]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Since the defendants did not address the lack of informed consent cause of action in their motion papers, they have failed to establish their prima facie entitlement to judgment as a matter of law, and that branch of their motion seeking summary judgment dismissing that cause of action must be denied.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] 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]). In opposition to the defendants' prima facie showing in this regard, the plaintiff's expert did not address this issue and, hence, summary judgment must be awarded to the defendants dismissing that cause of action.

"'In general, under the doctrine of respondeat superior, a hospital [or corporate healthcare provider] 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]).

There is no dispute that Dinnall was employed by Columbus Circle when she performed the May 28, 2008 examination upon the plaintiff. Hence, to the extent that there are triable issues of fact as to whether Dinnall committed malpractice or failed to obtain the plaintiff's fully informed consent to a vaginal examination with a metal speculum, there are triable issues of fact as to whether Columbus Circle may be held vicariously liable therefor.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing the negligent hiring, training, supervision, retention, and credentialing cause of action, and so much of the medical malpractice cause of action as was premised upon the defendants' failure to take a proper medical history and performance of a contraindicated pap smear test, that cause of action and those claims are dismissed, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the attorneys for all of the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, November 18, 2025, at 10:30 a.m., at which time they shall be prepared to discuss resolution of the action, and the scheduling of both a future two-hour settlement conference and a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

10/24/2025
DATE

JOHN J. KELLEY, J.S.C.

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