

Diaz v Harlin
2019 NY Slip Op 32425(U)
August 6, 2019
Supreme Court, New York County
Docket Number: 805662/15
Judge: Joan A. Madden
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op <u>30001</u> (U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11

----- X
ALEJANDRO DIAZ and BELKIS DIAZ,

INDEX NO. 805662/15

Plaintiffs,

-against-

BRIAN HARLIN, EDWARD CHAU and
NEW YORK UNIVERSITY LANGONE
MEDICAL CENTER,

Defendants.

-----X
JOAN A. MADDEN, J.:

In this action for medical malpractice and lack of the informed consent, defendants Brian Harlan (Dr. Harlan), Edward Chau (Dr. Chau) and New York University Langone Medical Center (NYU) move for summary judgment dismissing the complaint against them. Plaintiffs partially oppose the motion.

Background

This action arises out of a laparoscopic sigmoid colon resection for sigmoid diverticulitis¹ performed on the then 57 year-old plaintiff Alejandro Diaz (“Diaz”) by Dr. Harlan at NYU on August 6, 2013, and the pre-operative and post-operative treatment in connection with this surgery. At oral argument, plaintiffs confirmed that they do not oppose the summary judgment

¹According to defendant’s expert, “[d]iverticulitis is inflammation or infection of the diverticula - small, bulging pouches that can form in the lining of the digestive system - that develop along the intestines, at the weakest, thin-walled spots [and that] [t]he most common cause of a colovesicular fistula is diverticulitis. The mechanism of the fistula's development is the direct extension of a ruptured diverticulum or secondary erosion of a diverticular abscess into the bladder. Diverticula develop in the sigmoid colon because of the increase in pressure within the colon resultant from the propulsive mass movement. Because diverticula develop at the weak point where the vessels penetrate the wall, they can perforate or cause infection, inflammation, abscess, or, in a chronic state, a fistula.” (Sher Aff. ¶ 48).

motion to the extent it seeks to dismiss that part of the medical malpractice claim arising out of Diaz's pre-operative treatment and the subject surgery, or the lack of informed consent claim. In addition, plaintiffs do not oppose the dismissal of the claims against Dr. Chau, the resident who assisted with Diaz's surgery. Accordingly, the remaining issues on this motion concern Diaz's post-operative treatment by Dr. Harlin between August 9, 2013 and December 17, 2013, including in connection with his treatment of Diaz at NYU in November 2013.

With respect to Diaz's post-operative treatment, the Bills of Particulars and Amended Bills of Particulars, allege that defendants were negligent in prematurely discharging Diaz and in failing to promptly monitor Diaz postoperatively by failing to recognize, treat, test for, and operate on, Diaz's bowel injury and fistula. As for causation, plaintiffs allege that as a result of these departures, Diaz was caused to sustain various injuries, including aggravation of a colovesicular fistula and diverticulitis, feculent drainage and bladder perforation, bladder repair, a colostomy and colostomy reversal, infection, extended hospitalization, debilitation and weight loss and other associated injuries in Diaz's lifestyle and mental condition. Plaintiff Belkis Diaz, who is Diaz's wife, seeks damages for loss of spousal services, companionship and consortium.

The subject surgery was performed by Dr. Harlin to address Diaz's severe diverticulitis involving the colon and sigmoid colon (Defendants' Exhibit M, Records of New York Hotel Trades Council at Harlem Hosp at 209; Harlin EBT at 18-20). Dr Harlin testified that during the surgery, he found inflammation consistent with the CT scans, that was suggestive of a fistula, and used blunt dissection to resect to sigmoid colon from the bladder (Id at 28). He then inspected the remaining colon and small bowel and found no remaining evidence of any other fistulas and connected the distal left colon to the proximal (higher up) rectum (Id at 28; 35-39;

Exhibit K at 18).

Following the surgery, plaintiff remained at NYU from August 6, 2013, to August 9, 2013. Dr. Harlin examined Diaz three times in the first postoperative month (on August 14, 28 and September 4, 2013), during which time Diaz reported eating well and feeling good (Exhibit M at 298-299). During the September 4, 2013 visit, it was indicated that Diaz had clear drainage from the incision, which were treated by cauterizing the granular tissue and redressing the wound (Id at 297). On September 11, 2013, Diaz returned to Dr. Harlin and reported he had experienced a fever the day before and some discomfort urinating, and Dr. Harlin noted that the incision was open 2 cm with excess granulation and purulent drainage, though less than previously existed (Id at 296; Harlin EBT at 44-45). Dr. Harlin documented his belief that Diaz may be experiencing a “smoldering wound infection” at the incision (Id). Dr. Harlin testified, however, that the intact fascia and lack of abdominal symptoms was evidence against a deeper infection (Harlin EBT at 45). Dr. Harlin prescribed Ciproflaxacin empiric antibiotic (“Cipro”) and recommended follow-up in two weeks to evaluate the wound and instructed Plaintiff to return sooner if the fever persisted or if abdominal pain developed (Id at 48; Exhibit M at 296).

On September 20, 2013, before his scheduled visit with Dr. Harlin, Diaz presented to Harlem Health Center with abdominal and rectal discomfort (Id at 251). Diaz was instructed to follow up with Dr. Harlin, which he did on September 25, 2013 (Id at 252). At the September 25, 2013 visit, Diaz reported feeling febrile and that he experienced some urinary hesitancy since his last visit (Id at 295; Harlin EBT at 46). Diaz also reported constipation with straining and rectal pain with blood in his stool and accompanying chills afterwards (Id; Exhibit M at 295). Dr. Harlin testified that Diaz denied fevers or pain while at work, that his physical examination

of Diaz found no tenderness on palpation of the abdominal wall or deep into the pelvis, and that Diaz had a post-midline fissure and was tight on digital rectal exam (Id at 46-47). Diaz's anoscopy was normal (Exhibit M at 295). Dr. Harlin indicated in the record that Diaz's rectal pain and bleeding were related to an anal fissure and ordered lab work and a urine analysis to rule out a urinary tract infection or other bladder problems (Id). Diaz was provided instructions for treatment of an anal fissure, including a high fiber diet and fluids to soften the stool, and was told to return in two weeks (Id; Harlin EBT at 49).

Diaz was seen by physicians at the Harlem Health Center on October 16, 2013, October 21, 2013, and October 28, 2013. During this time, he was diagnosed with an E.coli urinary tract infection and suspected diverticulitis, and his antibiotics were changed to Augmentin, Flagyl, and Pyridium after a susceptibility report showed that the infection was resistant to Cipro (Exhibit M at 245, 247, 249, 235)..

On October 30, 2013, Diaz saw Dr. Harlin and presented with granular urine (i.e. sediment in his urine), unspecified pain, and, for the first time since his pre-operative CT scan, pneumaturia (the passage of gas and air in urine) (Exhibit M at 222; 232). While Diaz reported eating well and having normal bowel movements, he also felt weak and tired (Id at 294). Dr. Harlin's physical examination showed no abdominal tenderness on palpation or fever (Id). Dr. Harlin noted the possibility of a "persistent fistula, although it seems unlikely" and ordered a CT scan with IV contrast (Id; Harlin EBT at 50-51).

On October 31, 2013, November 7, 2013, and November 8, 2013, Diaz was seen by physicians at Harlem Health Center for several urology follow-ups related to complaints of painful urination (Exhibit M at 355-357). A flexible cystoscopy performed on November 8, 2013

revealed inflammation in the bladder and changes on its left floor but a fistula site could not be seen (Id at 354). A CT scan performed on November 4, 2013 was reviewed by Dr. Harlin. (Id at 333-335). Dr. Harlin testified that based on his review of the CT scan images, he believed the study suggested that there was an anastomotic disruption that drained into the bladder (Harlin EBT at 59). He further testified that he was not concerned that Diaz had a recurrent fistula or untreated sigmoid diverticular disease because the sigmoid colon, the origin of the fistula, was clearly seen in the resected colon that was sent to pathology on August 6, 2013, at the time of the surgery (Id at 60). Instead, he suspected a new, anastomotic fistula (Id). Since Diaz had been minimally symptomatic on antibiotics, Dr. Harlin continued antibiotic coverage as it would control the risk of Diaz developing sepsis and would allow the anastomotic disruption to heal on its own, without surgical intervention, if given time (Exhibit M at 293). However, after speaking with the interpreting radiologist, Dr. Harlin ordered a barium enema to obtain a clearer understanding of the CT scan findings (Harlin EBT at 60; Exhibit M at 293).

Diaz presented to Dr. Harlin on November 13, 2013, at which time he he reported pain in the bladder and passing air (Exhibit M at 292). A cystoscopy was performed and showed air in the bladder and some inflammation, but no clear fistula (Id). Dr. Harlin noted in the medical record that he “was concerned that [Diaz] may have a disruption of the anastomosis that connected the previous fistula tract and now was a recurrent fistula” (Id). He remarked, however, that he was “confident that the diverticulitis was removed and pathology confirmed this. But there is a 1% leak rule with sigmoid colon resection and this may represent a minor form of this” (Id). Dr. Harlin indicates that he would order a “gastrograffin enema and take it from there”(Id).

Before Diaz underwent a gastrograffin study, he presented to NYU's Emergency Room on November 17, 2013, with complaints of acute rectal and bladder pain, diarrhea, and increased urination frequency with burning, and fecal matter in his urine (Exhibit K at 220-221; 225; 227). Lab work and a urine culture and analysis were ordered, and a CT scan was performed (Id at 222-223). Although the resident documented that the CT scan showed a "likely recurrent colovesicular fistula," Dr. Harlin testified that the primary concern at that time was for a new anastomotic fistula rather than a persistent fistula as the origin of the original colovesicular fistula had been removed on August 6, 2013 (Harlin EBT at 66).

After further discussions between the attending radiologist and Dr. Harlin, Diaz was discharged from NYU on the morning of November 18, 2013, with a prescription for pain medication (Percocet 10/325) and antibiotics (Augmentin 875-125 BID) and instructions to follow up with Dr. Harlin on November 25, 2013 (Id at 217). On November 22, 2013, Diaz underwent a sigmoidoscopy, performed by Dr Harlin, which revealed localized granularity and friability of the colon with no bleeding. Multiple biopsies were taken and sent to pathology. (Defendants' Exhibit L, Records from the Offices of Dr. Harlin, at 4-5).

Dr. Harlan testified that from the testing there appeared to be an anastomosis at 12 cm with a fistula but indicated that the presence of a fistula altogether could not be confirmed from the study (Harlin EBT 70-71; Exhibit L at 5). According to Dr. Harlin, he explained these results to Diaz relaying that, while there was evidence Diaz's condition was resolving, the specific issue remained unclear from testing (Id at 71-72). Dr. Harlin informed Diaz that in light of this improvement, that his white blood cell count remained normal, his abdomen was soft and benign, he was not experiencing significant abdominal pain, and he had been moving his bowels

normally after his fissure treatment, Dr Harlin determined that conservative management continued to be the correct course of treatment (Id at 71-72; 83-84). He recommended that Diaz resume his medications and undergo an MRI so he could better evaluate his symptoms, determine whether or not a fistula existed, and treat him accordingly (Id at 72). An MRI was ordered but there is no record of it ever being undertaken by Diaz.

On November 28, 2018, Diaz presented at Hackensack Medical Center (“Hackensack”) with complaints of pain that had become increasingly worse over the pervious two days, along with burning and difficulty urinating (Defendant’s Exhibit N, Medical Records from Hackensack Medical Center at 5). Plaintiff also complained of nausea, diarrhea, left lower quadrant pain, and right lower back pain² (Id at 5, 9). A CT scan revealed findings considered likely reflective of sigmoid diverticulitis with associated pericolic abscess formation resulting in pericolic fistula (Id at 12; 36). Surgery was consulted and Diaz was admitted for further evaluation (Id at 13).

Over the next few days, after attempts to place a Foley catheter were unsuccessful and, on December 5, 2013, Diaz underwent surgery (Id at 57). Due to significant inflammation identified intraoperatively at the colon, a diverting descending end colostomy was created to allow the inflammation to subside prior to further intervention (Id at 74-75; 85-86). Following the surgery, Diaz was treated with antibiotics, and was discharged from Hackensack on December 12, 2013, with the colostomy in place and a referral for home nursing care for wound and colostomy care (Id at 76). The colostomy was reversed at Hackensack Medical Center on May 3, 2014 (Id at 87).

²Diaz provided the physicians at Hackensack with Dr. Harlin’s contact information, but there is no record that there was an attempt to contact Dr. Harlin to discuss Diaz’s case (Id).

Defendants' Summary Judgment Motion

Defendants move for summary judgment, arguing that the record demonstrates that they did not depart from the standard of care in their treatment of Diaz, and that any departure was not a proximate cause of injuries alleged in this action. In support of their summary judgment motion, defendants submit the affidavit of Mark Sher, MD, a physician licensed to practice medicine in New York who is Board Certified in Colon and Rectal Surgery and General Surgery.

With respect to the post-surgical care and treatment of Diaz, which remains at issue on this motion, Dr. Sher opines that defendants properly monitored Diaz following his surgery and prior to his discharge from NYU and that Dr. Harlin's care and treatment of Diaz following the surgery was at all times appropriate and in accordance with good and accepted standards of care. Specifically, he opines that Diaz's complaint of clear drainage from the incision with granulation tissue during the August 28 and September 4, 2013 post operative visits were appropriately treated by Dr. Harlan "by cauterizing the granulation tissue and redressing the wound" (Sher Aff. ¶ 65), and that Diaz's complaint at the September 11, 2013 visit of discomfort in urination was properly treated with antibiotics (Id ¶ 66). He also opines that Diaz's complaints at the September 25, 2013 visit of of urinary hesitancy, constipation with straining, rectal pain with blood in his stool, and accompanying fever and chills were appropriately address by Dr. Harlin when he performed a work up for a suspected anal fissure and ordered labs to rule out a urinary tract infection, which was positive, resulting in him prescribing antibiotics (Id ¶ 67).

As for the October 30, 2013 exam, where it was determined that Diaz was not improving and there was a new complaint of pneumaturia (the passing of gas in the urine), Dr. Sher opines that Dr. Harlin acted properly by ordering additional tests, including a CT scan with oral and IV

contrast, and states that the CT scan was timely performed on November 4, 2013, and that upon reviewing the results of the scan, Dr. Harlin “appropriately continued to suspect an anatomic leak or postoperative fistula.”(Id ¶ 69). Dr Sher opines that “because the impression of the November 4, 2013 CT Scan was unclear regarding the location of the inflammatory mass...it was not only appropriate, but necessary for Dr. Harlin to order a clarifying image,” which he did when recommended that Diaz undergo a gastrografiin enema. (Id ¶ 72).

As for Dr. Harlin’s and NYU’s treatment of Diaz after he went to NYU’s Emergency Room on November 17, 2013, Dr. Sher opines that “in light of [Diaz’s] complaints, symptoms, and the work up undertaken, the NYU physicians and Dr. Harlin appropriately decided to attempt further conservative treatment of the suspected anatomic leak or fistula by continued antibiotic coverage and instruction of close follow up with Dr. Harlin rather than the extreme step of surgical intervention..” (Id ¶ 75). He further opines that “the decision was in accordance with good and accepted standards since [Diaz] showed no signs of infection, peritonitis or sepsis...” (Id). In this connection, Dr. Sher notes that Dr. Harlin’s plan following Diaz’s discharge from NYU, included performing a sigmoidoscopy on November 22, 2013, the submission of specimens for pathological examination and ordering an MRI (Id ¶ 76).

Dr. Sher opines that “Dr. Harlin’s plan to closely follow [Diaz] and treat him with antibiotics so as to avoid a colostomy and, in turn, the need for colostomy reversal, was entirely appropriate, [and that] Dr. Harlin’s medical judgment and decisions concerning the conservative management of [Diaz’s] complaints and symptoms was particularly appropriate given the fact that, through November 2013, [Diaz] had not experienced any signs or symptoms of a systemic infection, such as an elevated temperature or elevated white blood cell count, and had not shown

any evidence of peritonitis, which would have been indicative of a more serious abdominal complication.” (Id at ¶ 77). Her further opines that “[t]he lack of progression to sepsis shows that Dr. Harlin’s plan to conservatively manage [Diaz] as not only appropriate, but was reasonably expected to work if given the necessary time to allow Plaintiffs colon and anastomotic site to naturally heal. (Id).

As for causation, Dr. Sher opines that Dr. Harlin’s decision to conservatively manage [Diaz’s] condition, rather than perform unnecessary additional surgeries, did not cause [Diaz’s] alleged damages [and that] [t]he damages claimed ... were the result of the alternative treatment undertaken by the non-party physicians at Hackensack as the conservative management effectuated by Dr. Harlin was not given sufficient time to permit healing without surgery. He further opines that “[t]he alternative surgical treatment plan undertaken by the physicians at Hackensack does not indicate that Dr. Harlin’s conservative treatment plan failed or that it was negligently recommended and undertaken.” (Id ¶ 78).

In opposition, plaintiff submits the expert affidavit of Dr. Saraswati D. Dayal, M.D., Diaz’s treating surgeon at Hackensack University Medical Center on December 3, 2013, who is Board Certified in both surgery and critical care. She states that based on her “own treatment and observations at surgery, as well as [her] review of the history and record of Mr. Diaz, ...[and the affirmation....of Dr. Sher, that she makes the affidavit with a reasonable degree of medical certainty.” Dr. Dayal opines that Diaz “lost a significant chance of avoiding extensive surgery and colostomy from the untreated fistula that existed from the time of his surgery August 6, 2013 until I operated on December 3, 2013” (Dayal Aff at 1). She also states that “[t]his fistula connected Mr. Diaz’ colon to his bladder, and allowed bowel contents to leak across the fistula

tract through his abdomen and to the bladder” (Id at 1-2). She states that “[a]ccording to his records, and deposition, Dr. Harlin intentionally elected to leave the distal end of the fistula open at the bladder with the explanation that it would close by itself. While this decision may be questionable, it is not the basis of my opinion” (Id at 2).

Instead, she opines that Dr. Harlin departed from acceptable medical practice in connection with Mr. Diaz’s post operative treatment. Specifically she states that:

Following that surgery, in visits between August 2013 and late November 2013, Mr. Diaz demonstrated multiple symptoms of a persistent or existent fistula which required surgical intervention. The visits, outlined in Dr. Sher’s affirmation highlight the persistent symptoms and test results that ultimately resulted in a diagnosis of fistula. It is particularly inappropriate that Dr. Harlin discharged the patient on November 18, 2013 with pain medication and more antibiotics; that he conducted a sigmoidoscopy on November 22, 2013 and confirmed the existence of a fistula and merely ordered an MRI. At that point, the patient came under my care at Hackensack University Medical Center. My findings at surgery confirmed, not only the fistula, but an inflammatory mass that involved both the colon and the bladder. The section of colon which was in the place of the sigmoid (which had been removed) was sacrificed, the fistula was cleared, and a very large adhesive inflamed mass was cleared. At this point, the colostomy was the only option.

(Id at 2) .

In this connection, she states that “on a post-operative visit on September 4, 2013, the wound was showing signs of ‘granulation tissue’ and a week later the patient had discomfort on urinating which was diagnosed as a UTI, notwithstanding that the bladder had been at the far end of a fistula and the wound was weeping purulent drainage.” (Id) In addition, she states that “on September 25, 2013 the patient had blood in his stool which Dr. Harlin thought might be an anal fissure [and that] [b]y October 30, 2013 the patient had air in the bladder (pneumaturia) which was positive evidence of a fistula” (Id). Dr. Dayal opines that “[a]t this point, whether it

was persistent old fistula, anastomotic leak from the joiner point to the bowel where the sigmoid had been removed, or an entirely new fistula, it did not matter. The patient needed resolution of the fistula at both ends, and continued conservative treatment at that point invited infection, inflammation and other damage” (Id at 2-3).

As for her findings during surgery, she opines that such findings “confirmed that Mr. Diaz should not have been continued along without surgical intervention for resolution of the fistula. Findings at surgery by Dr. Kim, the urologist, preliminary to my operation... show that the entire posterior wall of the bladder was completely inflamed.” (Id at 3) She further opines that “it was unrealistic, on the basis of the surgical findings, to expect that conservative treatment was appropriate for Mr. Diaz’ condition.” She opines that “to a reasonable degree of medical certainty, that conservative treatment worsened his condition and increased the likelihood that he would need the colostomy he underwent.” (Id). In support of her opinion, Dr. Dayal attaches the operative report for the December 3, 2018 surgery, and Dr. Kim’s operative report dated December 3, 2018, showing the results of a preoperative cystoscopy.

In reply, defendants argue that plaintiffs’ out-of-state expert affidavit (from New Jersey) does not satisfy the requirements of CPLR 2309(c) as it is not accompanied by “[a]n oath or affirmation taken without the state shall be treated as if taken within the state if it is accompanied by such certificate or certificates as would be required to entitle a deed acknowledged without the state to be recorded within the state if such deed had been acknowledged before the officer who administered the oath or affirmation.” Defendants argue that as Dr. Dayal’s affidavit is not accompanied by a certificate of conformity as required by CPLR 2309(c), it is a nullity.

Alternatively, defendants argue that if the court considers Dr. Dayal's affidavit that it is insufficient to raise a triable issue of fact as Dr. Dayal fails to address the opinions of Dr. Sher, relies on incomplete facts, and fails to incorporate citations to facts particular to the case supporting her opinions. Defendants also assert that plaintiffs have conceded by omission the dismissal of all claims regarding defendants' post-operative care of Diaz between August 6, 2013 and October 30, 2013. In addition, they argue the plaintiffs have failed to establish a legal basis for denying the motion as to NYU as it relates to Diaz's post-operative care based on plaintiff's presentation to NYU's emergency department on November 17, 2013, particularly as plaintiffs admit that Dr. Harlin, who is not an employee of NYU, managed Diaz's care, and plaintiffs' expert does not opine as to NYU's care and treatment. Defendants also argue that plaintiffs' expert affidavit is based on hindsight and mischaracterizes Dr. Harlin's post-operative care after October 30, 2019 and fails to raise an issue of fact as to causation.

Discussion

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Id.

In claiming that any treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. See Joyner-Pack v.

Sykes, 54 AD3d 727, 729 (2d Dept 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify “in what way” a patient’s treatment was proper and “elucidate the standard of care.” Ocasio–Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dept 2010). A defendant’s expert opinion must also “explain what defendant did and why.” Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 (1st Dept 2003)).

Here, with respect to the post-operative treatment remaining at issue on this motion, defendants have made a prima facie showing entitling them to summary judgment based on the expert opinion of Dr Sher that based on the medical evidence and Dr. Harlin’s testimony that defendants did not depart from the applicable standard of care in their care and treatment of Diaz.

Accordingly, the burden shifts to plaintiffs, as the parties opposing the motion “to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action.” Alvarez v. Prospect Hosp., 68 NY2d 320, 324-325. Specifically, this requires, in a medical malpractice action, that a plaintiff opposing a defendant’s summary judgment motion “submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact.... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant[’s]... summary judgment motion.” Id. at 324–25. In addition, a plaintiff’s expert’s opinion “must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered.”

Dallas-Stephenson v Waisman, 39 AD3d 303, 307 (1st Dept 2007)(internal citations and quotations omitted). If “the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation . . . the opinion should be given no probative force and is insufficient to withstand summary judgment.” Diaz v. Downtown Hospital, 99 NY2d 542, 544 (2002). On the other hand, “[t]he law is well settled that when competing experts present adequately supported but differing opinions on the propriety of the medical care, summary judgment is not proper.” See Rojas v. Palese, 94 AD3d 557 (1st Dept 2012).

Here, based on the opinion of plaintiffs’ expert, which is adequately supported by the record, including the medical records, plaintiffs have raised triable issues of fact as to whether Dr. Harlin departed from the applicable standard of care in connection with his post-operative treatment of Diaz and, in particular, by failing to perform surgery to repair the fistula earlier. As for causation, plaintiffs have demonstrated “the requisite nexus between the medical malpractice allegedly committed and the harm suffered” (Wasiman, 39 A.D.3d at 307), based on plaintiff’s expert’s opinion that the departures from the standard of care in connection with Diaz’s post operative treatment worsened Diaz condition and lead to his need for a colostomy.

With respect to defendants’ argument that plaintiffs conceded by omission the dismissal of all claims regarding defendants’ post-operative care of Diaz between August 6, 2013 and October 30, 2013, such argument is unavailing as the plaintiffs’ expert opinion is based on the period immediately following the August 6, 2013 surgery, and discusses plaintiff’s symptoms throughout the period should have alerted Dr. Harlin to “a persistent or existent fistula which required surgical intervention.”

Next, as to defendants’ argument that plaintiffs’ expert conclusion is based on hindsight

and “reasoning back” from the results of the surgery, such argument ignores that Dr. Dayal’s opinion is based on the symptoms documented by Diaz in the months following the August 6, 2013 surgery and leading up to his December 3, 2013 surgery at Hackensack.

In addition, contrary to defendants’ argument, the court may consider plaintiffs’ expert affidavit which was sworn before a notary public. See Ortiz v. City of New York, 129 AD3d 611, 612 (1st Dept 2015)(motion court properly considered out-of-state expert affirmation which was sworn to before a notary public). Furthermore, while Dr. Dayal’s affidavit was notarized in New Jersey and therefore under CPLR 2309(c) should be accompanied by a certificate of conformity, this defect is not a fatal to plaintiffs’ opposition. See Matapos Technology Ltd. v. Compania Andina de Comercio Ltda, 68 AD3d 672, 673 (1st Dept 2009)(the absence of a certificate as required under CPLR 2309(c) “is a mere irregularity, and not a fatal defect”); Rivers v. Birnbaum, 102 AD3d 26, 44 (2d Dept 2012)(trial court improvidently exercised its discretion in refusing to consider plaintiff’s expert affidavit submitted in opposition to summary judgment motion where affidavit was notarized in Massachusetts but did not include a certificate of conformity as required by CPLR 2309(c)); Bey v. Neuman, 100 AD3d 581, 582 (2d Dept 2012)(finding that the affidavit of plaintiff’s expert, which was notarized in Pennsylvania, may be considered by the court even though it lacked a certificate of conformity); but see Scott v. Westmore Fuel, Co., Inc., 96 AD3d 520, 521 (1st Dept. 2012)(trial court properly rejected plaintiff’s expert affidavit, which was notarized in New Jersey and lacked certificate of conformity, and where the expert was not disclosed until after the note of issue and certificate of readiness had been filed).

That said, however, as defendants argue, plaintiffs have failed to raise an issue of fact as

to whether NYU departed from standards of medical care in its treatment of Diaz at NYU on November 17 and 18, 2013, as plaintiffs' expert does not opine as to any departures by NYU in connection with Diaz's treatment during this hospital stay, and plaintiffs do not dispute that Dr. Harlin is not an NYU employee.

Conclusion

In view of the above, it is

ORDERED that defendants' motion for summary judgment is granted to the extent of dismissing the complaint and any cross claims against defendants Edward Chau and New York University Langone Medical Center, and dismissing that part of the medical malpractice claim against defendant Dr. Harlin arising out of Diaz's pre-operative treatment and the August 6, 2013 surgery, as well as the claim for lack of informed consent; and it is further

ORDERED that the caption is amended so as to delete these defendants Edward Chau and New York University Langone Medical Center from the caption and the amended caption which shall read as follows:

-----X

ALEJANDRO DIAZ and BELKIS DIAZ,

INDEX NO. 805662/15

Plaintiffs,

-against-

BRIAN HARLIN,

Defendant.

-----X

and it is further

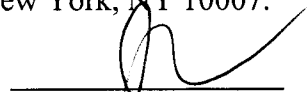
ORDERED, that defendants shall serve a copy of this order with notice of entry on the Clerk of the General Clerk’s Office (Room 119) and the County Clerk (room 141B), who are directed to mark the court records to reflect the removal of defendants Edward Chau and New York University Langone Medical Center from the caption; and it is further

ORDERED that such service upon the General Clerk’s Office and the County Clerk shall be made in accordance with the procedures set forth in the Protocol on Courthouse and County Clerk Procedures for Electronically Filed Cases (accessible at the “E-Filing” page and on the court’s website at the address (www.nycourts.gov/supctmanh)); and it is further

ORDERED that the remainder of the action shall continue as against Dr. Harlin; and it is further

ORDERED that remaining parties shall appear for a pre-trial conference on August 29, 2019 at 11:30 am in Part 11, room 351, 60 Centre Street, New York, NY 10007.

DATED: August 13, 2019



HON. JUAN A. MADDEN
J.S.C.