

Dignan v Vincent

2021 NY Slip Op 33630(U)

July 6, 2021

Supreme Court, Suffolk County

Docket Number: Index No. 617306/2016

Judge: Joseph A. Santorelli

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SHORT FORM ORDER

ORIGINAL

INDEX No. 617306/2016
CAL. No. 202000532MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 10 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH A. SANTORELLI
Justice of the Supreme Court

MOTION DATE 9/21/20
ADJ. DATE 12/10/20
Mot. Seq. # 001 MotD

-----X
JAMES DIGNAN, as Executor of the Goods,
Chattels, and Credits of CARA DIGNAN,
Deceased, and JAMES DIGNAN, Individually,

Plaintiff,

- against -

ROBERT OLIVER VINCENT, M.D., MARK
GELFEND, M.D. and INFECTIOUS DISEASE
ASSOCIATES, P.C.,

Defendants.
-----X

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Upon the following papers read on this e-filed motion for summary judgment : Notice of Motion/ Order to Show Cause and supporting papers by defendant Robert Vincent, M.D., filed September 21, 2020 ; Notice of Motion/Order to Show Cause and supporting papers ; Answering Affidavits and supporting papers by plaintiff, filed December 3, 2020 ; Replying Affidavits and supporting papers by defendant Robert Vincent, M.D., filed December 9, 2020 ; Other ; it is

ORDERED that the motion by defendant Robert Oliver Vincent, M.D., for summary judgment dismissing the complaint, or, in the alternative, for leave to serve an amended answer adding an affirmative defense pursuant to General Obligations Law § 15-108 is granted to the extent of dismissing the cause of action of lack of informed consent, and is otherwise denied.

This is a medical malpractice action brought to recover damages allegedly arising from the treatment of plaintiff's decedent and wife, Cara Dignan, then 43 years old, by defendant Robert Oliver Vincent, M.D., from August 12, 2013 to November 22, 2014. Plaintiff alleges that Dr. Vincent was negligent in, among other things, prescribing oxycodone and lorazepam. Plaintiff also sues, individually, for loss of services. By stipulation of the parties dated September 3, 2020, all claims against Mark Gelfend, M.D., have been discontinued.

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The facts of this case, subject to some dispute, can be summarized as follows: Mrs. Dignan had a history of physical injuries and ailments, often requiring hospitalization and surgery, psychiatric illness, and anxiety. She began treating with Dr. Vincent sometime before February 2013 for pain management. On November 26, 2014, Mrs. Dignan was found in a conscious, but incoherent, state on the bathroom floor of a hotel. Bottles of prescription medications were found in her hotel room and she was transported to Stony Brook University Hospital status post cardiac arrest. Mrs. Dignan passed away on November 28, 2014.

Dr. Vincent now moves for summary judgment dismissing the complaint on the grounds that he did not depart from good and accepted practices in the medical treatment he provided to plaintiff, that such medical treatment did not cause the alleged injuries, and that he was not required to obtain Mrs. Dignan's informed consent. In the alternative, Dr. Vincent seeks leave to amend his answer to assert an affirmative defense pursuant to General Obligations Law § 15-108. He submits, among other things, copies of the pleadings, the bill of particulars, the transcripts of his deposition testimony, the transcripts of the deposition testimony of plaintiff, Dr. Gelfand, Mariah Dignan, Kaylan Dignan, and Marilyn Bossert, various medical and pharmaceutical records, a death certificate, an autopsy report, and the expert affirmation of Christopher Gharibo, M.D. In opposition, plaintiff argues that triable issues of fact remain as to whether Dr. Vincent departed from the accepted standards of medical care, whether such departures caused Mrs. Dignan's injuries and death, and whether he obtained her informed consent. He submits, in opposition, a death certificate, a publication of the Federation of State Medical Boards, and the expert affirmation of Alexander Weingarten, M.D.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law by tendering evidence in admissible form sufficient to eliminate any material issues of fact from the case (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 508 NYS2d 923 [1986]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 487 NYS2d 316 [1985]). The movant has the initial burden of proving entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, *supra*). Once such proof has been offered, the burden then shifts to the opposing party who must proffer evidence in admissible form and must show facts sufficient to require a trial of any issue of fact to defeat the motion for summary judgment (CPLR 3212 [b]; *Alvarez v Prospect Hosp.*, *supra*; *Zuckerman v City of New York*, 49 NY2d 557, 427 NYS2d 595 [1980]).

To establish a claim for medical malpractice based on lack of informed consent, a plaintiff must prove: (1) that the person providing the professional treatment failed to disclose alternatives to such treatment, and the alternatives, and failed to inform the plaintiff of the reasonably foreseeable risks of such treatment that a reasonable medical practitioner would have disclosed in the same circumstances; (2) that a reasonably prudent patient in the same situation would not have undergone the treatment had he or she been fully informed of the risks; and (3) that the lack of informed consent was a proximate cause of the plaintiff's injuries (*see* Public Health Law § 2805-d [1]; *Wright v Morning Star Ambulette Servs., Inc.*, *supra*; *Dyckes v Stabile*, 153 AD3d 783, 785, 61 NYS3d 110 [2d Dept 2017]; *Schussheim v Barazani*, 136 AD3d 787, 24 NYS3d 756 [2d Dept 2016]). To establish the proximate cause element, a plaintiff must show that the operation, treatment or procedure for which there was no informed consent was a substantial cause of the injury (*Thompson v Orner*, 36 AD3d 791, 828 NYS2d 509 [2d Dept 2007]; *Trabal v Queens Surgi-Center*, 8 AD3d 555, 779 NYS2d 504 [2d Dept 2004]; *Mondo v Ellstein*, 302 AD2d 437, 754 NYS2d 579 [2d Dept 2003]).

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Dr. Vincent established prima facie entitlement to summary judgment dismissing the cause of action for lack of informed consent (*cf. Lavi v NYU Hosps. Ctr.*, 133 AD3d 830, 21 NYS3d 143 [2d Dept 2015]). Dr. Vincent's contention that he did not have a duty to obtain Mrs. Dignan's informed consent, as he did not perform surgery or an invasive procedure, is unavailing. However, his deposition testimony demonstrated that he explained the risks associated with the prescribed medications, as he testified regarding a pain management plan in the form of a "paper agreement" that both he and Mrs. Dignan signed that warned that "the substances are dangerous, the substances can become habit forming and if taken to excess, can have detrimental side effects." He also testified that every time he saw Mrs. Dignan, he repeated the risks and dangers of taking the prescribed medications and that she had to take them as directed. Dr. Vincent having met his prima facie burden on the motion with respect to the causes of action for lack of informed consent, the burden now shifts to the non-moving party to raise a triable issue of fact (*see Alvarez v Prospect Hosp.*, *supra*). In opposition, plaintiff failed to raise a triable issue of fact as to whether Dr. Vincent obtained Mrs. Dignan's informed consent. Therefore, the cause of action of lack of informed consent is dismissed.

Healthcare providers owe a duty of reasonable care to their patients while rendering medical treatment; a breach of this duty constitutes medical malpractice (*Dupree v Giugliano*, 20 NY3d 921, 958 NYS2d 312, 314 [2012]; *Scott v Uljanov*, 74 NY2d 673, 675, 543 NYS2d 369 [1989]; *Tracy v Vassar Bros. Hosp.*, 130 AD3d 713, 13 NYS3d 226, 288 [2d Dept 2015]). To recover damages for medical malpractice, a plaintiff patient must prove both that his or her healthcare provider deviated or departed from good and accepted standards of medical practice, and that such departure proximately caused his or her injuries (*Gross v Friedman*, 73 NY2d 721, 535 NYS2d 586 [1988]; *Macancela v Wyckoff Heights Med. Ctr.*, 176 AD3d 795, 109 NYS3d 411 [2d Dept 2019]; *Jagenburg v Chen-Stiebel*, 165 AD3d 1239, 85 NYS3d 558 [2d Dept 2018]; *Stukas v Streiter*, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]). To establish a prima facie entitlement to summary judgment in a medical malpractice action, a defendant healthcare provider must prove, through medical records and competent expert affidavits, the absence of any such departure, or, if there was a departure, that such departure did not proximately cause the plaintiff's injuries (*Joynes v Donatelli*, 190 AD3d 845, 140 NYS3d 241 [2d Dept 2021]; *Macancela v Wyckoff Heights Med. Ctr.*, *supra*; *Wright v Morning Star Ambulette Servs., Inc.*, 170 AD3d 1249, 96 NYS3d 678 [2d Dept 2019]; *Wodzinski v Eastern Long Is. Hosp.*, 170 AD3d 925, 96 NYS3d 80 [2d Dept 2019]; *Jagenburg v Chen-Stiebel*, *supra*; *Mitchell v Grace Plaza of Great Neck, Inc.*, 115 AD3d 819, 982 NYS2d 361 [2d Dept 2014]). The defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 912 NYS2d 77 [2d Dept 2010]; *LaVecchia v Bilello*, 76 AD3d 548, 906 NYS2d 326 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 866 NYS2d 726 [2d Dept 2008]). However, "bare conclusory assertions by defendants that they did not deviate from good and accepted medical practices . . . do not establish that the cause of action has no merit so as to entitle defendants to summary judgment" (*DiLorenzo v Zaso*, 148 AD3d 1111, 1112, 50 NYS3d 503 [2d Dept 2017], quoting *Winegrad v New York Univ. Med. Ctr.*, *supra* at 853; *see Garcia-DeSoto v Velpula*, 164 AD3d 474, 77 NYS3d 887 [2d Dept 2018]).

If the defendant establishes a prima facie case of entitlement to summary judgment, the burden shifts to the plaintiff to submit evidentiary facts or materials that raise a triable issue as to whether a deviation or departure occurred and whether this departure was a competent cause of plaintiff's injuries (*Williams v Bayley Seton Hosp.*, 112 AD3d 917, 977 NYS2d 395 [2d Dept 2013]; *Makinen v Torelli*, 106 AD3d 782,

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965 NYS2d 529 [2d Dept 2013]; *Stukas v Streiter, supra*). The plaintiff need only raise a triable issue as to the elements on which the defendant met the prima facie burden (*Joynes v Donatelli, supra*; *Bueno v Allam*, 170 AD3d 939, 96 NYS3d 623 [2d Dept 2019]; *Spiegel v Beth Israel Med. Ctr.-Kings Hwy. Div.*, 149 AD3d 1127, 53 NYS3d 166 [2d Dept 2017]; *Hernandez v Hwaishienyi*, 148 AD3d 684, 48 NYS3d 467 [2d Dept 2017]). “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 physician’s summary judgment motion” (*Alvarez v Prospect Hosp., supra* at 325; see *Wright v Morning Star Ambulette Servs., Inc., supra*; *Spiegel v Beth Israel Med. Ctr.-Kings Hwy. Div., supra*; *Hernandez v Hwaishienyi, supra*). Summary judgment is inappropriate in a medical malpractice action where the parties present conflicting opinions by medical experts (*Joynes v Donatelli, supra*; *Macancela v Wyckoff Heights Med. Ctr., supra*; *Lefkowitz v Kelly*, 170 AD3d 1148, 96 NYS3d 642 [2d Dept 2019]; *Lowe v Japal*, 170 AD3d 701, 95 NYS3d 363 [2d Dept 2019]; *Henry v Sunrise Manor Ctr. for Nursing and Rehabilitation*, 147 AD3d 739, 46 NYS3d 649 [2d Dept 2017]).

Dr. Vincent’s submissions established a prima facie case of entitlement to summary judgment dismissing the medical malpractice claim against him by demonstrating the absence of a deviation or departure from good and accepted standards of medical practice in the medical treatment rendered to Mrs. Dignan, and lack of proximate causation (see *Joynes v Donatelli, supra*; *Larcy v Kamler*, 185 AD3d 564, 127 NYS3d 122 [2d Dept 2020]; *Jagenburg v Chen-Stiebel, supra*; *Galluccio v Grossman*, 161 AD3d 1049, 78 NYS3d 196 [2d Dept 2018]). In his affirmation, Dr. Gharibo stated that he is board certified in anesthesiology and subspecialty certified in pain medicine and that he reviewed the bill of particulars, medical and pharmaceutical records, the autopsy report, New York State Prescription Registry records, and deposition testimony.

Dr. Gharibo opined that Dr. Vincent properly evaluated and treated Mrs. Dignan’s condition and used appropriate judgment in prescribing oxycodone and lorazepam. He stated that Mrs. Dignan needed these medications throughout the course of Dr. Vincent’s treatment for her long-standing anxiety and for pain management due to a severe and ongoing injury, and that prescribing this combination of medications was within the standard of care. He stated that Dr. Vincent prescribed dosages well-within CDC guidelines for a chronic pain patient, and prescribed medications for an appropriate period of time based on Mrs. Dignan’s complaints of pain and anxiety, while attempting to safely wean her from these drugs. Dr. Gharibo opined that Mrs. Dignan showed signs of drug-seeking and drug dependence over the years, including before Dr. Vincent’s care. He opined that keeping such a patient within the controlled confines of a physician’s care is the way to manage such a patient. He stated that Dr. Vincent acknowledged and was aware of Mrs. Dignan’s likely addiction and dependence of oxycodone and lorazepam, and that he closely followed her to assess her compliance with instructions and degree of functioning, and to safely wean her in a controlled environment.

Dr. Gharibo explained that in 2014, it was within the standard of care to prescribe benzodiazepines, such as lorazepam, and opioids, such as oxycodone, simultaneously. He stated that there are known risks to prescribe any medication or combination of medications, that they are evaluated by the physician and discussed with the patient, and that the patient is monitored to evaluate adverse reactions. He opined that Dr. Vincent appropriately followed Mrs. Dignan closely to determine any such adverse effects of her medication regimen and was attempting to taper her dosages. Dr. Gharibo also stated that specific dosage

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and administration instructions were provided to Mrs. Dignan for each prescription ordered. He stated that Dr. Vincent did not arbitrarily or indiscriminately modify the dosages of the prescribed drugs, as his records describe when and why he changed the dosages of drugs, most of which were to taper the dosages downward. Dr. Gharibo opined that Dr. Vincent documented as assessment of Mrs. Dignan's leg injury on each visit and took into account her pain and functioning in determining the dosages of medication.

Dr. Gharibo opined that Dr. Vincent was appropriately weaning Mrs. Dignan down from her previously higher dosages of medications despite continuing leg pain at the time of her last few visits. He explained that under-treating a patient like Mrs. Dignan could have severe repercussions, and that it would have been a departure for Dr. Vincent to "cut off" or reduce the medications too quickly, particularly in light of Mrs. Dignan's psychiatric comorbidities. He stated that under-treating a patient with pain and anxiety could lead to loss of control and suicide, depression, self-injury, and/or seeking illegal street drugs. He explained that the drugs must be tapered slowly to avoid withdrawal symptoms, which could have life-threatening consequences. Dr. Gharibo opined that Dr. Vincent appropriately prescribed and tapered Mrs. Dignan's medications using an acceptable risk/benefit analysis. He stated that plaintiff was on 120mg of opioids per day at her last visit with Dr. Vincent, which was within the CDC guidelines for chronic pain management patients and on the low end of the spectrum for advanced chronic pain patients. He stated that at Mrs. Dignan's last visit with Dr. Vincent, he prescribed 15mg of oxycodone and 2mg of dilaudid, which were the lowest strengths available, and, therefore, easy to taper. He explained that Dr. Vincent attempted to take Mrs. Dignan off oxycodone entirely during the October 2014 visit, but reinstated it when Mrs. Dignan could not tolerate the reduction in light of her recent hospitalization for compartment syndrome. Dr. Gharibo agreed with Dr. Vincent's judgment call to wean Mrs. Dignan from opioids before reducing lorazepam, an anti-anxiety medication that Mrs. Dignan was on prior to Dr. Vincent's care. He stated that it is safer to taper a patient off opioids than benzodiazepines. He stated that it was appropriate for Dr. Vincent to assess Mrs. Dignan as continuing to need lorazepam to cope with life-stressors, severe leg pain, many surgeries and hospitalizations, incarceration, and marital and family issues.

Dr. Gharibo opined that Dr. Vincent appropriately prescribed other modalities of pain management while attempting to wean Mrs. Dignan from opioids. He "applaud[ed]" Dr. Vincent's efforts to utilize opioid-sparing strategies to treat Mrs. Dignan's pain in further attempt to wean her off opioids by prescribing neurontin and elavil. He described Dr. Vincent's care as "exemplary," and opined that Dr. Vincent did everything he could to safely wean Mrs. Dignan from opioid use. He opined that Dr. Vincent's attempts to previously wean Mrs. Dignan from opioid use were thwarted by the treatment she received while incarcerated and again during her October 2014 hospitalization, which required him to "start over" with the drug taper.

He stated that Mrs. Dignan did not take up to 35 pills of lorazepam before her death for recreational use or because she was addicted to them. Dr. Gharibo opined that Mrs. Dignan was safely functioning for years by taking the combination of benzodiazepines and opioids in the amounts prescribed. He opined that Mrs. Dignan did not accidentally take a large quantity of lorazepam, but rather that this was a conscious decision to overdose. Dr. Gharibo opined that Ms. Dignan intentionally overdosed by taking much more than prescribed, as only eight pills should have been missing from the bottle based on Dr. Vincent's last prescription of a twice-daily 30-day supply. He opined that a suicide attempt was the reason for Mrs. Dignan's overdose, causing respiratory depression and death. Dr. Gharibo stated that Dr. Vincent gave Mrs.

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Dignan specific instructions with respect to taking the medications he prescribed, advising her to only take lorazepam twice per day and oxycodone every six hours, as needed for pain. He stated that Mrs. Dignan failed to follow these instructions and decided to take 35 pills of lorazepam in a short period of time on her own.

Dr. Gharibo concluded that Mrs. Dignan's overdose and death was not due to any departures by Dr. Vincent. He opined that the 0.35mg of oxycodone found in Mrs. Dignan's blood at the hospital did not cause her unresponsiveness or death, as it was a relatively small amount for a patient who had built up a high tolerance to opioids. He explained that the small amount of oxycodone, combined with a massive overdose of lorazepam, can cause unresponsiveness, respiratory depression, and hypoxia, which may lead to death, as it did in this case. He stated that her suicide attempt is further supported by the facts that her family kicked her out of their home, that she was undergoing a divorce, that she could not see her children due to an order of protection, that she was living in a hotel the day before Thanksgiving, that the hotel manager described her as upset, depressed, and appeared "out of it" and "nodding off" the day before she was found on the hotel floor, and that she did not want the hotel manager to call 911 when she was found. The burden, therefore, shifted to the non-moving party to submit admissible evidence raising a triable issue of fact (*see Jagenburg v Chen-Stiebel, supra; Williams v Bayley Seton Hosp., supra; Makinen v Torelli, supra; Stukas v Streiter, supra*).

In opposition, Dr. Weingarten stated that he is board certified in anesthesiology with a subspecialty in pain management and that he reviewed the bill of particulars, medical and pharmaceutical records, a death certificate, an autopsy report, and deposition testimony. Dr. Weingarten opined that Dr. Vincent did not possess the requisite expertise to prescribe Mrs. Dignan with the levels and dosages of oxycodone and lorazepam. He stated that Dr. Vincent should have referred Mrs. Dignan to a physician more qualified to assess her medical and pharmacological statuses. Dr. Weingarten opined that Dr. Vincent's treatment of high doses and frequency of opioids and benzodiazepines with disregard to a high risk patient placed Mrs. Dignan in danger of abuse and diversion of her medications, which ultimately resulted in her death.

Further, Dr. Weingarten determined that Dr. Vincent's treatment was contrary to the standard of care for pain management purposes and that he mismanaged Mrs. Dignan's treatment. He stated that prescribing opiates and opiates in combination with lorazepam was not warranted under the circumstances. Dr. Weingarten opined that Dr. Vincent deviated from the standard of care through his consistent and numerous prescriptions of high levels of oxycodone, lorazepam, opioids, and narcotics. He stated that Dr. Vincent's only consistent pattern in treating Mrs. Dignan was in prescribing opioids and benzodiazepines.

Dr. Weingarten stated that Dr. Vincent laid the foundation to allow Mrs. Dignan to access multiple opioid and benzodiazepine medications that could be used improperly and unsafely by prescribing a total of 300-360 tablets combined of the previously noted medications per month for a recently incarcerated patient and by not providing ongoing evidence that she was using these medications in a safe manner. Dr. Weingarten opined that Dr. Vincent failed to perform periodic pill counts to ensure Mrs. Dignan was taking the medications in a proper manner and that Dr. Vincent failed to monitor Mrs. Dignan, a high risk patient, with frequent toxicology screening examinations. He stated that it was essential and imperative that Mrs. Dignan undergo toxicology screening tests, such as blood test and urine tests, but that none were ever performed. He also explained that it was not difficult to check for medication conflicts and medication

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listings for a specific patient in 2013 and 2014. He stated that hospital computer systems, the New York State Prescription Monitoring Program, a physician's own internal notes, and consulting with other treating physicians are some ways to perform this task.

Dr. Weingarten opined that Dr. Vincent failed to follow the standard of care following Mrs. Dignan's release from prison by not lowering the dosages of medication and consulting with a prison staff member to obtain a clearer picture of her pharmacological status at that time. Dr. Weingarten stated that Dr. Vincent deviated from the standard of care when he failed to consult with Mrs. Dignan's parole officer or prison health care provider following her incarceration from February to August 2014 in order to determine the optimal and safest plan for any future pain management treatment. He opined that such a plan would include pharmacological and non-pharmacological therapies. He stated that instead of placing Mrs. Dignan on her pre-incarceration medication regimen, which she was off during her incarceration and was able to remain without any major side effects upon being discontinued from these medications, Dr. Vincent should have prescribed suboxone/buprenorphine as a safe detox medicine for long-term ongoing use. Dr. Weingarten determined that Mrs. Dignan was instead provided inappropriate prescriptions for opioids and lorazepam by Dr. Vincent. He explained that "schedule II" medications such as dilaudid, oxycodone, and lorazepam are not prescribed to inmates during their incarceration, so Mrs. Dignan would not have had the opportunity for opioid intake for these medications during her incarceration. He stated that Dr. Vincent continued to prescribe lorazepam, hydromorphone, oxycodone, and morphine after Mrs. Dignan's prison release, which went unchanged during October and November 2014. Dr. Weingarten concluded that Dr. Vincent's lack of due diligence in knowing what Mrs. Dignan was taking during her incarceration period was a deviation from the standard of care.

Dr. Weingarten also opined that Dr. Vincent deviated from the standard of care by failing to provide Mrs. Dignan with the opportunity to be weaned off of the prescribed medications. He opined that had Dr. Vincent followed the standard of care, he would have lowered Mrs. Dignan's dosages following her incarceration and she would have started to wean off the medications in a proper, safe, and timely manner. He stated that such a deviation enhanced, escalated, and encouraged her behavior, which resulted in her premature death. Finally, Dr. Weingarten opined that Dr. Vincent's deviations from the standard of care were a proximate cause of Mrs. Dignan's untimely death due to an accidental overdose.

As Dr. Weingarten described the applicable standards of care under the circumstances, how Dr. Vincent departed or deviated from the applicable standards of care, and that these departures were competent causes of Mrs. Dignan's injuries, Dr. Weingarten's affirmation is sufficient to raise triable issues of fact (*see Joynes v Donatelli, supra; Larcy v Kamler, supra; M.C. v Huntington Hosp.*, 175 AD3d 578, 106 NYS3d 382 [2d Dept 2019]; *Memoli v Winthrop-University Hosp.*, 147 AD3d 931, 47 NYS3d 128 [2d Dept 2017]). As the parties have presented conflicting opinions by medical experts as to whether a departure from good and accepted medical practice occurred and whether such departure was a proximate cause of the alleged injuries, an order granting summary judgment is not appropriate (*see Rich v Donnenfeld*, 191 AD3d 909, 138 NYS3d 381 [2d Dept 2021]; *Jagenburg v Chen-Stiebel, supra*).

In the alternative, Dr. Vincent seeks an order pursuant to CPLR 3025 (b) to serve an amended answer to add an affirmative defense under General Obligations Law § 15-108. As a general rule, motions for leave to amend pleadings are to be liberally granted absent prejudice or surprise resulting from the delay (*US*

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Bank, N.A. v Primiano, 140 AD3d 857, 32 NYS3d 643 [2d Dept 2016]). In tort actions involving multiple defendants, where a plaintiff settles with one or more defendants and then proceeds to trial against the remaining defendants, General Obligations Law § 15-108 permits the non-settling defendants to claim a monetary offset against the amount of a verdict against them (*Whalen v Kawasaki Motors Corp., U.S.A.*, 92 NY2d 288, 680 NYS2d 435 [1998]; see *Gonzales v Armac Indus.*, 81 NY2d 1, 595 NYS2d 360 [1993]). A claim under General Obligations Law § 15-108 is an affirmative defense and must be pled by a party seeking its protection (see CPLR 3018 [b]; *Whalen v Kawasaki Motors Corp., U.S.A.*, 92 NY2d 288, 680 NYS2d 435). Further, a party may amend its pleadings to raise a General Obligations Law § 15-108 defense at any time, even after trial, provided such amendment does not prejudice the opposing party (see CPLR 3025 [b]; *Whalen v Kawasaki Motors Corp., U.S.A.*, *supra*).

Although no papers have been submitted controverting the allegation that the action has been settled as against the Knights of Columbus in a separate action entitled *Cara Dignan, plaintiff, against Club 4651, Inc., Knights of Columbus Club 4651, Inc., and St. Regis Knights of Columbus, Columbiettes and Squires and Squirettes of St. Mary Bernadetter Circle Aima, defendants*, assigned index number 37095/2011, which may contain allegations of injuries related to the injuries alleged in this action, the papers submitted by Dr. Vincent are insufficient, as they fail to include a copy of the proposed amended answer (CPLR 3025 [b]; see *Mendoza v Enchante Accessories, Inc.*, 185 AD3d 675, 126 NYS3d 187 [2d Dept 2020]; *G4 Noteholder, LLC v LDC Properties, LLC*, 153 AD3d 1326, 61 NYS3d 319 [2d Dept 2017]). Therefore, the alternative relief is denied at this time, without prejudice to renewal.

Accordingly, the motion is granted to the extent of dismissing the cause of action of lack of informed consent, and is otherwise denied.

Dated: JUL 06 2021



HON. JOSEPH A. SANTORELLI
J.S.C.

 FINAL DISPOSITION X NON-FINAL DISPOSITION