

Patterson v Lopez-Flores

2007 NY Slip Op 30238(U)

March 9, 2007

Supreme Court, Kings County

Docket Number: 0006239

Judge: Bernadette Bayne

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At an IAS Term, Part 18 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, Brooklyn, New York, on the 9th day of March 2007.

P R E S E N T:

HON. BERNADETTE BAYNE

Justice.

LINDLEY PATTERSON,

Plaintiff,

- against -

ARTURO LOPEZ-FLORES,

Defendant.

DECISION AND ORDER

Index No. 6239/05

The following papers numbered 1 to 6 read on this motion:

Papers Numbered

Notice of Motion/
Affidavits (Affirmations) Annexed _____

1

Affirmations in Opposition _____

2

Reply Affirmations _____

3

Plaintiff in the instant action was a pedestrian involved in an automobile accident with defendant Lopez-Flores in the intersection of Archer Avenue and Guy R. Brewer Boulevard in

Queens, New York on October 1, 2003. Defendant moves for summary judgment and dismissal of the instant action, pursuant to CPLR § 3212, on the grounds that plaintiff has not met the “threshold” for a “serious injury” as defined in New York Insurance Law § 5102 (d).

Plaintiff, in his bill of particulars [exhibit F of the motion] claims that as a result of the accident he sustained a “subligamentos posterior disc herniation at the L5-S1 level, impinging on the anterior aspect of the spinal canal; posterior disc herniations at C3-4 and C4-5 impinging on the anterior aspect of the spinal cord; traumatic injuries to the left ankle, neck, mid and lower back; post concussion syndrome; cervical radiculitis; lumbar and cervical myofascitis; subluxations at the C1-2, C5, T10 and L5 levels, and spasm with tenderness of the lumbar spine”.

Summary judgment standard

The proponent of 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. See Alvarez v Prospect Hospital, 68 NY2d 320, 324 (1986); Zuckerman v City of New York, 49 NY2d 557, 562 (1980); Sillman v Twentieth Century-Fox Film Corp., 3 NY2d 395, 404 (1957). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers. Matter of Redemption Church of Christ v Williams, 84 AD2d 648, 649 (3d Dept 1981); Greenburg v Manlon Realty, 43 AD2d 968, 969 (2d Dept 1974); Winegrad v New York University Medical Center, 64 NY2d 851 (1985).

CPLR § 3212 (b) requires that for a court to grant summary judgment the court must determine if the movant’s papers justify holding as a matter of law, “that the cause of action or

defense has no merit.” The evidence submitted in support of the movant must be viewed in the light most favorable to the non-movant. Marine Midland Bank, N.A. v Dino & Artie’s Automatic Transmission Co., 168 AD2d 610 (2d Dept 1990). Summary judgment shall be granted only where there are no issues of material fact and the evidence requires the court to direct judgment in favor of the movant as a matter of law. Friends of Animals, Inc., v Associated Fur Mfrs., 46 NY2d 1065 (1979).

Discussion

The first issue to be addressed is the timeliness of the motion itself. The movant is the party that brought this issue to the Court’s attention. Since the movant has adequately explained the reasons for the late submission and Plaintiff’s opposition papers are completely silent on the issue of the timeliness of the motion, the Court finds the movant’s explanation to be satisfactory and the motion is therefore deemed timely submitted.

Regarding the main issue, in support of their motion, Defendant submits medical reports/affirmations from four different doctors. The most persuasive of the reports proffered by the defendant is that of Dr. Robert Orlandi, an orthopedist who examined the Plaintiff in June of 2006 and concluded that the plaintiff sustained cervical, thoracic and lumbar strains that are all resolved. [Exhibits J of the motion papers] In Dr. Orlandi’s report, he states that he conducted a physical examination of the Plaintiff and found that the Plaintiff had a full ranges of motion in his cervical spine and shoulders. “Cervical lordosis was to a normal 40 degrees...the claimant had a cervical range of motion to a normal 60 degrees of forward flexion and a normal 50 degrees of cervical extension...Lateral bending to the right and left was to a normal 40 degrees...There was a normal 70 degrees of lateral rotation to the right and left...Both shoulders

and scapulothoracic joints had a painless range of motion to a normal 180 degrees of abduction and a normal 180 degrees of forward flexion...There was a normal 70 degrees of external rotation and a normal 100 degrees of internal rotation...” Dr. Orlandi, similarly found the Plaintiff to have full ranges of motion in his thoracic and lumbar spines. “Thorocolumbar flexion was to a normal 80 degrees...Thoracic rotation was to a normal 50 degrees right and left, and thoracolumbar flexion to the left and right was to a normal 40 degrees...Thoracic kyphosis was to a normal 35 degrees.” “The examination of the lower back revealed lordosis to a normal 40 degrees...The claimant had a normal 80 degrees of forward flexion and a normal 30 degrees of extension...Lateral bend to the left was possible to a normal 30 degrees as was lateral bend to the right...The straight leg raising test was negative to a normal 80 degrees on the right and left side.”

The evidence proffered by the Defendant is sufficient for proving as a matter of law that plaintiff has not sustained a “serious injury” pursuant to Insurance Law § 5102 (d), and as such, the burden shifts to the plaintiff to demonstrate, by the submission of objective proof of the nature and degree of the injury, that he did sustain such an injury, or that there are questions of fact as to whether the purported injury was serious. “The affirmed medical report of defendants' examining physician, who examined plaintiff approximately 1½ years after motor vehicle accident and opined that he had no disability, was sufficient to satisfy defendants' burden, in personal injury case arising from accident, of making prima facie showing that plaintiff did not sustain serious injury within meaning of No-Fault Law; the report was based on the physician's findings with respect to the various ranges of motion of plaintiff's cervical and lumbar spines and shoulders, lack of tenderness or muscle spasm, and the fact that the neurological examination was normal and other tests showed no abnormalities”, Willis v. New York City Transit

Authority, 14 A.D.3d 696, 789 N.Y.S.2d 223 (2nd Dept. 2005).

In opposition to the Defendant's motion, plaintiff submits an attorney's affirmation, a copy of plaintiff's deposition transcript, a narrative medical report from Dr. Harold James, and a copy of plaintiff's summons and complaint. Initially, it should be noted that self-serving statements contained in plaintiff's attorney's affirmation, plaintiff's deposition transcript and the summons and complaint have very little probative value and will not typically serve as evidence that plaintiff has sustained a serious injury. "Evidence consisting of counsel's affirmation, a copy of plaintiff's deposition testimony, a copy of an accident report, and photographs of the damaged vehicle, were insufficient to raise a triable issue of fact as to whether plaintiff's injuries were serious within the meaning of the No-Fault Law", Oliva v. Gross, 29 A.D.3d 551, 816 N.Y.S.2d 110, (2nd Dept. 2006).

In his affirmed report, Dr. James states that the Plaintiff *initially* came to see him on October 25, 2006. Despite the fact that Plaintiff testified at his deposition that he received medical care and treatment at "Healthmakers" after the accident, (which appears to be the same facility with which Dr. James is affiliated), Dr. James' affirmation makes no mention of when the Plaintiff first came for treatment at "Healthmakers", and as indicated earlier, plaintiff's deposition testimony concerning when he started his course of treatment is self-serving, and therefore, not persuasive. More confusing is the fact that on the third page of his report, Dr. James also states that "the patient was last seen for final evaluation on 10/25/06." The confusion continues in that the report makes reference to both an "initial physical examination" as well as a "final physical examination". These contradictions beg the question of whether the exam that was conducted by Dr. James on October 26, 2006 was the one and only time that he had seen the

Plaintiff, or is the date listed for the initial exam in Dr. James' report a typographical error?

While it *seems* that Dr. James *may have* seen the plaintiff on more than one occasion, there is no persuasive proof of that for the Court to consider. Dr. James' final assessment of the Plaintiff includes diagnoses of loss of range of motion and herniated discs in his cervical and lumbar spines. However, in his affirmation, Dr. James fails to state what tests he conducted on the Plaintiff to arrive at his diagnosis. With regard to range of motion, the section labeled "final physical examination" fails to mention any range of motion tests conducted on plaintiff's cervical spine, and although he finds a decreased range of motion in plaintiff's "thoracolumbar spine", this in and of itself is not persuasive.

With regard to the diagnosis of herniated discs, there is no mention or indication that Dr. James personally reviewed the MRI films. Indeed, it appears that in forming his diagnoses and conclusions, Dr. James improperly relied upon the diagnosis of the radiologist that originally interpreted the MRI films. It should be noted that conspicuously absent from plaintiff's papers is a copy of the MRI report, much less an affirmation from the radiologist that interpreted it. In fact, aside from Dr. James' narrative report, no other medical reports, records or affirmations have been offered for the Court to consider. "The affirmation of plaintiff's physician, which improperly relied upon unattached and unsworn records and reports by other medical providers and failed to set forth objective medical tests utilized, was insufficient to raise a fact issue as to whether the plaintiff sustained a "serious injury" under the No-Fault Law as result of a motor vehicle accident, as required to preclude summary judgment in a personal injury action", Springer v. Arthurs, 22 A.D.3d 829, 803 N.Y.S.2d 170 (2nd Dept. 2005). See also Shay v. Jerkins, 263 A.D.2d 475, 692 N.Y.S.2d 730, (2nd Dept., 1999), wherein the Court ruled that the

“evidence offered was insufficient to establish that the plaintiff sustained a serious injury for purposes of no-fault law's threshold for tort recovery, where the orthopedist failed to indicate in his affidavit that he reviewed the actual magnetic resonance imaging test (MRI) films upon which his opinion was allegedly based, and failed to attach copy of sworn MRI report to his affidavit.”

Although the defendant's papers were silent on the next issue, the Court feels compelled to mention the unexplained gap in the plaintiff's treatment. At his deposition, which was conducted approximately 2½ years after the accident that is the subject of this lawsuit, plaintiff testified that he sought treatment at “Healthmakers” for a total of eight months, and that other than “Healthmakers” and Mary Immaculate Hospital, Plaintiff didn't receive treatment from any other doctor, facility or provider. [See plaintiff's EBT p37, lines 20-25, cont. p38, lines 2-10 attached to plaintiff's opposition papers as Exhibit A] Plaintiff further testified that after the eight-month period that he spent going to “Healthmakers”, he never sought treatment from any other medical providers. [Plaintiff EBT p39, lines 23-25, cont. p40, line 2]

Based upon this testimony, the Court deduces that the Plaintiff stopped receiving medical treatment for injuries related to the subject accident on or about June or July of 2004. There is a gap in treatment of approximately two years and three months between the time that the plaintiff stopped receiving treatment in June/July 2004 and the time of his exam with Dr. James in October 2006. Neither the Plaintiff, nor his expert, Dr. James offer any explanation for the gap in treatment. See generally, Pommells v. Perez, 4 NY3d 566, 830 N.E.2d 278, 797 NYS2d 380, (Court of Appeals, 2005). In Colon v. Kempner, 20 A.D.3d 372, 799 N.Y.S.2d 213, (1st Dept. 2005), the Court held that an “automobile passenger did not suffer from a serious

injury under the No-Fault Law, where there was a three-year unexplained gap in medical treatment for her back pain, her physician stated that further treatment would include therapy, medication, and medical follow-up for symptomatic relief, and the passenger said she took one pain pill a day and still had pain, but had not received any treatment following massage and heat therapy, which ended five months after accident.”

See also Neugebauer v. Gill, 19 A.D.3d 567, 797 N.Y.S.2d 541, (2nd Dept. 2005), wherein the Court held that the personal injury plaintiff failed to prove that she suffered the requisite "serious injury" within the meaning of the no-fault statute's provision governing the threshold for tort recovery; the plaintiff failed to elicit any testimony from her treating physicians, or introduce medical records in admissible form, establishing what treatment she received for her alleged injuries in the more than four-year period between the date of her accident and the examination conducted by her expert, and she failed to adequately explain the four-year gap in medical treatment.”

Plaintiff also attempts to argue that he sustained a “medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitutes such person’s usual and customary activities for not less that 90 days during the 180 days immediately following the occurrence of the injury or impairment”. However, other than plaintiff’s self serving testimony, there is no persuasive proof whatsoever that plaintiff was disabled for any period of time. Dr. James’ report contradicts itself again in that on one page, it indicates that the plaintiff was unemployed, but on another page it states that the plaintiff was working at a fast food restaurant, with a “no heavy lifting” admonition. Regardless of the contradictions, Dr. James never states that he

instructed the plaintiff to remain out of work for any period of time, and he also never states that the plaintiff's injuries prevented him from working, or performing his customary duties.

However, there exists an even more persuasive piece of evidence that the plaintiff in this case was not prevented from "performing substantially all of the material acts which constitutes such person's usual and customary activities for not less that 90 days during the 180 days immediately following the occurrence of the injury or impairment". Despite the fact that plaintiff's bill of particulars states that "the plaintiff was incapacitated from employment for approximately one year after the date of the accident", at his deposition, plaintiff testified that he was unemployed at the time of the accident; that he was receiving unemployment benefits at the time of the accident; and that he continued to collect unemployment benefits until January of 2004 when he started to seek employment. [See plaintiff EBT p13, lines 12-25, cont. p14, lines 2-21]

In order to collect unemployment benefits in New York State, the unemployed person must attest, on a periodic basis, that they are "ready, willing and able" to work. The fact that the plaintiff in this case continued to collect unemployment benefits in the weeks and months following his accident indicates that the plaintiff was indeed, "ready, willing and able" to work, and is therefore fatal to plaintiff's attempt to prove that he was prevented from performing substantially all of the material acts which constituted his usual and customary activities for not less that 90 days during the 180 days immediately following the occurrence of the injury or impairment.

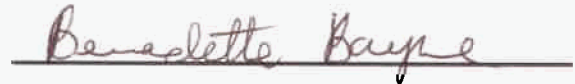
Conclusion

Accordingly, it is

ORDERED, that the motion of defendants for summary judgement and dismissal of the instant action, pursuant to CPLR § 3212, on the grounds that plaintiff has not met the “threshold” for a “serious injury” as defined in New York Insurance Law § 5102 (d), is granted.

This constitutes the Decision and Order of the Court.

E N T E R

A handwritten signature in cursive script, reading "Bernadette Bayne", is written over a horizontal line.

HON. BERNADETTE BAYNE

J. S. C.