Butler v Bruntel Realty Corp.
2018 NY Slip Op 32517(U)
October 4, 2018
Supreme Court, New York County
Docket Number: 157503/2013
Judge: Gerald Lebovits

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. GERALD LEBOVITS PART IAS MOTION 7EFM
Justice

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INDEX NO. 157503/2013

RICHARD BUTLER,

MOTION DATE 07/09/2018

Plaintiff,

MOTION SEQ. NO. 002

- v -

BRUNTEL REALTY CORP.,

Defendant.

DECISION AND ORDER

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The following e-filed documents, listed by NYSCEF document number (Motion 002) 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 54, 55

were read on this motion to/for DISMISSAL

Plaintiff alleges that cracked and loose tiles in his apartment kitchen caused him to fall and sustain serious injury to his feet. Defendant landlord moves for summary judgment on the basis of the contradictions between plaintiff's hospital records and his pleadings. The hospital records do not state that plaintiff fell.

In his complaint, his bill of particulars, deposition, and opposing affidavit, plaintiff alleges as follows. About midnight on November 9, 2011, he stepped into his kitchen, broken and loose tiles went out from under him, and he fell flat on his back with his legs outstretched. Plaintiff could not bend at the waist to get up. He hooked his feet under the kitchen cabinet to try to get up but could not. He tried to lay his foot flat to get traction so he could rise and could not. At his deposition, he testified that the efforts to get up caused his feet to become "torn up" and "a bloody mess" (Butler tr at 188, 199, NYSCEF 40). A large piece of skin came off on the bottom of the left foot near the big toe and the skin came off his toes on both feet.

Plaintiff stayed on the floor until his nephew came in the morning and got him up. Plaintiff did not go to the hospital that day. The next day, November 10, 2011, his nephew took him to the podiatry clinic at Bellevue Hospital where plaintiff had been treated before. Plaintiff was directed to the emergency room and that day was admitted to the hospital.

Surgery was performed on plaintiff's left foot, which included a skin graft being placed on the sole, which had become ulcerated. The skin graft was necessary because plaintiff suffered from peripheral vascular disease that prevented healing. Plaintiff was discharged from the hospital about December 23. His right foot worsened and the toes turned black and he returned to

the hospital. All the toes on his right feet had become gangrenous and were amputated. Plaintiff states that the fall caused the injuries on his feet.

Olabiyi Akala, M.D., a resident, made a record of his examination and treatment of plaintiff in the emergency room, which took place on November 10, 2011. During his deposition, Akala stated that he did not remember plaintiff. Akala was asked if the part of the record that stated "history provided by patient" indicated that the patient provided the information in the record (Akala tr at 19, NYSCEF 42). Akala answered "it doesn't necessarily" and that "it's kind of in the box you click . . . if patient . . . can't give you a history, sometimes you have to get a history from a collateral source, whether it is family or whoever" (*id.*). "If you click the box, then the patient gives the history usually" (*id.* at 20). He testified that the record contains his recollection of a conversation with the patient (*id.* at 28). Akala was asked if the note "represented . . . that Mr. Butler provided you with this statement, would it be in your custom and practice that it was Mr. Butler that provided this statement?" (*id.* at 29). He answered yes (*id.*).

The record made by Akala, which he read at the deposition, provided that plaintiff had a chronically infected left foot for three months, that he was returning to the emergency room because of increased pain, swelling, and blistering in his left foot for the past three days, accompanied by fever and chills. The record noted that plaintiff had peripheral vascular disease. The note said nothing about a fall. Akala testified that if he had been given that information he would have put it in the record, and that how the injury or wound occurred "would be an important part of the process" and could "possibly" determine treatment (*id.* at 22-23). Akala stated that knowing that plaintiff had a chronically infected foot for three months prior to an accident would be important to the treatment of plaintiff (*id.* at 23).

The second part of the November 10, 2011, hospital record was written by Susi Vassallo, M.D., the attending physician. She read her part of the record during her deposition. The record provides that she agreed with the resident's assessment and that "there is a point of penetrating injury on the plantar surface of the foot under the first metatarsal; patient states he stepped on a bamboo back scratcher two months ago; it did not break" (Hospital record, attached to NYSCEF 43). Vassallo testified that plaintiff's vascular disease meant that there was not a normal flow of blood to the foot, and that such "patients can have festering infections over time that can get worse" (Vassallo tr at 27, NYSCEF 43).

Vassallo testified that how the injury occurred was relevant to diagnosis and treatment, including the fact that plaintiff had sustained a "penetrating wound" (*id.* at 14). The part of the record that provides that "patient states he stepped on a bamboo back scratcher two months ago" is a direct statement from the patient (*id.*). "My practice is if I write patient states, that means the patient told me that" (*id.*). If he had told her anything else about how he was hurt or about tripping and falling on the kitchen floor, she would have put it in the record (*id.* at 15). That he lay on his back overnight would "not necessarily" be added to the record (*id.*). "Sometimes things like that, if somebody was down for a while, they might not relay everything because that would not be for me and would have gone to this diagnosis and treatment" (*id.*). If he told her he injured his foot by tripping and falling on his kitchen floor that would be in the record, as it would go to diagnosis and treatment (*id.* at 15-16).

Vassallo said that "penetrating injury . . . was a place where something entered on the bottom of the foot under the great toe" (*id.* at 16). She said that "I'm surprised that . . . the injury from two months before would present with such a severe infection to [sic] months later, unless there was a retained foreign body, which means there was some little splinter or something, a tendinitis, or a location of infection that was a continuing ongoing process" (*id.* at 17). "So I was looking for the possibility of bamboo stuck in the foot" (*id.*). The infection was "very serious," plaintiff had red streaking coming up from the foot, and fever (*id.* at 26). She said that the hospital record did not show injury to foot within the last two or three days (*id.* at 28).

Daniel Cuzzone, M.D., surgical resident, read his November 11, 2011, record during his deposition. The record provides that plaintiff "presents with 2-3 days of left foot swelling and redness that has not improved . . . he states that . . . feeling unwell in order to get himself out of bed he placed his feet underneath the dresser to pull himself up. He noticed he had bruising on his toes. Over the course of the next two days he developed a black blister over his" big toe joint and swelling . . ." (Hospital record, attached to NYSCEF 44). Cuzzone did not remember plaintiff (Cuzzone tr at 9, NYSCEF 44). Cuzzone testified that the record showed that plaintiff had peripheral arterial disease (*id.* at 12). Cuzzone said that he would have learned that the patient had peripheral arterial disease from "either from old records or from the patient himself" (*id.*). Cuzzone's record referred to a 2010 ankle ultrasound. He presumed he got it from the patient's older hospital records (*id.*).

Asked if the information in the record came from the patient, Cuzzone stated that "[i]f it is written in the chart, in this manner, it means that the patient did mention this. You're taking this as a firsthand encounter with the patient. This is what was discussed in dialogue" (*id.* at 14). Asked whether "this was would have been discussed with him directly," he answered "correct" (*id.*). Asked if it was important in regard to peripheral arterial disease and a foot injury to determine when the injury happened, he answered "yes, the temporality would help" (*id.* at 16). Asked if knowing the way the injury happened would help determine diagnosis and treatment he said it would (*id.*). Asked about the patient's statement in the record that he pulled himself out of bed, Cuzzone answered "I can only state that whatever is written there that's the case" (*id.* at 15). Cuzzone testified that he did not care where the furniture was; whether the dresser was in plaintiff's bedroom or kitchen, it would not matter to treatment (*id.* at 19-20).

Plaintiff states that he did not tell anyone that he had been having two to three days of foot pain, swelling, and redness or that he had felt unwell or that he ever placed his feet under the dresser to pull himself up. Plaintiff testified that, before the accident, he felt "grand," and that he had no medical problems, no vomiting, faintness, or cuts on his feet (Butler tr at 160, NYSCEF 40). He knew something was wrong with his legs because he tired easily, after walking four or five blocks. He had no wounds on his legs or feet or any part of his body. He denies telling the doctors that he tripped on a bamboo back scratcher or that he tried to get up by putting his feet under the dresser in his bedroom.

The proponent of a motion for summary judgment must show that the other side's claims have no merit (CPLR 3212 [b]), by evidentiary proof in admissible form, sufficient to warrant the court as a matter of law to direct judgment in its favor (*Bush v St. Claire's Hosp.*, 82 NY2d 738, 739 [1993]). The proponent's evidence must establish entitlement to judgment by

demonstrating the absence of any material issues of fact (*Thomas v Holzberg*, 300 AD2d 10, 11 [1st Dept 2002]). If the proponent of the motion meets this burden, the opponent of the motion must show the existence of genuine issues of fact needing to be resolved at trial, and the issues must be real not feigned (*Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; *Kornfeld v NRX Tech.*, 93 AD2d 772 [1st Dept 1983], *affd* 62 NY2d 686 [1984]).

According to defendant, the hospital records eliminate all issues of fact about how plaintiff was injured; the records show that plaintiff was not injured by faulty tiles in his apartment on November 9, 2011, but, rather, two to three months before that date. Defendant further contends that plaintiff's opposition to the motion is a feigned attempt to create an issue of fact.

The first issue is whether the hospital records constitute admissible evidence. In general, a hearsay entry in a hospital record is admissible under the business records exception to the hearsay rule if the entry is germane to the diagnosis or treatment of the patient (*Eitner v 119 W. 71st Owners Corp.*, 253 AD2d 641, 642 [1st Dept 1998]). "[T]he patient's explanation as to how he was hurt may be helpful to an understanding of the medical aspects of his case" (*Williams v Alexander*, 309 NY 283, 288 [1955]). Akala and Vassallo testified that knowing how the injury happened would enable them to better care for the patient. Vassallo testified that it was important to know if there was a foreign object in plaintiff's foot. Cuzzone testified that knowing when the injury occurred would aid in treatment. Thus, the records are admissible as they are germane to treatment and diagnosis.

Defendant also argues that the records are admissible as an admission. A hearsay entry in a hospital record as to the cause of an injury may be admissible at trial even if not germane to diagnosis, if the entry is inconsistent with a position taken at trial, provided there is evidence connecting the party to the statement (*Grant v New York City Tr. Auth.*, 105 AD3d 445, 446 [1st Dept 2013]; *accord Benavides v City of New York*, 115 AD3d 518, 519 [1st Dept 2014]). A motion for summary judgment "is the procedural equivalent of a trial" (*Rivers v Birnbaum*, 102 AD3d 26, 42 [2d Dept 2012]).

Akala was not certain that the information he recorded was told to him by plaintiff. But Vassallo and Cuzzone stated that, according to their habit and custom of making records, the records show that the information came from the patient. Their testimony is enough to connect plaintiff to the medical records.

Nonetheless, defendant fails to establish entitlement to summary judgment, because plaintiff testified during his deposition that he did not tell the doctors that he had been sick for three months before coming to the emergency room. Also, plaintiff submits an affidavit stating the same. The inconsistencies in the evidence raise a question of fact about how plaintiff was injured (*see Austin v Consilvio*, 295 AD2d 244, 246 [1st Dept 2002]).

Defendant cites cases in which the moving party showed that it was entitled to summary judgment because the other side admitted to certain facts in deposition transcripts, police reports, or accident reports. In each case, the court rejected the other side's affidavit in opposition to the motion as "an attempt to create feigned issues of fact designed to avoid the consequences of the

earlier testimony" and awarded summary judgment to the moving party (*Sunshine Care Corp. v Warrick,* 100 AD3d 981, 983 [2d Dept 2012] [finding affidavit contradicted earlier deposition testimony]; *Benedikt v Certified Lumber Corp.*, 60 AD3d 798, 798 [2d Dept 2009] [finding affidavit contradicted police accident report and the MV-104 accident report signed by party opposing motion]; *Nieves v JHH Transp., LLC,* 40 AD3d 1060, 1060 [2d Dept 2007] [finding affidavit contradicted police accident report and earlier deposition testimony]; *Sougstad v Meyer*, 40 AD3d 839, 840 [2d Dept 2007] [finding affidavit contradicted earlier deposition testimony]; *see also Capasso v Capasso,* 84 AD3d 997, 998 [2d Dept 2011] [finding affidavit contradicted plaintiff's signed statement]).

During his deposition, which is sworn and signed testimony, plaintiff in this case did not uphold the version of facts in the hospital records. Plaintiff's affidavit in opposition to the motion makes the same allegations as made in his deposition, his pleadings, and his affidavit. Therefore, the court cannot find that his affidavit is feigned. Unlike the cases defendant cites, this is not a case in which plaintiff said one thing in a deposition and another in an affidavit. It is noted also that the MV-104 accident report was signed; that may be one reason that it was taken as an admission against interest in *Benedikt* (60 AD3d at 798; *see Lebron v Mensah*, 161 AD3d 972, 974 [2d Dept 2018]). As for police reports, they are not always regarded as containing an admission (*see Ramos v Rojas,* 37 AD3d 291, 292 [1st Dept 2007]).

Accordingly, it is

ORDERED that defendant's motion is denied.

10/4/2018
DATE

GERALD LEBOVITS, J.S.C.

CHECK ONE: [ ] CASE DISPOSED [X] NON-FINAL DISPOSITION

APPLICATION: [ ] GRANTED [X] DENIED [ ] GRANTED IN PART [ ] OTHER

CHECK IF APPROPRIATE: [ ] SETTLE ORDER [ ] SUBMIT ORDER

[ ] INCLUDES TRANSFER/REASSIGN [ ] FIDUCIARY APPOINTMENT [ ] REFERENCE