



**SHORT FORM ORDER
SUPREME COURT - STATE OF NEW YORK**

Present:
HON. F. DANA WINSLOW,
Justice

BERNADETTE PIERRE,

Plaintiff,

-against-

**TONY GEVORKIAN and VARSENİK
GEVORKIAN,**

Defendants

**TRIAL/IAS, PART 12
NASSAU COUNTY**

MOTION DATE: 06/27/05

MOTION SEQ. NO.: 001

INDEX NO.: 10716/03

The following papers read on this motion (numbered 1-3):

Notice of Motion..... 1
Affirmation in Opposition.....2
Reply Affirmation.....3

Defendants Tony Gevorkian and Varsenik Gevorkians’ motion for summary judgment pursuant to **CPLR §3212** is determined as follows.

Plaintiff Bernadette Pierre, age 41 alleges that on December 15, 2001 at approximately 11:00 am, a vehicle owned and operated by her was involved in an accident with a motor vehicle operated by defendant Tony Gevorkian and owned by defendant Varsenik Gevorkian (collectively, the “defendants”). The accident occurred on McNiece Place, approximately fifty feet west of its intersection with Talon Way, Town of Huntington, County of Suffolk. Defendants now move for an order dismissing plaintiff’s complaint pursuant to **CPLR §3212**, on grounds that plaintiff failed to sustain a “serious

injury” within the meaning of **Insurance Law §5102(d)**.

Insurance Law § 5102(d) provides that a “serious injury means a personal injury which results in (1) death; (2) dismemberment; (3) significant disfigurement; (4) a fracture; (5) loss of a fetus; (6) permanent loss of use of a body organ, member, function or system; (7) permanent consequential limitation of use of a body organ or member; (8) significant limitation of use of a body function or system; or (9) 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 constitute such person’s usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment” (numbered by the court). The court’s consideration in this action is confined to whether plaintiff’s injuries constitute a permanent consequential limitation of use of a body organ or member (7) or significant limitation of use of a body function or system (8). The court finds that defendants have demonstrated a *prima facie* failure to prove a medically determined injury which prevented plaintiff from performing all of the material acts constituting her usual and customary daily activities for ninety days of the first one hundred eighty days following the accident (9).

In support of their motion for summary judgment, defendants submit an affirmed report of examination, dated October 20, 2004 of orthopedist Carl Austin Weiss, MD, an affirmed report, dated October 27, 2004 of neurologist Ira M. Turner, MD, and an affirmed report, dated October 14, 2004 of radiologist Alan B. Greenfield, MD.

Dr. Weiss found no restriction in range of motion of plaintiff’s head and neck, including full mobility in extension and forward flexion, normal coordination and normal examination of the knees, shoulders and arms. Dr. Weiss noted that motions of the low back were “slightly restricted” but he attributed this to plaintiff’s “underlying habitus.” Dr. Weiss concluded that plaintiff suffered from cervical and lumbar sprain injuries from which she recovered. Dr. Turner found plaintiff’s neck supple and spine nontender and

noted there was no pain on straight leg raising. Dr. Turner also found normal gait, strength, muscle tone and coordination, deep tendon reflexes of 2+ and symmetrical throughout and no Romberg sign. Dr. Turner concluded that plaintiff's neurological examination was normal. Dr. Greenfield examined MRIs of plaintiff's cervical spine conducted on January 17, 2002 and of plaintiff's lumbar spine conducted on January 22, 2002. With respect to the cervical spine, Dr. Greenfield found evidence of "diffuse degenerative disc disease." He concluded that the disc bulges at C5-C6 and C6-C7 are "degenerative and longstanding" and that the "shallow central disc herniation at C3-C4 and even smaller left paracentral disc herniation at C7-T1 cannot be attributed to the accident of 12/15/01." With respect to the lumbar spine, Dr. Greenfield concluded that plaintiff had degenerative disc disease along with a degenerative disc bulge and degenerative hypertrophic facet arthropathy at L5-S1, longstanding degenerative hypertrophic facet arthropathy at L4-L5 and a coexistent left paracentral disc herniation at L5-S1 all of which "cannot be attributed to the accident occurring on 12/15/01."

The court has reviewed MRI reports of plaintiff's cervical and lumbar spines. Plaintiff is permitted to submit these unsworn reports in opposition to defendant's summary judgment motion as a result of defendant's reference to these reports in the properly affirmed reports of defendants' medical experts. *See Kearse v. New York City Transit Authority*, 16 AD3d 45; *Ayzen v. Melendez*, 299 AD2d 381. The court reviewed the unaffirmed MRI report of plaintiff's lumbosacral spine dated January 22, 2002 by Douglas R. Cole, MD and unaffirmed MRI report of plaintiff's cervical spine, dated January 17, 2005 by Michael Streiter, MD. The court concludes that these reports are consistent with a finding of degenerative disc disease.

The court finds that the reports of defendants' examining physicians taken together are sufficiently detailed in the recitation of the various clinical tests performed and measurements taken during the examinations so as to satisfy the court that an "objective basis" exists for their opinions. Accordingly, the court finds that defendant has made a

prima facie showing that plaintiff Bernadette Pierre did not sustain a serious injury within the meaning of §§5102(d)(7) or (8), the only applicable sections. Consequently, the burden shifts to plaintiff to come forward with some evidence of a “serious injury” sufficient to raise a triable issue of fact. **Gaddy v. Eyler**, 79 NY2d 955, 957.

In her affidavit, sworn to June 13, 2005 submitted in opposition to defendants’ motion, plaintiff claims that after the accident she began treating with Dr. Titcomb, a chiropractor and later with Dr. Wani, a neurologist who sent her for MRIs of the neck and back. Plaintiff states that as she found it “too far to treat with Dr. Wani,” she returned to Dr. Titcomb. She claimed that she later stopped seeing Dr. Titcomb when her no-fault insurance no longer paid for treatment. She states that her problems persisted and deteriorated, especially those involving her right knee and that “as time went on, her knee got worse and worse.” Plaintiff asserts that her knee problems prompted her to see Dr. Chisnea who took x-rays and sent her for an MRI. Plaintiff asserts that after the accident she missed at least two weeks of work and three to four days of school, precluding consideration of a serious injury pursuant to §5102(d)(9).

Plaintiff states that although three years have passed since the accident, she continues to have headaches, terrible pain in her right knee, buckling of her right knee, pain and stiffness in her neck, shoulders, chest and back. She states that as a result she is unable to garden, perform housecleaning, take care of her children and is limited in her duties at work. She reports that she “recently” received trigger point injections from Dr. Wani.

The medical reports submitted by plaintiff include the affirmation of neurologist Shafi Wani, MD, dated June 13, 2005, affidavit of chiropractor John Titcomb, DC, PT, sworn to June 16, 2005 (improperly labeled as an affirmation even though notarized), unaffirmed MRI report of plaintiff’s lumbosacral spine, dated January 22, 2002 by Douglas R. Cole, MD and unaffirmed MRI report of the cervical spine, dated January 17, 2005 by Michael Streiter, MD. Plaintiff also submits various other unaffirmed reports

which were not adequately referred to by defendant's medical experts and consequently cannot be considered by the court. *See Kearse v. New York City Transit Authority, supra.*

In his affirmation of June 13, 2005, Dr. Wani states that his initial consult was on January 15, 2002 followed by "evaluation and/or testing" on January 22, 2002, January 29, 2002, January 31, 2002 and April 12, 2005. Dr. Wani found a "sensory deficit bilaterally C5-C6 and left L4-L5-S1," spasms in the right upper quadrant muscles, right lumbar and right lower extremity muscles, restrictions of range of motion for neck rotation, neck extension, lumbar extension and lateral flexion bilaterally and positive straight leg raising. Dr. Wani concluded that plaintiff suffers from "chronic posttraumatic myofascial pain and dysfunction syndrome with underlying disc disease." Dr. Titcomb treated plaintiff in 2001 on December 19 (initial evaluation), 26, and 31; in 2002 on January 4, 9, 10, and 18, April 10, 12 and 17 and May 1; and in 2005 on April 13, 19, 21, 27 and May 4. Dr. Titcomb reported that his 2001 and 2002 examinations revealed symptoms including restrictions (numerical measurements included) in left cervical rotation, left lateral flexion, modest to moderate right cervical spine myospasm, loss of trunk range of motion and myospasm, tenderness in the lumbosacral region and headaches. Dr. Titcomb reported that on April 13, 2005, plaintiff returned to his office for a reevaluation complaining of increased symptoms at which time Dr. Titcomb noted continuing restrictions in range of motion.

Plaintiff has submitted an unaffirmed report of plaintiff's lumbosacral spine, dated January 22, 2002 by Douglas R. Cole, MD who diagnosed a "L5-S1 subligamentous disc protrusion without spinal stenosis" and an unaffirmed report of plaintiff's cervical spine, dated January 17, 2002 by Michael Streiter, MD who diagnosed "multiple disc bulges/very small diffuse disc herniations of the cervical spine. Small annular tear, T1-2. No significant cord compromise." Plaintiff also submits electrodiagnostic studies, dated January 22, 2002, performed by Dr. Wani which revealed normal results. The court notes that it can consider these unsworn reports since the medical reports which rely on these

MRI and electrodiagnostic reports are in proper form. *See Pommells v. Perez*, 4 NY3d 566, 580.

It is the determination of this court that plaintiff has failed to submit *objective* medical evidence sufficient to raise a triable question as to whether or not she sustained a “serious injury” within the meaning of **Insurance Law § 5102(d)**. The court finds that the reports of electrodiagnostic studies are inconsistent with the medical report of Dr. Wani. Dr. Wani’s statement in his own neurological consultation notes, dated April 12, 2005, indicates that “electrodiagnostic studies and electroencephalogram noted to be normal.” In his affirmation of June 13, 2005, Dr. Wani merely states, without explanation, that plaintiff’s normal results of electrodiagnostic studies “do not contradict my findings of injury.” In fact, Dr. Wani even cites nerve conduction velocity results as support for his assertion that plaintiff suffers from “significant functional restrictions throughout her course of treatment” and “significant permanent injury from the subject accident.”

Plaintiff has not submitted affirmations from many of the other physicians and medical professionals mentioned in plaintiff’s deposition testimony and by Dr. Weiss and Turner (such as, Dr. Cormier, Dr. D’Ariano, Dr. Statler, Dr. Chisnea, and Dr. Allis). Plaintiff also fails to submit reports of various x-rays or MRIs allegedly taken of her right knee.

The court finds that the “gap in treatment” between the documented end of plaintiff’s treatments by Dr. Wani and Dr. Titcomb and the recent visits by plaintiff to Drs. Wani and Titcomb contradicts plaintiff’s claim that she suffered from a “serious injury” within the meaning of **Insurance Law §5102(d)**. “In the present case, the so called gap in treatment was, in reality, a cessation of all treatment.” *Pommells v. Perez*, 4 NY3d 566, 574. Dr. Wani reports that after the accident, plaintiff treated with him until January 31, 2002 but did not treat with him again until April 12, 2005. Dr. Titcomb’s treatment ended on May 1, 2002 and did not resume again until April 10, 2005. “While a cessation of treatment is not dispositive—the law surely does not require a record of needless treatment

in order to survive summary judgment—a plaintiff who terminates therapeutic measures following the accident, while claiming “serious injury,” must offer some reasonable explanation for having done so.” **Pommells v. Perez**, *Id* at 574.

Plaintiff has failed to submit notes or other reports from an insurance company physician to support the assertion that further treatment would only be palliative in nature. *See Pinales v. CSC Holdings, Inc.*, 2002 WL 31355602 (Winslow, J). The court notes that it is disingenuous for plaintiff to claim that further treatment would only be palliative and at the same time undergo multiple trigger point injection therapies in 2005. Plaintiff also does not provide proof to support her claim of lack of financial resources. *See McNeil v. Dixon*, 9 AD3d 481. Plaintiff also fails to provide an explanation for her visit to Dr. Chisnea or her sudden resumption of treatment with Dr. Wani. *See Pommells v. Perez, supra*, “Even where there is objective medical proof, when additional contributory factors interrupt the chain of causation between the accident and claimed injury—such as a gap in treatment, an intervening medical problem or a pre-existing condition—summary dismissal of the complaint may be appropriate.” **Pommells v. Perez**, *Id* at 572. *See Neugebauer v. Gill*, 2005 WL 1463185; **Mohamed v. Siffrain**, 2005 WL 1460300; **Batista v. Olivo**, 17 AD3d 494; **Garces v. Yip**, 16 AD3d 375; **Kearse v. New York City Transit Authority**, 16 AD3d 45; **Kulanda v. Ponce**, 13 AD3d 592; **Mooney v. Edwards**, 12 AD3d 424; **Yudkovich v. Boguslavsky**, 11 AD3d 607.

There is also insufficient evidence that plaintiff’s alleged injuries are permanent §5102(d)((7)). Drs. Wani’s assertion that plaintiff’s injuries are permanent is conclusory as he fails to offer any evidence of permanency. “Mere repetition of the word ‘permanent’ in the affidavit of a treating physician is insufficient to establish ‘serious injury’ and [summary judgment] should be granted for defendant where plaintiff’s evidence is limited to conclusory assertions tailored to meet statutory requirements.” **Lopez v. Senatore**, 65 NY2d 1017, 1019. *See also*, **Grossman v. Wright**, 268 AD2d 79; **Lincoln v. Johnson**, 225 AD2d 593; **Orr v. Miner**, 220 AD2d 567. Drs. Wani and Titcomb also make

conclusory assertions regarding plaintiff's abilities. Dr. Wani reports that at his April 12, 2005 examination, plaintiff exhibited limitations, pain and discomfort with "prolonged sitting, standing, taking the stairs, repeated bending, lifting, carrying and reaching." On April 13, 2005, three years after her last visit, Dr. Titcomb claims that plaintiff reported an increase in symptoms and limitations associated with daily living including work, stairs, walking and bending. Any statements of permanency of plaintiff's injuries are belied by plaintiff's deposition testimony that she returned to work approximately two weeks after the accident and missed only three to four days of school. *See Relaford v. Valentine*, 17 AD3d 339. The court notes that the plaintiff's complaints of limitations are also undermined by her testimony that she traveled to Disney World for two weeks in 2004 and Haiti in 2002.

Plaintiff's complaints of subjective pain do not by themselves satisfy the "serious injury" requirement of the no-fault law. *Scheer v. Koubek*, 70 NY2d 678; *Kivlan v. Acevedo*, 17 AD3d 321; *Rudas v. Petschauer*, 10 AD3d 357. Plaintiff's affidavit consists of self serving and conclusory statements with respect to her inability to do housework, take care of her children and shop at the mall and difficulty walking up and down the stairs at work which statements do not raise an issue of fact. *See Mercado v. Garbacz*, 16 AD3d 631; *Mooney v. Edwards*, *supra*.

The court is troubled by the extensive inconsistencies in the medical affirmations and affidavits submitted by plaintiff. Dr. Wani's affirmation of June 13, 2005 which fails to address right knee pathology even though plaintiff states in her affidavit that her "problems did not go away, they only got worse, especially my right knee." Dr. Titcomb noted plaintiff's knee complaints and on December 19, 2001 recommended an orthopedic consult "if symptoms persist." Plaintiff however does not submit MRIs or other tests covering her right knee. The medical affirmations also contain vague references to plaintiff's headaches but do not offer any treatment plan. In fact, plaintiff states in her affidavit that she complained to Dr. Wani of "constant, very painful headaches."

We have examined the parties' remaining contentions and find them to be without merit.

On the basis of the foregoing, it is

ORDERED, defendants TONY GEVORKIAN's and VARSENİK GEVORKIAN's motion for summary judgment dismissing the complaint by plaintiff BERNADETTE PIERRE on the grounds that plaintiff failed to sustain a "serious injury" within the meaning of Insurance Law § 5102(d) is granted.

Defendants shall serve plaintiff with copies of this Order, certified mail return receipt requested, within 15 days after entry of this Order in the records of the Nassau County Clerk.

This constitutes the order of the court.

Dated 9/12, 2005

ENTER:

[Handwritten Signature]
J.S.C.
ENTERED

OCT 11 2005
NASSAU COUNTY
COUNTY CLERK'S OFFICE