SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS Part MMESP6
HON. PATRIA FRIAS-COLÓN, J.S.C.

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Israel Stekel, as Administrator of the Estate of Chava G. Stekel, Deceased, and Israel Stekel, Individually,

PLAINTIFFS,

-against-

Aaron Weinreb, M.D., Robert Goodman, M.D., Maimonides Medical Center, and Asisa Acute Care,

DEFENDANTS.

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Index # 511058/2015
Cal. #s 1-3 Mot. Seq. #s 4, 6, 7

DECISION/ORDER

Recitation as per CPLR §§ 2219(a) and/or 3212(b) of papers considered on review of this motion:
NYSCEF Doc. #s 65-78; 110-112; 233 by Def. MMC
NYSCEF Doc. #s 99-124; 246 by Def. Weinreb
NYSCEF Doc. #s 125-143; 229-232 by Def. Goodman
NYSCEF Doc. #s 152-175; 177-199; 201-227 by Pls.

Upon the foregoing cited papers and after oral argument on May 6, 2025, pursuant to CPLR § 3212(b), the motions for summary judgment by Defendants Aaron Weinreb, M.D. (Motion Sequence # 6) and Robert Goodman, M.D. (Motion Sequence # 7), are each DENIED, whereas the motion for summary judgment by Defendant Maimonides Medical Center ("MMC") (Motion Sequence # 4) is GRANTED.

BACKGROUND

Plaintiff commenced this action sounding in medical malpractice and negligence against (among others) Dr. Weinreb and Dr. Goodman (physician Defendants), as well as Defendant MMC.[1] In essence Plaintiffs allege that Defendants (individually and collectively) failed to properly rule out retained products of conception and a uterine infection after a dilation and curettage procedure, which resulted in the death of Chava Stekel.[2] After discovery was completed and a note of issue was filed, Defendants separately moved for summary judgment. As noted, the Court heard oral argument on Defendants' motions on May 6, 2025, and reserved decision.

STANDARD OF REVIEW

Summary judgment is a "drastic remedy" that should be granted only where there is no material and triable issue of fact. *Sillman v. Twentieth Century-Fox Film Corp.*, 3 N.Y.2d 395, 404 (1957) *rearg denied* 3 N.Y.2d 941 (1957). The Court must view the evidence in the light most

[1] NYSCEF Doc. # 69, Summons and Complaint, dated September 8, 2019.
[2] NYSCEF Doc. # 152 at p.2.

favorable to the non-movant, drawing all permissible inferences in their favor. *De Lourdes Torres v. Jones*, 26 N.Y.3d 742, 763 (2016). In deciding a summary judgment motion, the Court must identify triable material issues of fact and may not invade the province of the jury by making credibility determinations or weighing the probative force of the evidence presented by each side. *See Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499, 503 (2012). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" because "[s]uch credibility issues can only be resolved by a jury." *Feinberg v. Feit*, 23 A.D.3d 517, 519 (2d Dept. 2005) (internal citation omitted).

Applying these principles in the light most favorable to non-movant Plaintiffs, the Court finds that triable issues exist as to the liability of the physician Defendants. Their own deposition testimony, with unsupported contemporaneous medical records and conflicting expert opinions, must be resolved by the trier of fact.[3]

DISCUSSION

a. Dr. Weinreb

Material issues of fact exist as to whether Dr. Weinreb, the patient's obstetrician-gynecologist, departed from accepted standards of care and whether such departures proximately caused or contributed to the decedent's injuries and death. A jury must resolve whether the patient's post-curettage uterine infection, ensuing sepsis, and ultimate death on November 8, 2013—approximately eight weeks after the procedure—were attributable to Dr. Weinreb's alleged negligence, including but not limited to:

1. Failure to prescribe/administer prophylactic antibiotics before or after the curettage;
2. Introduction of infection during the procedure;
3. Failure to identify and remove retained products of conception ("RPOC"), as opposed to only blood clots;
4. Omission of serial HCG testing post-procedure to rule out RPOC;
5. Failure to order hysteroscopy or repeat curettage to remove any RPOC;
6. Inadequate response to the patient's October 30, 2013 complaint of systemic weakness;[4]
7. Questionable prescription of NuvaRing despite ongoing vaginal bleeding[5].

See Petrolito-McCort v. Latefi, 237 A.D.3d 986, 988 (2d Dept. 2025); *Gupta v. Lescale*, 224 A.D.3d 668, 670 (2d Dept. 2024); *Roques v. Noble*, 73 A.D.3d 204, 207 (1st Dept. 2010).

b. Dr. Goodman

[3] The conflicting deposition testimony between Dr. Goodman and the patient's husband regarding receipt of the blood test reports raises triable issue. More specifically, Dr. Goodman alleges he never received the blood test reports and the patient's husband's gave pretrial testimony to the contrary. Additionally, the parties' respective experts' inconsistent assertions presents a credibility battle, requiring a jury to resolve.

[4] NYSCEF Doc. # 85, Dr. Weinreb's EBT transcript, page 175, lines 2-6 ("I...remember the October 30th phone call [in which] she told me she was feeling very weak[,]...walking with a cane[,]...and...very forgetful.").

[5] NuvaRing is an etonogestrel and ethinyl estradiol vaginal insert and a jury will have to determine whether it was appropriate to prescribe it despite the patient's vaginal bleeding and staining persisting after its placement.

Similarly, triable issues exist concerning Dr. Goodman, the patient's primary care physician. Plaintiffs' evidence raises questions as to whether Dr. Goodman failed to properly monitor and respond to the patient's deteriorating health condition,[6] regardless of whether he was aware of the prior curettage. Issues for a jury to decide include:

1. Whether he knew or should have known about the patient's recent procedure;[7]
2. Whether he appropriately evaluated her pancytopenia and systemic symptoms;[8]
3. Whether his failure to physically examine the patient or refer her to specialists between October 7 and November 6, 2013 constituted a breach of care (including given his unconfirmed suspicion that the patient was suffering from an active form of Cytomegalovirus).[9]

Contrary to Dr. Goodman's argument, his obligation extended beyond gynecological considerations to encompass the patient's general medical well-being.[10] Viewing the record in

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[6] the patient and her family maintained continuous contact given the documented office visits (both by the patient and, separately, by her husband) and numerous telephone calls between the patient and Dr. Goodman.

[7] The conflicting deposition testimony between the patient's husband and Dr. Goodman raises a triable issue to be determined by a jury. More specifically, the patient's husband's pretrial testimony that (1) his wife went to Dr. Goodman because she didn't feel comfortable the way Dr. Weinreb treated her, including telling her it was not his issue and (2) the patient told Dr. Goodman that Dr. Weinreb did a curettage procedure. Dr. Goodman's pretrial testimony indicates he was unaware of the patient's curettage procedure. NYSCEF Doc. #167, Patient's Husband's EBT transcript, page 67, lines 7-11; page 71, lines 3-6. *Compare* NYSCEF Doc. # 110, Dr. Goodman's EBT transcript (as corrected), page 70, line 17 to page 71, line 2; page 91, line 23 to page 92, line 15 (denying any knowledge of the patient's curettage procedure at the time of his pre-admission treatment of the patient).

[8] Pancytopenia is defined as a "[p]ronounced reduction in the number of erythrocytes [Hemoglobin], all types of leukocytes [White Blood Cells], and the blood platelets in the circulating blood." Stedman's Medical Dictionary, Entry No. 646930. Its features arise due to the combined impaired functions of the cell lines involved, and include fatigue, infection and bleeding. NYSCEF Doc. # 110, Dr. Goodman's EBT transcript (as corrected), page 34, line 21 ("[I]t is a primary physician's job to try to determine the cause of pancytopenia or refer the patient to a specialist."); page 36, line 18 (conceding that an infection can cause pancytopenia); page 38, line 14 ("Once again...it is a primary physician's job to try to rule out or rule in possible causes of pancytopenia or to refer the patient to a specialist.").

[9] Cytomegalovirus ("CMV") is defined as a "group of viruses in the family *Herpesvirida*e infecting humans and other animals, many of these viruses having special affinity for salivary glands, and causing enlargement of cells of various organs and development of characteristic inclusions (owl eye) in the cytoplasm or nucleus." Stedman's Medical Dictionary, Entry No. 226850. Although the patient's October 1, 2013 test was positive for the CMV antibodies (CMV IgM at 1.20 and CMV IgG at > 10), the test results were accompanied by a written caution that "[i]f an acute infection is suspected, consider obtaining a new specimen and submit for both IgG and IgM testing in two or more weeks." NYSCEF Doc. # 92, Dr. Goodman's records, October 1, 2013 test results from Shiel Medical Laboratory. Conversely, Dr. Goodman testified at his pretrial deposition (at page 99, lines 6-10; page 100, line 3; page 99, line 25; page 106, lines 17-18; page 107, lines 10-11) that he only "suspected" that the patient might have CMV because, at the time of the patient's October 7th visit, he only "had the IgG but not the IgM" values; in other words, that he did not see the October 1st test results which included both the IgG and IgM values at the time of her October 7th visit, but knew that the patient had "CMV at some point"; presumably, on October 9 when he instructed her by phone to repeat blood tests. In any event, approximately one month later November 7, 2013, in the course of the patient's terminal hospitalization at MMC, the repeated test for the CMV antibodies at 10:32 hours on that date indicated that the patient was *not* suffering from an active form of CMV. NYSCEF Doc. # 77, MMC's records. Patient's Medical Chart, pages MMC443-MMC444 and MMC675 (CMV IgM at < 0.2 on November 7 [compared to CMV IgM at 1.20 on October 1] and CMV IgG at 3.08 on November 7 [compared to CMV IgG at > 10 on October 1]). NYSCEF Doc. # 110, Dr. Goodman's EBT transcript (as corrected), page 64, line 23 to page 65, line 4 (testifying that CMV is in an acute stage only if CMV IgM is above 1.0); page 164, line 23 to page 165, line 16 (conceding that the patient's infection was bacterial in origin and that a viral infection "does not usually cause mortality.").

[10] In any event, Dr. Goodman assumed the duty to treat the patient's gynecological issues by diagnosing her with a

a light most favorable to Plaintiffs as non-movants, the record supports an inference that the patient's subsequent visits to urgent care and internists were prompted, at least in part, by Dr. Goodman's inadequate follow-up and treatment.[11]

Further, the absence of expert opinion from a pathologist in support of the physician Defendants' motions undermines their argument that post-hysterectomy pathology ruled out RPOC. In contrast, Plaintiffs' experts consistently opine that a uterine bacterial infection arising from RPOC contributed to the decedent's sepsis and death.[12] Without the submission of an expert pathologist's affirmation on the physician Defendants' behalf as part of their *prima facie* case, the negative pathology results which were obtained post-hysterectomy do *not* as a matter of law rule out the RPOC, considering the unanimous opinion of Plaintiffs' experts that the patient was suffering from a bacterial uterine infection as the result of the RPOC,[13] as summarized in the margin.[14]

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urinary tract infection and by prescribing her antibiotics (initially, Cipro; and, subsequently, Levaquin in place of Cipro). NYSCEF Doc. #92, Dr. Goodman's records, September 29, 2013 visit, pages 1-2; October 1, 2013 visit, pages 1-2; October 7, 2013 visit, pages 1-2.

[11] *See:* NYSCEF Doc. # 92, Dr. Goodman's records, October 7, 2013 visit, pages 1-2; NYSCEF Doc. # 167, Patient's Husband's EBT transcript pretrial testimony, page 95, lines 20-25; page 98, lines 11-14; page 99, lines 2-3; page 204, lines 20-23; page 209, lines 11-17 (testifying that he personally handed Dr. Goodman the results of the patient's subsequent, post-October 7th blood tests ordered by the nonparty healthcare providers). *Compare* NYSCEF Doc. # 120, Dr. Goodman's EBT transcript (as corrected), page 120, line 3 ("To be clear, the blood tests were not repeated...at my request."); NYSCEF Doc. # 110, Dr. Goodman's EBT transcript (as corrected), page 46, lines 20-22 ("I had a lot of walk-ins. There were a certain percentage [of patients] that had appointments, and a large percentage [of patients] that were walk-ins."); NYSCEF Doc. # 246, Patient's Husband's EBT transcript, page 246, line 18 to page 247, line 15 ("Dr. Goodman's office is a madhouse....You can wait a very, very long time....It's a community office;...everyone comes in over there."); and NYSCEF Doc. # 123, Thirteenth Avenue Pharmacy's records, entry for October 31, 2013.

[12] NYSCEF Doc. # 102, Expert Physician's Affirmation of Adiel Fleisher, M.D., a Board-Certified Obstetrician with sub-specialty in Maternal-Fetal Medicine, dated November 26, 2024, for Dr. Weinreb; NYSCEF Doc. # 103, Expert Physician's Affirmation of Bruce Farber, M.D., a Board-Certified Internist and Infectious Disease Specialist, dated November 22, 2024, for Dr. Weinreb; NYSCEF Doc. # 128, Expert Affirmation of Rosario Romano, M.D., a Board-Certified Internist, dated November 22, 2024, for Dr. Goodman.

[13] NYSCEF Doc. ## 156 and 204, Plaintiffs' Expert Obstetrician/Gynecologist's Affirmation, dated March 19, 2025, ¶¶ 88-89, 91-95; NYSCEF Doc. ## 157 and 205, Plaintiffs' Infectious Disease Expert's Affirmation, dated March 21, 2025, ¶¶ 69-70; NYSCEF Doc. ## 158 and 206, Plaintiffs' Expert Internist, dated March 19, 2025, ¶¶ 89-90.

[14] NYSCEF Doc. ## 157 and 205, Plaintiffs' Infectious Disease Expert's Affirmation, ¶¶ 72-74, 76, 80 ("[T]he pathology report [of the patient's uterus] describes [it] as abnormal and findings reported are all consistent with infection. It shows acute inflammation of the uterus and mild chronic inflammation in the endocervix. *No staining of the tissue for pathogens was performed per the pathology report, which is done when there is unclear etiology of infection, and therefore cannot rule out infection....[T]he lack of positive culture from the uterus does not rule out an infection for several reasons, in this case, with the main one being the single culture results [were] collected sub-optimally. The culture was done by a 'swab' of the tissue[,] instead of what is typically done when there is concern of infection, culture of the actual tissue....[A] section of the tissue should have been sent for both culture and gram stain* ...to assess for any pathogens. Sending the removed uterus tissue for culture would have been essential and standard practice in this case because the patient was critically ill with suspected [but] unidentified infection[,] and the uterus had already been removed....*[A] section of the tissue would allow the most optimal attempt to culture pathogens from exposure to deeper sections of the tissue where antibiotics may not have reached and/or for staining for pathogens within the tissue of the uterus for dead pathogens remaining in the tissue*. Despite the purpose of the urgent hysterectomy was for concern of an infectious source and source control, *tissue was not sent for culture. The 'swab' of the uterus surface sent for culture is inadequate for sampling purposes for culture growth....Owing to [the] limitations of swabs, only tissue and fluid specimens are typically sent from intraoperative specimens to ensure the best culture results. Cultures from swabs are known to often fail to identify deep tissue pathogens, and why only a swab was done on the infected uterine tissue and peritoneal fluid culture is unclear and not the standard of care, but*

c. Maimonides Medical Center

Unlike the physician Defendants, MMC has established its *prima facie* entitlement to summary judgment. Plaintiffs failed to raise a triable issue of fact as to whether any alleged delay in performing a hysterectomy upon the patient's admission proximately caused her death. Plaintiffs' expert opinion was conclusory and did not rebut MMC's showing that the infection had already progressed beyond the uterus by the time of admission.[15] *See Paxton v. Sosnowski*, 238 A.D.3d 779, 782 (2d Dept. 2025); *Kaur v. Jamaica Hosp. Med. Ctr.*, 237 A.D.3d 1178, 1180 (2d Dept. 2025); *E.G. v. Alzoobaee*, 237 A.D.3d 1052, 1053-1054 (2d Dept. 2025); *Daniels v. Pisarenko*, 222 A.D.3d 831, 833 (2d Dept. 2023), *lv denied* 42 N.Y.3d 903 (2024); *Nisevich v. Shorefront Ctr. for Rehabilitation & Nursing Care*, 216 A.D.3d 981, 983 (2d Dept. 2023).[16]

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a negative swab culture results is not unexpected in this case for all these described reasons....[N]either the ultrasounds, pathology or cultures performed on this patient adequately ruled out uterine infection. The only growth that was positive for 'scant growth' was the IUD tip, an indication of possible gynecological and/or uterine source of bacterial growth and infection in the setting of multiple course of antibiotics....I disagree that it is 'medically implausible' for a patient to have [RPOC] and uterine infection for nearly two months and then 'suddenly' develop multiorgan failure. *It is medically possible and quite common, as in [the patient's] case, to have an evolving infection, such as endometritis, that evolved into sepsis and her subsequent course and death*....[T]hough [the patient] was diagnosed with possible pneumonia based on [chest X-ray] and chest CT scan at [MMC] during her admission, *it is my opinion to a reasonable degree of medical certainty that she did not have pneumonia during those weeks of being ill and that was not the cause of her sepsis*. She had no cough or clear respiratory symptoms other than her general fatigue and weakness. The left lower opacity on chest imaging could certainly be a pneumonia resulting from the infection spread from the uterine through the bloodstream and to the lungs. It is well documented that sepsis in a patient can lead to bacteremia that causes spread of infection to other organs, most common as pneumonia. However, the opacity could also be consistent with ARDS [acute respiratory distress syndrome] as *by the time [the patient] was admitted to MMC, she was in severe sepsis and rapidly required intubation for respiratory support*. Her lack of respiratory clinical symptoms and laboratory test both do not support pneumonia as the source of infection after her [curettage]. Instead[,] *the pneumonia or opacity on lung imaging during admission is the result of a[n] untreated progressive uterine infection, either as a spread of infection into lung as pneumonia or ARDS from severe sepsis*.") (emphasis added).

[15] NYSCEF Doc. ## 156 and 204, Plaintiffs' Expert Obstetrician/Gynecologist's Affirmation, ¶¶ 100 and 106; NYSCEF Doc. ## 157 and 205, Plaintiffs' Infectious Disease Expert's Affirmation, ¶ 82. On admission to MMC at 3:09 am on November 6, 2013, the patient was extremely ill and hemodynamically unstable. At 3:38 am she was prescribed Ceftriaxone (an antibiotic) for a presumed "severe community-acquired pneumonia" which required that she be admitted to the intensive care unit, particularly because she underwent (at Dr. Goodman's prescription) a course of Levaquin 500 mg daily (a quinolone-type of antibiotic) in the preceding three months (*see* NYSCEF Doc. # 77, page MMC171, Patient's Medical Char, [ED Discharge Summary for the Medical ICU admission; Medication Order, dated November 6, 2013 and timed at 3:38 am]). By the second day of her hospitalization, November 7th, the patient progressed to: (1) respiratory failure and acute respiratory distress syndrome, requiring the extracorporeal membrane oxygenation; (2) septic shock either secondary to pneumonia or to a "possible florid pelvic sepsis"; (3) acute blood loss anemia; (4) pancytopenia; (5) disseminated intravascular coagulation; (6) elevated liver function tests (a sign of liver damage); (7) increased myoglobin and creatine phosphokinase levels (both signs of muscle damage); (8) encephalopathy; and (9) severe lactic acidosis. *See* NYSCEF Doc. # 77, Patient's Medical Chart, page MMC271 (Problem-Oriented Progress Note, dated November 7, 2013 and timed at 17:58 hours); page MMC286 (Interim Adult Note, dated November 7, 2013 and timed at 16:23 hours); page MMC318 (Metabolic Support Comprehensive Nutritional Assessment, dated November 7, 2013 and timed at 8:57 am). The patient passed away in the afternoon of the third day of her hospitalization, November 8.

[16] The dismissal of the medical malpractice and wrongful death claims as against MMC leads to the concurrent dismissal of the patient's husband's derivative claim for loss of consortium against it. *See Wittrock v. Maimonides Med. Ctr.-Maimonides Hosp.*, 119 AD2d 748 (2d Dept 1986), *lv denied* 68 N.Y.2d 607 (1986).

CONCLUSION

For the foregoing reasons, the motions for summary judgment by Defendants Dr. Weinreb and Dr. Goodman are denied. The motion by Defendant Maimonides Medical Center is granted.

The Court has considered the parties' remaining arguments and finds them unpersuasive or rendered academic by this determination.[17]

AMENDED CAPTION

In light of the prior unopposed dismissals of Defendants NYM Medical Associates and New York Methodist Hospital, and the granting of MMC's motion herein, the caption shall be amended accordingly as follows:

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Israel Stekel, as Administrator of the Estate of Chava G. Stekel, Deceased, and Israel Stekel, Individually,

PLAINTIFFS,

-against-

Aaron Weinreb, M.D., Robert Goodman, M.D., and Asisa Acute Care,

DEFENDANTS.
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This constitutes the Decision and Order of the Court.

Date: July 30, 2025
Brooklyn, New York

Hon. Patria Frias-Colón, J.S.C.

[17] The Court disregarded as irrelevant at this stage of litigation Plaintiffs' counsel's reference at oral argument to Dr. Weinreb's unrelated criminal conviction.