Friedman v Moshenyat
2026 NY Slip Op 31820(U)
April 17, 2026
Supreme Court, Kings County
Docket Number: Index No. 506485/2018
Judge: Ellen M. Spodek
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At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 17th day of April, 2026.

PRESENT:

HON. ELLEN M. SPODEK,
Justice.

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GREGORY FRIEDMAN, AS ADMINISTRATOR OF THE ESTATE OF OLGA FRIDMAN,

Plaintiff,

-against-

YITZCHAK MOSHENYAT, M.D.,

Defendants.

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DECISION AND ORDER

Index No. 506485/2018

MS #4

The following e-filed papers read herein: NYSCEF Doc. Nos.:

Notice of Motion, Affirmation, and Exhibits Annexed 65-88
Affirmation in Opposition and Exhibits Annexed 91-102

Defendant YITZCHAK MOSHENYAT, M.D. moved pursuant to CPLR 3212 for an Order granting summary judgment and dismissing the complaint made against him. Plaintiff GREGORY FRIEDMAN, AS ADMINSTRATOR OF THE ESTATE OF OLGA FRIDMAN opposed the motion.

Olga Fridman first presented to gastroenterologist Dr. Jane Vlodov on June 29, 2009 for a routine colonoscopy due to a family history of colorectal cancer. At the time of her presentment, her past medical history included obesity, osteoporosis, hypertension, atrial fibrillation, gout, dyspnea on exertion, fatigue, vertigo, and back pain. A colonoscopy was performed on September 1, 2009 and multiple polyps were removed. Pathology noted adenomatous polyps. At this time, Dr. Vlodov recommended repeat colonoscopy in 2-3 years.

Between 2009 and 2015, Fridman underwent cardiac surgery for mitral stenosis, requiring lifelong anticoagulation therapy. She was followed by her primary care physician and cardiologist for her chronic medical conditions which included new onset of lower extremity swelling due to chronic venous insufficiency, hypercholesterolemia, and fatty liver.

Fridman returned to Dr. Vlodov on August 4, 2015, and the request of Dr. Ilyayev for routine repeat colonoscopy. Leading up to the procedure, her only gastrointestinal complaint was diarrhea with dietary indiscretions. Contrary to her allegations, the referral was not due to complaints of anemia, feeling weak, or weight loss. The plan was for colonoscopy after cardiac clearance. Fridman was seen by cardiologist Dr. Chiam Kabalkin who provided instructions for reducing coumadin and bridging to Lovenox in anticipation of the colonoscopy, dependent on her INR values.

Fridman contacted Dr. Moshenyat to perform the colonoscopy and was admitted to Ambulatory Surgery at Maimonides on October 14, 2015. He endorsed the patient remaining on Lovenox to undergo the procedure due to her high risk.

After signing an informed consent form, the procedure was performed. According to the report, a polyp was seen in the descending colon. Because of the risk of bleeding, the patient was advised to return in 3-6 months to schedule a repeat procedure. The nurse at Maimonides had Fridman sign for receipt of discharge including repeat colonoscopy in 3-6 months. Dr. Moshenyat sent a report of the colonoscopy to Dr. Ilyayev which included the recommendation for follow-up colonoscopy in 3-6 months.

Between October 26, 2015 and May 5, 2016, Fridman saw Dr. Ilyayev twelve times. Dr. Ilyayev noted the findings on the colonoscopy though did not recommend follow-up per the report he received from Dr. Mosheyat. He treated Fridman for her chronic medical illness in conjunction

with physicians specializing in psychiatry (for depression and anxiety), hematology (for iron deficiency anemia), and pulmonology (for asthma) and cardiology.

Fridman was referred by Dr. Ilyayev to Dr. Kadirawel Iswara, a gastroenterologist, for iron deficiency anemia on May 18, 2016. His note documented that the last "CF: on 10/2015 was incomplete. The plan was to schedule colonoscopy and endoscopy after cardiac clearance. Fridman continued to be seen by Dr. Ilyayev, her hematologist, and her cardiologists but was not scheduled for colonoscopy.

On August 5, 2016, Dr. Iswara saw Fridman and ordered a CT scan of the abdomen and pelvis which was negative for acute intrabdominal disease. No visible dominant mass or pathologic lymphadenopathy was noted in the abdomen or pelvis. The radiologist noted that early superficial gastric or colonic malignancy may not be visible on CT. Consider further evaluation with colonoscopy and upper endoscopy, as clinically warranted.

On September 30, 2016, Dr. Iswara again advised colonoscopy. After cardiac clearance, the patient was admitted to Maimonides Medical Center on November 14, 2016. Dr. Iswara performed a colonoscopy identifying a lesion in the proximal ascending colon encompassing approximately 1/3 of the circumference of the lumen. An adherent clot was seen on top of the lesion which was lavaged. Targeted biopsies were taken of the lesion. The pathology report noted adenocarcinoma, moderately differentiated.

On November 16, 2016, Dr. Sherwinter performed a right hemicolectomy, lymph node dissection, and repair of a very large pre-existing umbilical hernia which was primarily closed at the end of the procedure. The pathology report noted moderately differentiated invasive adenocarcinoma with negative margins of resection and 23 negative lymph nodes. Following discharge from the hospital, Fridman followed with Dr. Iswara. She underwent surveillance

colonoscopy on November 13, 2017 and the pathology was negative for cancer. The next colonoscopy was performed on February 14, 2009 and also had no reoccurrence of cancer. On February 3, 2020 Fridman underwent another colonoscopy which again was negative for cancer.

A ventral wall hernia was found during a CT scan of the abdomen and pelvis performed on May 17, 2018. Dr. Sherwinter evaluated Fridman on June 12, 2018 and noted a reducible hernia. The created a plan for herniorrhaphy pending cardiac clearance. Fridman underwent repair of the hernia with mesh through surgery on November 14. 2019. Fridman also had a long history of right inguinal hernia but refused surgery. The hernia developed and became non-reducible on April 14, 2020. She underwent emergency surgery on April 15, 2020. Fridman died on April 18, 2020.

Expert Affirmations in Support

Dr. Moshenyat submitted two expert affirmations in support of his motion. The first expert affirmation was furnished by Dr, Daniel L. Feingold, who specializes in colorectal surgery. Among other things, he served as a Professor of Surgery, Chief of Division of Colorectal Surgery, Colorectal Surgery Fellowship Site Director, and Chief of the Colorectal Surgery Service at Rutgers Robert Wood Johnson Hospital, Chief of Section of Colorectal Surgery, Division of Surgical Oncology and Rutgers Cancer Institute, and is a former President of the New Jersey Society of Colon and Rectal Surgeons.

Dr. Feingold began his affirmation by stating it is his opinion to a reasonable degree of medical certainty that "regardless of when the diagnosis of colon cancer was made, the goal was to achieve complete cancer removal and improve survival." He provided that a hemicolectomy is recommended over less extensive interventions, such as colonoscopy, for patients with Fridman's presentation as it removes the primary cancer along with a wide margin of healthy tissue ensuring that all cancer cells are eliminated. In Fridman's case, it was the standard of care to remove all

the regional lymph nodes and it is crucial for determining if the cancer has spread. Here, the treatment provided was curative and Fridman died cancer free. Dr. Feingold asserts that it is his opinion within a reasonable degree of medical and surgical certainty that the injuries alleged to be sustained by Fridman were not proximately caused by any alleged negligence or omission by Dr. Moshenyat.

First, Dr. Feingold referenced the consent form signed by Fridman prior to the procedure. He noted that Dr. Moshenyat's testimony provides that Fridman was informed of the risks and benefits of the proposed procedure, and that she consented to similar procedures on multiple occasions both before and after October 14, 2012. Dr. Feingold stated that it is well known that lesions of the colon can be missed for a wide variety of reasons, which is why a follow-up was recommended.

Dr. Feingold then turned to assessing the colonoscopies performed on October 14, 2015 and November 14, 2016. He reiterated that "the gold standard procedure for moderately differentiated adenocarcinoma of the ascending colon regardless of the size of the lesion is hemicolectomy and lymph node dissection which provide the best chance for long term survival." As such, it is his opinion within a reasonable degree of surgical certainty that any growth of the cancer before it was removed did not have a negative impact of Fridman's outcome. The entirety of the cancer was removed and there was no metastatic spread. The measured sized of a colon cancer does not influence the chance of cure, and ultimately Fridman was cancer free when she died.

Dr. Feingold then opined that that the claim that Fridman sustained damages including ventral hernia is unsupported. Fridman had a large umbilical hernia that Dr. Sherwinter repaired primarily during the hemicolectomy. The hernia recurred shortly after, and Dr. Feingold does not

attribute its return to be related to any care provided by Dr. Mosheyat. Dr. Feingold continued that the remaining damages alleged by plaintiff are not related to Dr. Moshenyat's care but are instead related to her cardiac condition and iron deficiency anemia which Fridman continued being treated for after her cancer was excised. Ultimately, Dr. Feingold concluded that it is his opinion within a reasonable degree of medical and surgical certainty that none of the injuries alleged by the plaintiff were proximately caused by Dr. Moshenyat or the care he provided.

The next expert affirmation provided in support of Dr. Moshenyat's motion was submitted by Dr. Paul Oberstein, a physician who is Board Certified in Internal Medicine and Medical Oncology. Among other qualifications, he has served as Assistant Professor of Medicine at New York University and Columbia University, and serves as the Director of GI Medical Oncology at Perlmutter Cancer Center.

Dr. Oberstein's affirmation independently supports many of the opinions raised by Dr. Feingold, and as such this Court will focus on opinions exclusive to Dr. Oberstein's affirmation. First, Dr. Oberstein focused on the notion that following Fridman's October 14, 2015 colonoscopy performed by Dr. Moshenyat, she was instructed to return in 3-6 months for a short interval repeat colonoscopy and polypectomy after a proper prep. Despite this instruction, Fridman did not return to Dr. Moshenyat. Instead, Fridman sought care from Dr. Iswara in May of 2016, and did not have the recommended procedure until November of 2016, 13 months after the instruction was made. Dr. Iswara's November 2016 colonoscopy revealed colon cancer in the ascending colon.

In November 2015, Fridman's hemoglobin was 12, in March 2016 it was 10.4, and it was 10-11 in May and June 2016. Dr. Oberstein asserted that such values are not indicative of bleeding from GI cancer, however, by the end of September hemoglobin dropped to 8.5 which suggested a change in condition. At that time, Fridman was no longer under Dr. Moshenyat's care and her

treatment was being managed by "many other physicians." In order to attain a proper diagnosis and staging, Fridman would need to undergo surgery. The surgery was performed and once the diagnosis was established, it was determined all cancer was removed and Fridman would not need chemotherapy. As the cancer never recurred, Dr. Oberstein opined that the surgery was curative and as such he determined that any delay in diagnosis did not make a difference in terms of Fridman's survival from colon cancer.

Dr. Oberstein then provided that it would be speculative to opine on when the cancer progressed to Stage T3. "Most adenocarcinomas of the ascending colon derive from polyps that take an estimated 10-15 years to become cancer of this stage. However, some cancers are slow growing, and others progress more rapidly." He states that is his opinion within a reasonable degree of medical certainty that Fridman likely had colon cancer for "some years" before it was diagnosed, but individual cases vary widely and can be influenced by genetics and a patient's behaviors in ways that are not currently measurable.

Discussion

Summary judgment is a drastic remedy that deprives a litigant of his or her day in court and should, thus, only be employed when there is no doubt as to the absence of triable issues of material fact (*Kolivas v Kirchoff*, 14 AD3d 493 [2005]; *see also Andre v Pomeroy*, 35 NY2d 361, 364 [1974]). However, a motion for summary judgment will be granted if, upon all the papers and proof submitted, the cause of action or defense is established sufficiently to warrant directing judgment in favor of any party as a matter of law (CPLR 3212 [b]; *Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966, 967 [1988]; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), and the party opposing the motion for summary judgment fails to produce evidentiary proof in admissible form sufficient to

establish the existence of material issues of fact (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986], citing *Zuckerman*, 49 NY2d at 562).

"The proponent of a motion for summary judgment must make a prima facie showing of entitlement to judgment, as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (*Manicone v City of New York*, 75 AD3d 535, 537 [2010], quoting *Alvarez*, 68 NY2d at 324; *see also Zuckerman*, 49 NY2d at 562; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). If it is determined that the movant has made a prima facie showing of entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Garnham & Han Real Estate Brokers v Oppenheimer*, 148 AD2d 493 [1989]).

The court must evaluate whether the issues of fact alleged by the opposing party are genuine or unsubstantiated (*Gervasio v Di Napoli*, 134 AD2d 235, 236 [1987]; *Assing v United Rubber Supply Co.*, 126 AD2d 590 [1987]; *Columbus Trust Co. v Campolo*, 110 AD2d 616 [1985], *affd* 66 NY2d 701 [1985]). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat a motion for summary judgment (*Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966, 967 [1988]; *Spodek v Park Prop. Dev. Assoc.*, 263 AD2d 478 [1999]). "[A]verments merely stating conclusions, of fact or of law, are insufficient to defeat summary judgment" (*Banco Popular N. Am. v Victory Taxi Mgt.*, 1 NY3d 381, 383-384 [2004], quoting *Mallad Constr. Corp. v County*

Fed. Sav. & Loan Assn., 32 NY2d 285, 290 [1973]). If there is no genuine issue of fact, the case should be summarily determined (*Andre*, 35 NY2d at 364).

Here, the Court finds that the Defendant met his burden in making a prima facie showing of an entitlement to judgment. The burden now shifts to the plaintiff to successfully produce evidence in an admissible form establishing that material issues of fact exist.

Plaintiff submitted an expert affirmation in opposition to the motion, prepared by an unnamed physician who is Board Certified in Internal Medicine and Oncology. Among 0ther qualifications, Plaintiff's Expert has served as Chief of Hematology and Oncology and Cancer Center Director at major New York metropolitan area hospitals.

Upon review of the affirmation submitted in opposition, this Court finds it to be unavailing and insufficient to defeating Dr. Moshenyat's motion for summary judgment. Most importantly, Plaintiff's expert acknowledges that Dr. Moshenyat specifically instructed Fridman to return for a repeat colonoscopy in 3-6 months after he discovered a "very small polyp" during the October 14, 2015 colonoscopy. Plaintiff's Expert discusses the fact that Dr. Moshenyat did not address with her that bowel preparation was incomplete, preventing him from visualizing the ascending colon and completing the colonoscopy. He used this omission to infer a deviation from the standard of care that proximately caused harm to Fridman, however the Court finds such an inference to be unsupported. First, Plaintiff's Expert fails to establish how Dr. Moshenyat should have proceeded differently, and further, he fails to rebut Dr. Mosheyat's explanation that he particularly did not utilize more methods to complete the colonoscopy because Fridman was a high-risk patient and he did not want to risk bleeding. Further, Plaintiff's Expert speculated that a thirteen-month delay between Dr. Moshenyat's procedure and Fridman's diagnosis by Dr. Iswara caused a worse

outcome for her, and potentially impacted what type of surgery would be required to treat her cancer. However, Plaintiff's Expert fails to acknowledge that Fridman did not follow Dr. Moshenyat's instruction to return in 3-6 months for a repeat colonoscopy.

Without a supported allegation that Dr. Moshenyat departed from the standard of care by not observing more as the result of incomplete bowel preparation and instructing Fridman to return in 3-6 months, this Court cannot find that Dr. Moshenyat's acts or omissions proximately caused damages to Fridman.

Accordingly, it is

ORDERED Defendant's motion for summary judgment is granted in its entirety; and it is further

ORDERED that this action is dismissed with prejudice against the Defendant; and it is further

ORDERED that the clerk is directed to enter judgment in favor of the defendant and against plaintiff; and it is further

ORDERED that counsel for defendant is directed to electronically serve a copy of this Decision, Order, and Judgment with notice of entry on Plaintiff's counsel and to electronically file an affidavit of said service with the Kings County Clerk.

This Constitutes a decision and order of the court.

ENTER,

Hon. Ellen M. Spodek