

**Arocho v Passick**

2025 NY Slip Op 32872(U)

July 24, 2025

Supreme Court, Kings County

Docket Number: Index No. 517875/2022

Judge: Consuelo Mallafre Melendez

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**At an IAS Term, Part MMESP – 7 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 24th day of July 2025.**

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF KINGS

-----X  
MARIA AROCHO and HERMINIO AROCHO,

Plaintiffs,

-against-

JEFFREY PASSICK and NEW YORK CITY HEALTH & HOSPITALS CORPORATION,

Defendants.

-----X  
**HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.**

Recitation, as required by CPLR § 2219 [[a], of the papers considered in the review:

NYSCEF #s: 28 – 33, 34 – 80, 82 – 84, 85, 87

**DECISION & ORDER**

Index No. 517875/2022  
Mo. Seq. 1

Defendants, Jeffery Passick, M.D (“Dr. Passick”) and New York City Health and Hospitals Corporation (“NYCHHC”) move (Seq. No. 1) for an Order, pursuant to CPLR § 3212, granting summary judgment in their favor and dismissing all claims against them.

Plaintiffs, Maria Arocho (“Mrs. Arocho” or “the patient”) and Herminio Arocho, oppose this motion as to the care and treatment received pursuant to the patient’s total knee revision surgery on December 7, 2021. Plaintiffs claim that Defendant Dr. Passick departed from the standard of care in performing the knee revision surgery. They further claim that the patient’s popliteal artery was injured during the procedure, resulting in the requirement for vascular bypass surgery, a knee joint infection, abscess, antibiotics, incision and drainage, surgical knee revision, spacer, and surgical knee prosthesis replacement.

Plaintiffs do not oppose Defendants' motion with respect to whether the December 7, 2021 revision surgery was indicated, the timeliness of the detection, diagnosis, treatment, and repair of the popliteal artery injury, the manner in which the hospital is run, the recording of the patient's histories and physical exams, or the timeliness of tests, consults, and exams. At oral argument before this Court on June 30, 2025, Plaintiffs stated they did not oppose dismissal of those claims. Regarding the prosthetic joint infection, no departure from the standard of care is alleged as to the treatment of the infection itself. Accordingly, the part of Defendants' motion seeking summary judgment on those claims is granted without opposition.

Plaintiffs commenced this action on June 22, 2022, asserting claims of medical malpractice, lack of informed consent, and negligent hiring/retention in connection to care and treatment provided regarding Mrs. Arocho's knee revision surgery on December 7, 2021. Mrs. Arocho's husband also asserts derivative claims for loss of services.

At the start of the treatment in question, the patient was 72 years old. She had prior visits to South Brooklyn Health, (then Coney Island Hospital) ("CIH") for chronic hip pain and frequent falls as well as chronic right ankle and foot pain. On November 18, 2021, the patient presented to CIH complaining of right knee pain for approximately a year and constant 8/10 pain after walking three blocks. An x-ray was taken since the patient's medical history included that she had bilateral knee replacements more than ten years prior and had suffered from frequent falls, syncope, and collapse. The x-ray of the right knee revealed loosening of the tibial component. On December 7, 2021, Dr. Passick performed a right total knee revision surgery on the patient.

During the surgery, the knee was bent in flexion position, a tourniquet was applied, and retractors were placed behind the tibia. Dr. Passick then used a bone saw to resect the top of the

tibia and used a rongeur to clear osteophytes (bone spurs). Upon completion of the surgery, the tourniquet was removed, and a large amount of active bleeding was observed from the popliteal space with 2000 cc of blood pooling in the operative site. Interventional radiology and vascular teams were immediately contacted, and an intraoperative angiogram revealed an occluded right popliteal artery. Jon Kirwin, M.D. (“Dr. Kirwin”), a vascular surgeon, performed a right knee popliteal artery bypass graft surgery and fasciotomy. The specific bleeding site was not identified during the bypass surgery. Transfusions were administered. Dr. Passick irrigated and closed the knee. The patient was transferred to the intensive care unit. On December 9, Dr. Kirwin performed an extension of the fasciotomy. On December 15, the fasciotomy site was partially closed. On December 28, Sreedkar Kallakuri, M.D., a vascular surgeon debrided and closed the wound. The patient was discharged from CIH on December 30 with orders to follow-up in one week with the orthopedic and vascular clinics and in two weeks with primary care.

On January 6, the patient presented to the orthopedic clinic for her follow-up. No signs of infection were recorded, and the patient had intact sensation and ambulated with a walker. On January 23, the patient presented to the CIH emergency department with complaints of pain and difficulty extending the right knee. An orthopedic PA attempted right knee aspiration with less than 1 cc aspirated and a culture was sent. The patient’s C-Reactive Protein (“CRP”) was recorded as 99.4. On January 25, Dr. Passick performed an examination under anesthesia with fluoroscopy and aspiration of the patient’s right knee with lateral flow test for alpha-defensin. The alpha-defensin test was negative. On January 26, the culture obtained on January 23 grew out staph lugdunensis. On January 27, the patient’s CRP was recorded as 39.3. On January 28, the patient was discharged with instructions to wear a knee immobilizer, follow-up with the orthopedic clinic in one week, follow-up with primary care in two weeks, and to attend occupational and physical therapy.

On June 30, 2022, the patient presented to the CIH orthopedic clinic complaining of knee stiffness. To address the stiffness, Dr. Passick performed an outpatient manipulation under anesthesia on July 18, 2022. On August 18, 2022, the patient's range of motion was limited, and appointments were made with physical therapy, the vascular clinic, orthopedics, and physiatry. On September 15, 2022, the patient reported stopping physical therapy due to lack of progress and pain and was prescribed pain medication to be taken prior to physical therapy. On January 18, 2023, a bilateral arterial ultrasound Doppler of the legs revealed that the right lower extremity bypass graft was patent without stenosis.

On July 28, 2023, EMS brought the patient to the CIH Emergency Room for right knee pain and an oozing/draining wound for three days. The patient was prescribed antibiotics and given instructions to follow-up with her doctor the following Monday. On October 2, 2023, the patient presented to the primary care clinic complaining of purulent discharge from the wound. The purulent discharge was confirmed, a dressing was applied, and the patient was prescribed Augmentin. On October 4, 2023, the patient presented to the CIH Emergency Room complaining of swelling, pain, and purulent discharge coming from the wound. The patient had a draining of the lateral aspect of her knee, was diagnosed with an infected superficial abscess, and was prescribed Augmentin. On November 9, 2023, the patient presented to the orthopedic clinic reporting persistent drainage. A CAT scan was performed but no source was identified. On December 15, 2023, an MRI revealed a soft tissue defect along the lateral aspect of the right knee with soft tissue edema, and irregular fluid collection. On December 21, 2023, no fluid could be expressed and the patient reported that the abscess had improved. The patient's CRP was recorded as 19 and was prescribed three more weeks of antibiotics.

On February 8, 2024, the patient presented to CIH orthopedic clinic reporting drainage over the last two weeks and had obvious swelling and moderate purulent drainage. An infected tract was discovered, swabbed, and the cultures grew out methicillin sensitive staph aureus (“MSSA”) and staph lugdunensis. The patient was prescribed ten days of antibiotics. On March 25, 2024, Dr. Passick performed an in-patient Incision and Drainage procedure and confirmed that the tract communicated with the knee joint. Intravenous antibiotics were administered. A surgical swab culture grew out MS staph aureus.

On April 11, 2024, Dr. Passick performed the first stage of a two-stage revision surgery which included removal of the infected knee replacement, debridement of the joint, and insertion of an antibiotic impregnated cement spacer. A surgical swab of clear knee fluid grew no cultures after five days. On May 22, 2024, Dr. Passick performed the second stage of the revision surgery, removing the cement spacer and implanting a new knee replacement. On May 24, 2024, a venous duplex ultrasound of the lower extremities demonstrated normal flow in all veins. On May 30, 2024, the patient was discharged.

Plaintiffs allege that Dr. Passick departed from the standard of care by failing to control the depth of the cutting blade of the bone saw on the tibial bone during the December 7, 2021 knee revision surgery. Plaintiffs further allege this departure caused injury to the popliteal artery and resulting blood loss, compartment syndrome, fasciotomy, infection, diminished range of motion, requirement for a subsequent knee revision surgery, pain and suffering. Plaintiffs claims against NYCHHC arise from vicarious liability for Dr. Passick.

To evaluate a summary judgment motion in an action of medical malpractice, the Court applies the burden shifting process as summarized by the Second Department: “[A] defendant must make a prima facie showing either that there was no departure from good and accepted

medical practice, or that the plaintiff was not injured by any such departure. Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions.” (*Rosenzweig v. Hadpawat*, 229 AD3d 650, 652 [2d Dept 2024] [internal quotation marks and citations omitted]). However, “expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact” (*Barnaman v. Bishop Hucles Episcopal Nursing Home*, 213 AD3d 896, 898-899 [2d Dept 2023]).

In support of this motion, Defendants Dr. Passick and NYCHHC submit an expert affirmation from Bruce A. Seideman, M.D. (“Dr. Seideman”), a licensed physician board certified in orthopedic surgery, who sets forth his experience and familiarity with the standard of care for performing total knee replacement surgeries, performing knee replacement revisions, and treating knee infections.

Dr. Seideman opines that all care and treatment provided to the patient by Dr. Passick complied with the accepted standards of care. First, regarding the technique of the December 7, 2021 procedure, Dr. Seideman opines that the median peripatellar approach, the placement of the knee in flexion, application of tourniquet, and placement of retractors behind the tibia were all appropriate for preparation of this procedure and were within the standard of care. Dr. Seideman further opines that the removal of synovial tissue along the internal surface of the articular capsule, removal of the polyethylene spacer and old tibial component, and debridement to create a well-prepared tibial surface were proper to ensure proper fixation, stability, and longevity of the new implant. Dr. Seideman opines that when operating near the popliteal artery, Dr. Passick

correctly cut across the tibial surface with the bone saw, appropriately removing cement and bone, and correctly used a rongeur to remove large osteophytes medially and posteriorly. Dr. Seideman then opines that Dr. Passick properly found the correct tibial component size and obtained excellent range of motion, stability, and good patella tracking.

Dr. Seideman additionally opines that one cannot assert within medical certainty the exact time or mechanism of the popliteal artery injury, but he opines that Dr. Passick detected the injury at the earliest appropriate opportunity. Specifically, Dr. Seideman opines the large amount of active arterial blood that Dr. Passick observed after removing the tourniquet and the corresponding inability to obtain a pulse in the foot properly led Dr. Passick to remove the polyethylene component. Upon removal, Dr. Passick observed a large amount of active bleeding, which Dr. Seideman opines he correctly recognized as a likely injury to the popliteal artery and took accurate steps to address that injury. Dr. Seideman opines that immediately upon detection of the injury, Dr. Passick timely requested assistance from the interventional radiology team to perform an emergency, intra-operative angiogram, and correctly requested the vascular team to prepare for an emergency bypass surgery. Dr. Seideman further opines that Dr. Kirwin's performance of the bypass surgery then successfully restored perfusion to the patient's lower extremity, that the prophylactic fasciotomy successfully prevented an acute compartment syndrome, and that timely fasciotomy extension and wound debridement was performed and successfully preserved all muscle function in the leg.

Dr. Seideman opines that the injury to the popliteal artery was not proximately caused by any negligence or wrongdoing by Dr. Passick. The expert opines that after one undergoes a total knee replacement, as the patient had, inflammatory changes, bone overgrowth, and scar tissue development alter the position of the popliteal artery in its proximity to the tibia. More

specifically, Dr. Seideman opines that scar tissue pulls more proximately, becomes adherent to, and wraps itself around the wall of the popliteal artery. Additionally, Dr. Seideman opines that this same scar tissue may become adherent to osteophytes or other bone fragments that are removed during the revision procedure. As such, Dr. Seideman opines that it is possible for the patient's popliteal artery injury to have occurred when the wall of the artery was inadvertently pulled, ripped, or cut with the rongeur during osteophyte removal. Alternatively, Dr. Seideman opines that it is also possible for the patient's popliteal artery injury to have occurred when inadvertently cut by the oscillating bone saw during the tibial cut. In both cases, Dr. Seideman opines that because of the scar tissue bringing the popliteal artery closer to the tibia, an injury to the popliteal artery is a known risk which may occur without any surgical negligence.

On the issue of causation between the popliteal artery injury and the prosthetic joint infection, Dr. Seideman opines that the patient contracted an infection in July 2023 "spontaneously or independently," due to contamination from another existing infection. He opines that the infection was likely from a late hematogenous infection or from trauma to the lateral side of the knee, which initially became a skin abscess. Dr. Seideman opines that in either case, the patient's infection was unrelated to the popliteal artery injury and would have occurred anyway, whether hematogenous or skin-based. Dr. Seideman further opines that had the patient's infection been caused by the popliteal artery injury, it "would be unusual" for the patient's infection not to have manifested more aggressively over the twenty-month period between the procedures.

Additionally, Dr. Seideman opines that the patient's infection was not caused by the injury to the popliteal artery because of the negative test results from the Synovasure alpha defensin lateral flow test on January 25, 2022. Dr. Seideman opines that the alpha defensin test is

an accepted tool for diagnosing periprosthetic joint infections and opines that these tests “demonstrate extremely high accuracy” for diagnosing such infections. He continues that the test requires an exceptionally small amount of fluid upon which to test, only 15 microliters, and therefore opines the sample collected from the patient, while less than 1 cc, was still more than sufficient to ensure test accuracy.

The movants also submit an affirmation in support of this motion from Dr. Passick, a licensed physician and orthopedic surgeon and a party in this action. He offers his own expert opinions, based on his personal knowledge of Plaintiff’s course of treatment.

Dr. Passick states that post-operatively, the patient remained neurovascularly intact with good strength, intact pulses, and less tenderness and pain than prior to the December 7, 2021 revision surgery. He opines that the patient’s joint stiffness and mild to moderate swelling were expected within the recovery period and were appropriately addressed. Dr. Passick opines that after the December 7, 2021 surgery, the patient had good compression and augmentation, that no filling defects were visualized, and that there was “no sonographic evidence of deep venous thrombosis in the right lower extremity.” Dr. Passick also opines that the fasciotomy and debridement left the patient without any permanent muscle damage. Dr. Passick attributes the fasciotomy’s incision being only fascial and the debridement including only necrotic muscle for his opinion that the underlying muscles and tendons were untouched, healthy, and intact. Dr. Passick opines that the leg compartments being soft to the touch and there being a viable wound noted additionally indicated intact muscle.

Dr. Passick further opines that the patient’s knee functioning, activities of daily living, and quality of life are also overall superior to what they were prior to the December 7, 2021 revision. Specifically, Dr. Passick attributes this assessment to the patient’s reduction in reported

pain level from 8/10 pre-operatively to 5/10 post-operatively, the patient's increased muscle strength of 5/5 in the lower extremities, her increased functional range of motion of 0-90 degrees, and the healing of the wounds without warmth or erythema. Dr. Passick opines that upon his final assessment on September 18, 2024, the patient was able to perform basic activities such as walking with less pain or assistance than prior to the December 7, 2021 surgery. Therefore, he opines that Plaintiff's mobility and quality of her life were not impaired as a result of the December 7 surgery.

Regarding the patient's nerve-related injuries, Dr. Passick opines that the patient's pre-existing conditions of diabetic neuropathy and obesity are the causes of the alleged neurogenic injuries after December 7, 2021. Dr. Passick opines that the recovery period being longer and including pain, tightness, and weakness is attributable to having prior knee replacement surgeries. Given the patient's age, medical history, and pre-existing conditions, Dr. Passick opines that it was expected for the patient not to have a pain-free recovery and would require physical therapy and pain medication. Dr. Passick additionally cites the patient's osteoarthritis, Grade 1 anterolisthesis of L4 in relation to L5 vertebral body, degenerative disc disease from L2 to S1 levels, and obvious vertebral abnormality to be an additional direct cause of the patient's alleged back, hip, and nerve pain. Dr. Passick opines that the patient's post-operative 5/5 lower extremity strength indicates a lack of permanent nerve damage and also notes that the patient never developed a foot drop. Dr. Passick opines that some difficulty is expected in tasks such as bending, kneeling, squatting, heavy lifting, or long periods of time on her feet following the surgery and notes this can be recovered slightly with physical therapy. Dr. Passick opines that the patient's improved ability to perform activities of daily living would be the expected post-operative activities for her to be performing. For these reasons, Dr. Passick opines that no alleged

departures from the standard of care were a proximate cause of Plaintiff's claimed injuries including nerve damage.

Based on the submissions, movants have established prima facie entitlement to summary judgment. They have proffered an expert opinion that the surgical procedure and technique employed on the December 7, 2021, revision was appropriate and within the standard of care to address the patient's loosening tibial component. Movants' expert Dr. Seideman further established prima facie that the popliteal artery injury was timely recognized, appropriately intervened, and successfully addressed.

The movants have also established prima facie that no departure from the standard of care was a proximate cause of the patient's alleged injuries. The movants submit an expert opinion that the popliteal artery injury itself occurred in the absence of negligence. The movants further established that Plaintiff's prosthetic joint infection was contracted due to a *de novo* infection which contaminated the joint, opining that the patient did not show signs of infection following the popliteal artery injury. The burden therefore shifts to the Plaintiffs to raise an issue of fact.

In opposition to the motion, Plaintiffs submit an expert affirmation from a licensed physician [name of expert redacted], board certified in orthopedic surgery. The unredacted, signed expert affirmation was presented to the Court for *in camera* inspection. The Court finds the expert has laid a proper foundation to opine on the issues of this case, setting forth his experience in performing total knee replacements and knee revisions, and diagnosing and treating intraoperative and post-surgical complications, infections, and vascular injuries.

Plaintiffs' expert counters Dr. Seideman's opinion that the patient's popliteal artery injury occurred without surgical negligence and opines instead that the injury sustained by the patient demonstrates a "careless technical performance" by the surgeon. Plaintiffs' expert opines that the

popliteal artery was not within the operating field of the surgery as it lays behind the tibia, not within. Plaintiffs' expert therefore opines that injury to the popliteal artery would "involve negligence on the part of the surgical team" and would be "due to a departure from the standards of good and accepted practice."

Plaintiffs' expert opines it was a sharp injury to the popliteal artery that caused the patient's blood loss and subsequent occlusion. Plaintiffs' expert opines that while an occlusive blockage by a thrombus can occur during manipulation, such a thrombus could not cause the 2,000 cc of bleeding that the patient exhibited. Plaintiffs' expert therefore opines that there was excessive pressure with the bone saw during the tibial cut, and a resultant erroneous entry of the bone saw into the popliteal space, causing the injury to the popliteal artery.

Plaintiffs' expert further counters Dr. Seideman's opinion that the injury to the popliteal artery could occur without negligence if the scar tissue drew the popliteal artery closer to the operating field. The expert opines in direct contradiction that post-total knee replacement scar tissue "actually displaces the popliteal artery posteriorly (further away from the tibia)" and thus it would not have raised the probability of injury to the artery. Plaintiffs' expert opines that Dr. Passick should have known when to stop the saw at the end of tibial bone cut and failing to do so was a departure from the standard of care.

Plaintiffs' expert also opines that if Dr. Passick were concerned about either the placement of the popliteal artery or his ability to perform the cut, then he should have ordered a pre-operation angiogram. Plaintiffs' expert opines that failure to perform this test and nonetheless proceeding with the operation, despite concerns about the artery placement, would constitute a departure from the accepted standard of care.

Plaintiffs' expert opines that the popliteal artery injury was most likely caused by operation of the bone saw, relying on Dr. Passick's own deposition testimony that it was "most likely" that the popliteal artery was "injured by one of the sharp instruments, the cutting instruments, that was used during the surgery." There were two such instruments, the bone saw and rongeur. Regarding the other sharp instrument, the rongeur, Plaintiffs' expert opines that the injury could not have occurred during osteophyte removal with the rongeur, because P.A. Gavriel Pinchasov stated in deposition that Dr. Passick was not removing osteophytes in the proximity of the popliteal artery. As such, Plaintiffs' expert opines that the injury to the popliteal artery most likely occurred during the use of the oscillating bone saw and was the result of a departure from the standard of care.

Plaintiffs' expert also counters Dr. Passick's opinion that the patient did not sustain muscle and nerve damage as a result of the alleged departures. The expert notes, based on the medical record, that the patient developed lower extremity compartment syndrome from the "interruption of the blood supply to the lower leg resulting from the popliteal artery injury." The expert also opines that the patient sustained muscle and nerve damage from the fasciotomy and debridement procedures she underwent during her extended hospital stay, as well as scar tissue and restricted range of motion, and all these injuries were causally linked to the popliteal artery injury.

On the issue of proximate causation with respect to the infection, Plaintiffs' expert opines that the alleged malpractice leading to the injury to the popliteal artery was the most likely cause of the infection that led to the 2024 surgery. Plaintiffs' expert counters Dr. Seideman's opinion that it would be unusual for an MSSA infection not to manifest more aggressively over the period of twenty months after the surgery. Since the patient had pain, swelling, stiffness, and a

knee joint aspiration showing elevated CRP and positive for a staph infection in the months following the December 7, 2021 surgery, Plaintiffs' expert opines that the infection causing the 2024 surgery was due to a chronic, ongoing, and continuous infectious process in and around the knee joint from 2022 through 2024.

Plaintiffs' expert further attributes the duration of the infection to the notoriously chronic nature of joint and bone infections, especially in the context of a prior open wound with the presence of a culture media of blood. Plaintiffs' expert opines that the patient had a prior open wound due to her fasciotomy and a present culture media of blood from her 2,000 cc of intra-operative blood loss. Thus, Plaintiffs' expert opines that there is no "probable explanation for the events that occurred in this case" other than a chronic, ongoing, and continuous infectious process stemming from the injury to the popliteal artery in the December 7, 2021 surgery.

Regarding the alpha defensin test, Plaintiffs' expert counters the movants as to the accuracy of the test to conclusively "rule out infection." The expert opines that the test is more useful in detecting an infection after a total knee replacement surgery, and it is much less sensitive in knee *revision* surgeries, returning positive for only 50% of patients with post-revision surgery infections. Thus, in the expert's opinion, the fact the alpha defensin test was negative does not demonstrate that the December 7, 2021 surgery was not the source of infection.

The Court notes that substantive matters brought up for the first time in reply, through the supplemental affirmation of Defendants' expert, have not been considered.

The Court finds the opinion of Plaintiffs' expert was sufficiently detailed, supported by the record, and countered the specific assertions of Defendants' expert. To introduce an issue of fact, a plaintiff must provide expert affirmations that are not speculative or conclusory. "In order not to be considered speculative or conclusory, expert opinions in opposition should address

specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record” (*Avgi v. Policha*, 232 AD3d 838, 840 [2d Dept 2024], quoting *Tsitrin v. New York Community Hosp.*, 154 AD3d 994, 996 [2d Dept 2017]).

In this matter, Plaintiffs’ expert based their detailed opinions on the depositions of Dr. Passick and P.A. Pinchasov and on the tests, consults, and examinations taken of the patient, including the 2,000 cc of recorded intra-operative blood loss, intra-operative angiogram, post-operative complaints of pain, swelling, and stiffness, and the cultures that grew out positive for staph lugdunensis and MSSA. Contrary to the movant’s argument in reply, Plaintiffs’ expert affirmations opinions were not conclusory or unsupported by the record. Plaintiffs have raised multiple issues of fact sufficient to defeat the motion for summary judgment, including whether Dr. Passick departed from the standard of care in his performance of the December 7, 2021 surgery by using excessive pressure with the bone saw and not ordering a preoperative angiogram to show to position of the artery.

The experts also adduce conflicting opinions on proximate causation, as to the injury itself and the subsequent infection. The opinions of Plaintiffs’ expert and Dr. Seideman conflict regarding whether the injury to the popliteal artery was a result of a deviation from the standard of care or whether it was a risk of the procedure due to the involvement of scar tissue in displacing the popliteal artery from its usual position within the popliteal space during surgery

Plaintiffs have additionally raised issues of fact sufficient to defeat Defendants’ prima facie showing on proximate causation of the infection of the knee joint that led to the 2024 surgery. While the movant’s expert opines that the patient contracted a *de novo* infection, Plaintiffs’ expert opines that her post-operative symptoms demonstrate an ongoing and continuous infectious process.

As these issues of fact and credibility must be resolved by a jury, Defendants' motion for summary judgment as to the medical malpractice cause of action is denied.

Regarding the cause of action sounding in lack of informed consent, Defendants' expert, Dr. Seideman, opines that informed consent was obtained regarding the patient's treatment. He opines that the patient was properly advised of the reasonably foreseeable complications, benefits, and alternatives to the procedure. Dr. Seideman further opines that a reasonable person in the patient's position would have underwent the surgery and that the patient "understood and signed consents" prior to her surgeries.

Defendants also argue as a matter of law that Plaintiff cannot maintain a cause of action against NYCHHC for negligent hiring and retention, as this is an alternative theory of liability in the absence of a "scope of employment" relationship. "[W]here an employer is liable for the employee's negligence under the theory of respondeat superior, the plaintiff may not proceed with a cause of action to recover damages for negligent hiring and retention" (*Tabchouri v Hard Eight Restaurant Company, LLC*, 219 AD3d 528, 533 [2d Dept 2023], quoting *Ashley v City of New York*, 7 AD3d 742 [2d Dept 2004]). It is undisputed by the parties that NYCHHC is vicariously liable for Dr. Passick as his employer. The cause of action for negligent hiring and retention is therefore inapplicable to the facts in the record.

Plaintiffs do not oppose the branch of the motion seeking summary judgment on informed consent or negligent hiring/retention, and they raised no issues of fact on these issues. During oral argument, Plaintiffs conceded that they would not oppose summary judgment as to these claims. As such, Defendants' motion for summary judgment is granted to the extent of dismissing the informed consent and negligent hiring/retention causes of action.

Finally, the movants argue that co-plaintiff Herminio Arocho's claim for loss of consortium/services cannot be maintained if there are no viable underlying claims for medical malpractice (*see Klein v Metropolitan Child Services, Inc.*, 100 AD3d 708, 711 [2d Dept 2012]). However, because issues of fact remain as to the underlying malpractice claims, the part of the motion seeking summary judgment on the derivative loss of services claim is denied.

Accordingly, it is hereby:

**ORDERED** that Defendants Dr. Passick and NYCHHC's motion (Seq. No 1) for an Order pursuant to CPLR § 3212, granting summary judgment in their favor and dismissing all of Plaintiffs' claims against them, is **GRANTED TO THE EXTENT** of dismissing Plaintiffs' claims of lack of informed consent, negligent hiring and retention, and all claims related to the indication of the December 7, 2021 knee revision, the timeliness of the detection, diagnosis, treatment, and repair of the popliteal artery injury, the manner in which the hospital is run, the recording of histories and physical exams, the treatment of the prosthetic joint infection and the timeliness of tests, consults, and exams, and the motion is otherwise **DENIED**.

This constitutes the decision and order of this Court.<sup>1</sup>

**ENTER.**



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**Hon. Consuelo Malfre Melendez**  
**J.S.C.**

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<sup>1</sup> This decision was drafted with the assistance of legal intern Jack Rowe, Brooklyn Law School.