Health & Hospitals Corp. (Queens Hospital Ctr.) v. Toval

OATH Index No. 500/11 (Dec. 23, 2010), *rejected*, Hospital's Dec. (Apr. 28, 2011), **appended**, *aff'd*, HHC Personnel Review Bd. Dec. No. 1434 (Dec. 16, 2011), **appended**

Respondent is charged with insubordination and dereliction of duty for refusing to follow the directives of a staff nurse and nurse practitioner to change ventilator equipment for a neo-natal patient. In addition, respondent is charged with being disrespectful and discourteous during a discussion about whether to change the equipment. Judge finds that petitioner failed to meet its burden and recommends that the charges be dismissed.

The Hospital disagreed with the ALJ's recommendation to dismiss all charges and found respondent guilty of dereliction of duty. A 15 day suspension without pay was imposed.

On appeal, the Personnel Review Board dismissed the charges.

NEW YORK CITY OFFICE OF
ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION
(QUEENS HOSPITAL CENTER)
Petitioner
-against-
JOSEPH TOVAL
Respondent

REPORT AND RECOMMENDATION

KARA J. MILLER, *Administrative Law Judge*

The Health and Hospitals Corporation brought this disciplinary proceeding pursuant to section 7:5 of its Personnel Rules and Regulations. Respondent Joseph Toval, an associate respiratory therapist, is charged with insubordination and dereliction of duty for refusing to follow the directives of a staff nurse and nurse practitioner to change ventilator equipment for a neo-natal patient. In addition, respondent is charged with being disrespectful and discourteous during a discussion about whether to change the equipment.

A hearing was held before me on October 14, 2010. The record remained open until October 29, 2010, to permit petitioner to submit additional evidence. For the reasons provided below, I find that petitioner failed to establish the charges by a preponderance of the credible evidence and recommend that the charges be dismissed.

ANALYSIS

Respondent was assigned to work in the Neonatal Intensive Care Unit (NICU) on October 21, 2009. As a respiratory therapist, part of respondent's responsibilities included maintaining and troubleshooting the respiratory equipment, such as the ventilators. NICU patients include premature babies as young as 24 weeks and full term babies with medical issues at birth (Tr. 16, 69, 98, 144).

Amanda Torre, a staff nurse assigned to the NICU, testified that her shift started at 7:00 p.m. on October 21, 2009. She was assigned to monitor and care for a severely premature neonatal patient who was approximately 28 weeks old and was experiencing respiratory problems. The baby was unable to breathe on his own so he was in a heated isolette and attached to a ventilator to assist with his breathing. The patient was also attached to intravenous drips and various monitors, including a cardio monitor (Tr. 17-19, 23, 43).

Ms. Torre testified that when she arrived on her post at approximately 7:15 p.m., she noticed that the ventilator was continuously "alarming." When she looked at one of the screens on the ventilator it flashed "apnea" and the alarm rang, indicating that the patient was not breathing. After examining him, however, Ms. Torre observed that he was breathing. At approximately 7:30 p.m., Ms. Torre removed the baby from the respirator to check if there were any secretions in the intratracheal tube that could have been affecting his breathing. She suctioned the secretions from the patient and put him back on the respirator to recover and stabilize. Ms. Torre explained that by suctioning out the secretions, oxygen is also suctioned out causing the patient to appear desaturated, which means that he is not getting enough oxygen. Once the patient is returned to the ventilator, it takes time for him to recover and for his oxygen levels to return to normal. Once the patient has recovered sufficiently, it is possible to continue to clear secretions by suctioning the airway again. But, it is necessary to do it in stages, so that the patient does not go too long without oxygen (Tr. 23-25, 43, 46-47).

After suctioning the baby's airway three times, Ms. Torre determined that his airway and the intratracheal tube were clear and returned him to the ventilator. Nevertheless, the apnea alarm continued to ring intermittently. Ms. Torre testified that she thought, "that there must be something wrong with the machine." (Tr. 24). Ms. Torre called for assistance sometime between 8:30 and 9:00 p.m. When respondent appeared at NICU a few minutes later, Ms. Torre asked him to check the respirator. Ms. Torre testified that respondent checked the respirator but he could not find the problem. She was very concerned because the baby was desaturating. Ms. Torre checked the baby's intratracheal tube to see if it was positioned properly and decided to remove the patient again to suction any potential secretions, but there was nothing there. Ms. Torre told respondent that if he could not figure out what was wrong with the ventilator, he should replace it with a different machine. Respondent replied that there was nothing wrong with the ventilator and that he was not going to change it (Tr. 25-28, 44, 49-51, 58).

Ms. Torre maintained that during respondent's inspection of the ventilator, the apnea alarm kept flashing and the baby was "desaturating now and then and sometimes more frequent" (Tr. 28). Although she did acknowledge that removing the patient from the respirator to suction away secretions causes the baby to desaturate, she implied that it was respondent's failure to change the ventilator that was causing the desaturation. Ms. Torre noticed that the ventilator had stopped alarming while respondent was working on the machine. Initially, she thought that respondent fixed the problem until she saw that he had disconnected the apnea alarm. Ms. Torre was so concerned she called the nurse practitioner, Helen Tipawan, to explain the situation (Tr. 28-30, 32, 45, 51).

When asked at what time she had called Ms. Tipawan, Ms. Torre testified "I could not remember, but [Ms. Tipawan] said that I called around 10 o'clock" when they discussed the case the day before the hearing. Petitioner's counsel prepared both witnesses for trial together (Tr. 52). Ms. Torre was unable to recall on her own what time she called Ms. Tipawan or when Ms. Tipawan arrived at the NICU (Tr. 52-53, 55-56).

After Ms. Tipawan checked the patient and assessed that the tubes were clear, she instructed Ms. Torre to ask respondent to return to the NICU. When respondent returned, instead of approaching Ms. Tipawan and Ms. Torre, he went directly to another isolette, which was working properly and started "fiddling" with it. Ms. Torre opined that respondent should not have been wasting his time with a working isolette. Ms. Torre testified that at this point, Ms.

Tipawan told respondent that “she thought he should change the machine.” Ms. Torre agreed with Ms. Tipawan and told respondent that, “this is a nurse practitioner who is telling you to change the machine” but “he did not even come near us” (Tr. 30-31). Respondent told them that he was not going to change the ventilator because there was nothing wrong with the machine. Ms. Torre described respondent as being “very arrogant, like he didn’t care what [was] going to happen to the baby” (Tr. 33). They asked him why he was working on the other machine and he did not respond (Tr. 30-33, 54, 59). Although Ms. Torre denied telling respondent that he did not know what he was doing, she reluctantly conceded that she might have spoken to him in an “angry tone” (Tr. 62-63).

Ms. Torre further testified that she was concerned about the baby so she decided not to waste her time trying to convince respondent to do what he was supposed to do. Instead, she called the respiratory department and requested that they send another respiratory therapist to change the ventilator because she thought it needed to be changed. By the time additional respiratory therapists arrived in the unit, Ms. Torre had removed the patient from the respirator again because the machine was “going crazy” and decided to use a neo-puff, which is a hand held device, to assist the patient with his breathing. Despite the fact that the ventilator was alarming, Ms. Torre noted that the patient was breathing while he was in the ventilator (Tr. 33-35, 65).

After the two other respiratory therapists appeared at NICU to work on the respirator, Ms. Torre focused her attention on the patient but overheard respondent telling them that there was nothing wrong with the machine. The other two respiratory therapists took sometime to check and calibrate the machine. Ms. Torre conceded that respondent assisted the other respiratory therapists when they arrived. He left for a few minutes and returned with a new part for the machine. Eventually they replaced the sensor and the alarm stopped flashing and ringing. Ms. Torre was later told that it was the neo-flow sensor that was malfunctioning, not the ventilator itself (Tr. 37-38, 61-62).

As a nurse practitioner, Helen Tipawan works in conjunction with an attending physician. She makes assessments of patients with regard to medication and treatment and refers this information to the doctor she is working with. Ms. Tipawan explained that “[a nurse practitioner] cannot just do things on [her] own” (Tr. 114).

Ms. Tipawan recalled that on October 21, 2009, Ms. Torre contacted her regarding a neonatal patient on a ventilator. Ms. Tipawan testified that sometime between 9:30 and 10:00 p.m. she reported to the NICU in response to Ms. Torre informing her that a ventilator was continuously alarming and she was concerned about the patient. Ms. Torre asked Ms. Tipawan to examine the baby to determine whether something was wrong (Tr. 113-15, 130-31).

After examining the patient, Ms. Tipawan asked Ms. Torre if she had suctioned the baby, and Ms. Torre indicated that she had done so several times. Ms. Tipawan determined that the intratracheal tube was clear of any obstructions, so she was puzzled as to why the apnea alarm kept ringing. She asked Ms. Torre to contact a respiratory therapist to check the ventilator. Ms. Torre told Ms. Tipawan that she had already spoken to respondent and he said that there was nothing wrong. Ms. Tipawan directed Ms. Torre to ask respondent to return to the NICU and respondent arrived shortly thereafter (Tr. 116-17, 132).

Ms. Tipawan testified similarly to Ms. Torre, that they were at the patient's ventilator, attending to the baby when respondent arrived. Rather than approach them, respondent went to another ventilator that was working properly. Ms. Tipawan told him that the ventilator which had a problem was located where they were standing. Ms. Tipawan testified that, to the best of her recollection, respondent did not respond so she "suggested" that he change the ventilator that was alarming. When respondent told her that there was no problem with the ventilator, she asked why it was alarming. Ms. Tipawan testified, "he just was resistant not to change the ventilator and he cannot give me a clear explanation why and I cannot accept that explanation, nothing" (Tr. 118). She maintained that respondent never explained why the ventilator was alarming or what he was doing at the other ventilator. Ms. Tipawan was annoyed by respondent's lack of communication because she was responsible for the patient. She testified that he never told her that he was working on the problem or that he had not yet figured out what was wrong. He kept insisting that nothing was wrong (Tr. 117-18, 132-34).

As a consequence, she asked Ms. Torre to seek assistance from another respiratory therapist. Two female respiratory therapists responded immediately and inspected the ventilator to determine what was causing the alarm to ring and assessed the patient to determine whether he was breathing properly. Ms. Torre used a neo-puff to resuscitate the baby manually, while the respiratory therapists troubleshot the machine. Ms. Tipawan testified that she asked the new respiratory therapists to change the ventilator, but they told her that they needed to troubleshoot

the machine to determine if that was necessary. Ms. Tipawan acknowledged that she did not stay with the patient the entire time that they were working on the machine because she had other patients to attend to. She learned that the neo-flow sensor was replaced and the apnea alarm stopped ringing (Tr. 118-21, 134-35).

Respondent initially worked at Harlem Hospital from 1982 until 1990, as a respiratory therapist technician before becoming a respiratory therapist. He has been working as a respiratory therapist at Queens Hospital for the past 20 years (Tr. 142-43, 155). He is licensed by the New York State Board of Education and has been certified by the National Board for Respiratoy Care (Tr. 144). As a respiratory therapist, he is responsible for evaluating patients' treatments, intubating patients, drawing blood to determine blood gas levels, and responding to emergencies (144).

On October 21, 2009, respondent was working from 7:30 p.m. to 8:10 a.m. Respondent testified that at approximately 8:20 p.m., he received a message from Ms. Connelly that there was a problem with a ventilator in the NICU. He went directly to the NICU to troubleshoot the problem. When he arrived at approximately 8:30 p.m., he heard the ventilator alarming and went to the machine to determine what was wrong. He observed that everything was working with the exception of the minute ventilation reader. Respondent realized that there was something wrong with the neo-flow sensor. In order to calibrate the sensor he had to remove it from its location at the Y port between the tubing. Respondent asked Ms. Torre to remove the patient from the ventilator and resuscitate him with the neo-puff. The calibration indicated that the sensor was functional and that there were no occlusions or secretions in the device. Respondent reconnected it to see if it would read properly and it did not. At this point, he silenced the alarm by resetting the apnea parameter. Respondent testified that he had never encountered a situation before where the calibration indicated that the sensor was functional but it was not displaying a reading (Tr. 144-49, 156-60, 163-64).

Respondent testified that Ms. Torre asked him to change the ventilator, but he told her that there was nothing wrong with the machine, so there was no need to change it. He knew that the problem was with the sensor, but he was still trying to figure out why it was malfunctioning. Respondent maintained that he tried to explain to Ms. Torre what he was doing, but she was not listening to him. Respondent wanted to check how the two other ventilators in the NICU, one in the same room and another in a nearby room, were operating to try to pinpoint the problem. In

addition, he called the respiratory therapy office to see if someone could help him figure out the problem. Respondent testified that he spoke with Earl Bailey, another respiratory therapist, who came to the NICU to assist him. Unfortunately, Mr. Bailey was also unable to determine what was causing the problem (Tr. 149-51, 162-67).

Respondent further testified that Ms. Torre then "commanded" him to change the ventilator (Tr. 151). He believed that she did not care whether he was trying to fix the ventilator; she just wanted the machine changed. Respondent told her again that he was not going to change it because there was nothing wrong with it. Respondent maintained that the ventilator as a whole was functioning properly. Ms. Torre was dissatisfied with respondent's response so she called the respiratory office and asked Diane Connelly, another respiratory therapist, if she could fix the ventilator. Ms. Connelly arrived at the NICU a short time later with respiratory therapist Dale Mills. Respondent testified that he wanted to see if Ms. Connelly and Ms. Mills also thought the problem was the sensor, so he did not interfere with the calibrations that they ran. In the process of testing the sensor, Ms. Connelly checked a wire attached to the sensor and determined that there was a short in the wire. She asked respondent to get a new sensor and wire attachment to replace the malfunctioning one. When he returned with the parts he installed it on the ventilator. Respondent testified that the problem with the ventilator was rectified at approximately 9:25 p.m. (Tr. 151-53, 162, 168-69, 172-73).

Diane Connelly, an associate respiratory therapist at Queens Hospital, testified that as the lead therapist on October 21, 2009, she was responsible for overseeing the other respiratory therapists and responding to any problems that arose. That evening she received a call from someone in the NICU about a ventilator alarming. Ms. Connelly asked Dale Mills, another respiratory therapist on duty, to come with her to the NICU to assist. When they arrived, they heard a ventilator to the right of the entrance alarming. Respondent was present but was standing four to five feet away, towards the center of the room. Neither Ms. Connelly nor Ms. Mills could recall if respondent had said anything to them when they arrived. Moreover, they did not notice what he was doing when they arrived because they immediately focused their attention on the baby. Both Ms. Connelly and Ms. Mills testified that they noticed that the patient's respiratory rate was high, his heart rate was high, and his saturation level was dropping (Tr. 70-73, 78-80, 82-84, 85-86, 100-03, 107).

Ms. Connelly testified that she asked Ms. Torre to use a neo-puff to resuscitate the baby manually so that he could be removed from the ventilator and she could determine what was wrong with the machine. Once the baby was removed, Ms. Connelly covered up the ventilator tubing to see if it was pressurizing. At some point, respondent came over to Ms. Connelly and Ms. Mills to assist. Only one person can perform the calibration, so Ms. Mills and respondent stood next to Ms. Connelly while she was working. During the calibration process, Ms. Connelly touched the wire attached to the neo flow sensor and the alarm stopped. She asked respondent to retrieve a new wire and neo-flow sensor and replace those parts on the ventilator. Respondent left immediately and returned a few minutes later with the correct parts, which he installed in the ventilator as directed by Ms. Connelly (Tr. 73-74, 87-89, 104-06).

In assessing the credibility of a witness' testimony, it is necessary to consider whether the testimony is consistent, corroborated, and comports with common sense. For the most part, I found respondent to be credible, professional, and knowledgeable. Other than respondent's contention that he called the respiratory department and spoke with Mr. Bailey, who came to assist him, no one else placed Mr. Bailey in the NICU that evening. Respondent's assertion regarding Mr. Bailey is somewhat suspect, but Ms. Connelly testified that respondent may have called the office for assistance when she had stepped out to the ladies room (Tr. 76-77). The lack of corroboration regarding Mr. Bailey, however, did not diminish the overall weight of respondent's testimony. Respondent's testimony regarding his troubleshooting process and whether a ventilator should be changed at the request of a nurse or nurse practitioner seemed logical and reasonable. For the most part, with some minor discrepancies, his testimony regarding the troubleshooting process was corroborated by Ms. Connelly and Ms. Mills.

In contrast, petitioner's complaining witnesses, Ms. Torre and Ms. Tipawan, were less reliable. This is partly due to petitioner's counsel's surprising decision to prepare them for this hearing together. Ms. Torre was forthright enough to admit that she had trouble recollecting exactly what occurred the night in question, which is not difficult to believe considering that the incident occurred one year ago. It was unexpected, however, to learn that her testimony was based on a conversation she had with Ms. Tipawan while being prepared for hearing the day before (Tr. 59-60). It is unclear, which portions, if any, of Ms. Torre's testimony were based on her independent recollection. This caused doubt as to whether her sworn statements were actually from what she remembered or pieced together and shaped by Ms. Tipawan's recall.

Counsel's decision to prepare multiple witnesses for trial or hearing together, was inappropriate and undermined the reliability of both of petitioner's complaining witnesses.

Respondent is charged with insubordination for refusing to change the equipment on an unstable neonatal patient in the NICU "at the request of the staff nurse and at the directive of the nurse practitioner" (ALJ Ex. 2). It is well settled that once an order has been given, an employee must abide by the principle of "obey now, grieve later." This means that an employee is required to obey the order when it is given and subsequently challenge it through formal grievance procedures if there are any substantive or procedural objections. *See Ferreri v. NYS Thruway Auth.,* 62 N.Y.2d 855 (1984); *Strokes v. City of Albany,* 101 A.D.2d 944 (3d Dep't 1984); *Dep't of Correction v. Shabazz,* OATH Index No. 111/03 at 6 (Aug. 21, 2003); *Health & Hospitals Corp. (Kings County Hospital Ctr.) v. Gordon,* OATH Index No. 1843/98 at 8-9 (Nov. 2, 1998). This principle has three recognized exceptions including orders that are unlawful, *Alper v. Gaffney,* 73 A.D.2d 644 (2d Dep't 1979), clearly beyond the authority of the supervisor to make *Ferreri,* 62 N.Y.2d at 856-57, or imminently threaten the health or safety of the employee or others, *Reisig v. Kirby,* 62 Misc. 2d 632 (Sup. Ct. Suffolk Co. 1968), *aff'd,* 31 A.D.2d 1008 (2d Dep't 1969).

Respondent testified that he takes orders from physicians, not nurses or nurse practitioners. Respondent denied receiving an order from Ms. Tipawan to change the ventilator and testified that he never even saw a nurse practitioner that evening in the NICU (Tr. 172). He further testified that he had not seen a physician on duty nor was there a written order from a physician regarding the ventilator. Respondent maintained that only a doctor has the authority to prescribe that a patient be placed on a ventilator. Similarly, only a doctor or a respiratory therapist can make the decision to change a ventilator (Tr. 153-55).

There was a general consensus that respiratory therapists receive their orders from physicians. Additionally, both Ms. Connelly and Ms. Mills agreed with respondent that a staff nurse does not have authority to give a respiratory therapist an order. They disagreed with respondent, however, regarding orders from nurse practitioners. According to Ms. Connelly and Ms. Mills, a respiratory therapist would follow an order from a doctor, a physician's assistant, and a nurse practitioner (Tr. 91, 93, 100). Yet, both qualified their answers, testifying that if a nurse practitioner directed them to change a ventilator they would troubleshoot it before changing the machine, in accordance with the respiratory department's policy (Tr. 93-94, 98-99).

It is undisputed that Ms. Torre, as a staff nurse, does not have the authority to direct respondent or any other respiratory therapist to change a ventilator. As such, respondent can not be found guilty of insubordination with respect to his interaction with Ms. Torre. It is less clear, however, whether Ms. Tipawan, as a nurse practitioner, had the authority to issue an order to respondent to change the ventilator. Ms. Tipawan acknowledged that she does not have the authority to prescribe that a baby be attached to a mechanical ventilator. She explained that she can recommend it to the attending physician, but it can only be prescribed by a doctor. She further testified that she can request that a ventilator be changed if it is malfunctioning but she has to also refer this to a doctor for approval (Tr. 131). In this instance, however, Ms. Tipawan testified that she did not call the attending doctor to obtain his approval to change the ventilator. Indeed, she did not even call him to apprise him of the situation until the following morning, more than six hours later (Tr. 136).

When asked again on redirect if she has the authority to direct a respiratory therapist to change the ventilator, Ms. Tipawan equivocated and replied, "I believe it is part of [my] scope of practice" (Tr. 138). The scope of practice for a nurse practitioner delineates all of the activities and procedures a nurse practitioner is permitted to do. This list has a preface which reads, "[a]ll activities and procedures as indicated below are performed in consultation and collaboration with, and under the supervision of, as appropriate, the responsible attending physician within the institution." (Pet. Ex. 6). While the nurse practitioner is given a broad mandate "to preserve quality of life and deliver palliative care," nothing is explicitly stated or implied granting authority to order or direct staff to change ventilators. Even if this broad mandate could be considered the source of Ms. Tipawan's authority to issue an order to a respiratory therapist, according to her scope of practice, this type of order may only be issued after consultation and collaboration with a physician.

Respondent correctly noted that respiratory therapists are licensed under the New York State Education Law and certified by the National Coalition for Respiratory Care. Respondent argued that the licensing statute specifically states that the practice of respiratory therapy shall be undertaken pursuant to the direction of a duly licensed physician. Educ. Law § 8501 (Lexis 2010). A subsection of this paragraph, however, states that "respiratory therapy services may be performed pursuant to a prescription of a licensed physician or certified nurse practitioner."

Educ. Law § 8501(3). In other words, this statute permits a nurse practitioner to prescribe respiratory services, which would likely include changing a ventilator.

The statute provides Ms. Tipawan with a more authoritative role than the hospital's scope of practice which seems to require a nurse practitioner to consult with a physician before performing her duties. A reading of the statute, in conjunction with Ms. Tipawan's scope of practice, indicates that generally a nurse practitioner may prescribe respiratory services, but at Queens Hospital Center, she should do so only after consultation and collaboration with a physician. Since Ms. Tipawan did not consult with a physician regarding the ventilator, it appears to be beyond her authority to order respondent to change it.

Even if Ms. Tipawan had authority to issue an order to respondent, the petitioner must prove, by a preponderance of the credible evidence, three elements to establish insubordination: first, that an order was, in fact, communicated to respondent; second, that the order was clear and unambiguous in its content; and, third, that having heard a clear and unambiguous order, the respondent willfully refused to obey. *Health & Hospitals Corp. (Woodhull Medical & Mental Health Ctr.) v. Muniz*, OATH Index No. 1666/05 at 8 (Oct. 17, 2005). *See also, Dep't of Sanitation v. Dobie,* OATH Index Nos. 2092/07, 2093/07, 2094/07 & 2095/07 at 8 (May 2, 2008).

Petitioner failed to establish by a preponderance of the evidence, that Ms. Tipawan ever issued an order. Though an order need not be made in definitive language containing the word "order," the language used should be clear and unambiguous. *Dep't of Environmental Protection v. Salinas*, OATH Index No. 1020/04 at 5 (Nov. 15, 2004), *aff'd,* NYC Civ. Serv. Comm'n Item No. CD 06-16-SA (Jan. 9, 2006) (citing *Human Resources Admin. v. Aguirre*, OATH Index No. 1734/00 (Sept. 14, 2000)); *Police Dep't v. McKeon*, OATH Index No. 736/90 (Mar. 29, 1990). *See also Transit Auth. v. Wong,* OATH Index No. 1866/08 at 16 (Aug. 28, 2008).

Ms. Tipawan never stated in either her testimony or her written statement that she ordered respondent to change the ventilator. To the contrary, Ms. Tipawan testified that she "suggested" to respondent that he change the ventilator (Tr. 118). This is corroborated by Ms. Tipawan's written statement that indicates that problems persisted with the apena alarm on the ventilator, but respondent "refused to change the machine despite suggestion from the staff" (Pet. Ex. 5; Tr. 127). Once again, Ms. Tipawan used the word suggest, rather than order or direct.

Moreover, in her written statement she maintains that the suggestion came for the "staff." Unless she was referring to herself in the third person, which is unlikely, it seems that Ms. Tipawan was actually referring to the staff nurse, Ms. Torre, who requested that the ventilator be changed. Either way, Ms. Tipawan never asserted that she ordered respondent to change the ventilator.

Petitioner did not meet its burden in establishing the three elements necessary to prove insubordination, namely that an order was given. Despite petitioner's argument that this is merely form over substance, the language used in communicating an order can not be ambiguous or equivocal. Ms. Tipawan's testimony and written statement, gives the impression that she was asking respondent if he thought it would be appropriate to change the ventilator. The only person who issued an order to respondent to change the ventilator was Ms. Torre, who as discussed above, did not have authority to do so. Accordingly, petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate for refusing to change the ventilator on October 21, 2009.

Respondent is further charged with conduct unbecoming an employee for being disrespectful and discourteous to a co-worker. More specifically, respondent is charged with misconduct for speaking in an inappropriate manner. When a staff nurse requested and a nurse practitioner directed that he change the ventilator, he stated "that will not happen." (ALJ Ex. 1).

Both Ms. Torre and Ms. Tipawan were frustrated by respondent's refusal to change the ventilator, but both indicated that he spoke to them in a normal conversational tone and did not raise his voice. There were no allegations that he used profanity or disrupted the work place. Moreover, his conduct was not threatening in any way. The only person to lose her temper was Ms. Torre. She conceded that she spoke to respondent in an "angry tone" and that she may have raised her voice (Tr. 62-63). When asked to describe his tone of voice and demeanor, Ms. Torre described respondent as being "very arrogant, like he didn't care what [was] going to happen to the baby" (Tr. 33). Ms. Tipawan testified similarly that she was frustrated by respondent's unresponsiveness. She was dissatisfied with the way he handled the situation because he did not come directly to her when he entered the room and he did not explain why the machine was alarming (Tr. 118-21, 134-35).

It is permissible to disagree with a supervisor or a co-worker so long as the disagreement remains within the bounds of decorum and discretion. *Health & Hospitals Corp. (Lincoln*

Medical & Mental Health Ctr.) v. Thomas, OATH Index No. 531/04 at 6 (May 4, 2004). *Cf. Triborough Bridge & Tunnel Auth. v. Simms*, OATH Index No. 1303/97 (May 30, 1997), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 98-123-SA (Dec. 30, 1998). Respondent is charged with misconduct because he stated "that will not happen." Making this statement is not misconduct, especially since respondent was not loud, disruptive, threatening or using profanity. At most, he was uncommunicative.

Petitioner argued that respondent was obstinate and Ms. Torre described him as arrogant. Respondent, on the other hand, testified that he tried to explain to Ms. Torre what he was doing, but she did not want to listen to him. He maintained that she insisted that the ventilator be changed, which he was not permitted to do until he completed troubleshooting the machine. This appears to be more of a personality conflict than misconduct. Ms. Torre did not like how respondent was handling the situation and became frustrated and angry, while respondent did not like Ms. Torre issuing him orders. Although respondent maintained that he tried to explain what he was doing and why he was not changing the ventilator, perhaps he could have tried a little harder. Ms. Torre was very concerned and stressed about the patient and may not have been hearing what he was telling her.

Regardless, petitioner failed to establish that respondent committed misconduct with respect to this charge. I would, however, suggest to respondent that it would behoove him to be more communicative. If respondent had been more forthcoming and responsive this whole situation, including these charges, could probably have been avoided.

Finally, respondent is charged with dereliction of duty for refusing to change the ventilator on an unstable neonatal patient at the request of the staff nurse and the directive of the nurse practitioner, causing a delay in patient care (ALJ Ex. 1). Dereliction of duty is defined as "willful or negligent failure to perform assigned duties; culpable inefficiency in performing assigned duties." Black's Law Dictionary at 475 (8th ed. 2004). Petitioner argued that since respondent was having trouble determining the cause of the alarm, he should have heeded the neonatal staff's request to switch the ventilator with another machine.

All three respiratory therapists credibly testified that the respiratory department has a policy that malfunctioning ventilators should be calibrated and tested to determine whether the problem can be remedied without changing the machine. The ventilator is only swapped out as a last resort. Ms. Connelly testified, as did respondent, that the hospital has two different models

of ventilators and some of the nurses and nurse practitioners have a preference for a particular model of ventilator over the other. Ms. Connelly further testified that although she has been asked by a nurse or nurse practitioner in the NICU to switch a ventilator, she generally does not change it because it is unnecessary (Tr. 92-94).

Petitioner further argued that respondent's delay in remedying the problem negatively impacted the baby's care. It is understandable that due to the age, size, and health of the patient attached to this particular ventilator that the NICU staff were concerned about his welfare. Yet, all of the respiratory therapists concluded that the machine was functioning and that it was the sensor that was faulty. Indeed, even Ms. Torre testified that the baby was breathing, so she concluded that there was something wrong with the machine. Although there was testimony that the baby was desaturating because he was not receiving enough oxygen, I am not convinced that the delay attributed to respondent was the cause of the desaturation. Nurse Torre suctioned the baby three or four times. She acknowledged that each time she suctions out secretions, she is also suctioning out oxygen. The patient was removed from the ventilator five or six times, either to have secretions suctioned or to permit a respiratory therapist to work on the ventilator. Ms. Torre testified that the patient was given time to recover and resume normal breathing before he was removed from the ventilator for a treatment, but the testimony was unclear as to whether removing the baby so frequently from the ventilator over the course of an hour, would not affect his saturation levels.

Although Ms. Torre's and Ms. Tipawan's complaints were the source of these charges, both conceded that respondent troubleshot the ventilator. They just thought he was taking too long to figure out and correct the problem.

Ms. Torre testified that she heard the alarm at 7:15 p.m., but she did not call respondent until 8:30 or 9:00 p.m. (Tr. 44). She had trouble recalling when she called Ms. Tipawan, but believed that it must have been around 10:00, 10:30 or 10:45 p.m. (Tr. 32). Ms. Tipawan testified that Ms. Torre called her at 9:00, 9:30 or 10:00 p.m. (Tr. 115, 131). Yet, her report indicates that the incident occurred at 11:30 p.m. When asked what exactly occurred at 11:30 p.m., Ms. Tipawan testified that is probably when Ms. Torre called her (Pet. Ex. 5; Tr. 137-38). Ironically, the joint preparation of these witnesses did not sharpen the accuracy of their statements regarding the timeline. There were numerous inconsistencies with respect to when

respondent was called to the NICU, when Ms. Torre called Ms. Tipawan, when Ms. Tipawan reported to NICU, and when the neo-flow sensor was replaced.

Respondent testified that he arrived in the NICU around 8:30 p.m. and the neonatal sensor was changed at 9:25 p.m. (Tr. 156, 173). Ms. Connelly was unable to recall when she arrived in the neonatal unit, other than to say it had to be before 10:00 p.m. (Tr. 85). Petitioner's counsel argued that it took approximately one hour for the neonatal sensor to be replaced. If respondent arrived at the NICU at approximately 8:30 p.m. and the sensor was replaced by 9:30 p.m., it would most likely mean that Ms. Connelly was called to assist with the ventilator by 9:15 p.m. at the latest. After Ms. Connelly was called, she reported to the NICU from her office on a different floor and troubleshot the machine. She testified that the troubleshooting took about five minutes. Once she figured out what was wrong, respondent had to go to a different floor to retrieve the new parts before he installed them. From the time Ms. Connelly was called to the time respondent replaced the neonatal sensor probably took at least 15 minutes. This would mean that respondent was calibrating the ventilator and trying to determine the problem for approximately 45 minutes.

Each respiratory therapist testified differently as to what they considered an appropriate amount of time to wait before changing the ventilator. Ms. Connelly testified that it usually takes her five minutes to assess what a problem is. She further stated that, in her opinion, if it is taking a long time to troubleshoot the ventilator, 30 to 60 minutes, she would most likely change the machine (Tr. 92-93). She was called onto the scene after respondent had been working with the machine for approximately 45 minutes. It would have been preferable for respondent to have called Ms. Connelly for assistance, rather than Ms. Torre, but I was not persuaded that the length of time that it took respondent to work on the machine put the patient in jeopardy. The ventilator was operable and the patient was breathing.

When respondent was told to report to the NICU, he did so immediately. It is undisputed that he performed tests on the ventilator and calibrated it. He determined that the problem was the neonatal sensor but was having some trouble trying to remedy it. Since the patient was not in jeopardy, he turned down the apnea alarm parameters before he started to look at some properly functioning ventilators to determine what the problem with the sensor was. When Ms. Connelly and Ms. Mills arrived he observed Ms. Connelly while she troubleshot the machine. She determined that the neo-flow sensor was malfunctioning as well, but unlike respondent was able

to quickly ascertain that it was due to a loose wire. She directed respondent to get a replacement and install it. He did so immediately. Once it was changed the alarming stopped. Although the neonatal staff would have preferred for this problem to be resolved by switching ventilators, it was unnecessary to change the machine because they were able to correct the problem without changing it. While respondent could have handled the situation better, by being more communicative and requesting assistance from Ms. Connelly sooner, his conduct falls short of willfully or negligently failing to perform his duties. Accordingly, I find petitioner failed to establish that respondent was derelict in his duty on October 21, 2009.

FINDINGS AND CONCLUSIONS

1. Petitioner failed to establish by a preponderance of the credible evidence that on October 21, 2009, respondent was insubordinate for failing to follow the directives of a staff nurse and nurse practitioner to change the ventilator equipment on a neo-natal patient.

2. Petitioner failed to establish by a preponderance of the credible evidence that on October 21, 2009, respondent spoke to a co-worker in an inappropriate manner.

3. Petitioner failed to establish by a preponderance of the credible evidence that on October 21, 2009, respondent was derelict in his duties by failing to follow the directives of a staff nurse and nurse practitioner to change the ventilator equipment on a neo-natal patient.

RECOMMENDATION

I recommend that all of the charges be dismissed.

Kara J. Miller
Administrative Law Judge

December 23, 2010

SUBMITTED TO:

JULIUS WOOL, MPA
Executive Director

APPEARANCES:

SANDRA AUNG, ESQ.
Attorney for Petitioner

SCHWARTZ, LICHTEN & BRIGHT, PC
Attorney for Respondent
BY: STUART LICHTEN, ESQ.

Hospital's Decision (Apr. 28, 2011)

I am in receipt of Judge Kara Miller's Report and Recommendation regarding respondent's Administrative Hearing. As the designee of Julius Wool, Queens Hospital Center's Executive Director, I have reviewed the entire record and respondent's counsel's letter pursuant to *Fogel v. Board of Education*. After careful consideration, I disagree with Judge Miller's recommended dismissal of all of the disciplinary charges against respondent. Specifically, I find that the testimony and evidence adduced at trial clearly establishes that she is guilty of dereliction of duty. For her conduct, I am imposing a penalty of a fifteen (15) day suspension without pay.

The disciplinary charges that were preferred against respondent by the facility stem from respondent's behavior on October 22, 2009, when she reported to the Neonatal Intensive Care Unit after being notified by Associate Respiratory Therapist Dianne Connelly of a ventilator alarm on the unit. Upon respondent's arrival to the unit, she was notified that the ventilator unit used by Patient B.P.P., a twenty-eight week old premature baby, was alarming. Respondent indicated in her testimony that she thought there was something wrong with the sensor on the ventilator unit and had Nurse Torre "neopuff" Baby B.P.P. while respondent calibrated the sensor. Respondent conceded in her testimony that after she calibrated the sensor, it did not read and that she did not know what was wrong with the sensor. She also acknowledged that Baby B.P.P's ventilator alarm did not cease following her calibration of the sensor and yet, respondent took it upon herself to manually silence this alarm. When asked by Nurse Torre to change Baby B.P.P's ventilator, respondent stated to her that "I am not going to change a ventilator because that's what you want me to do, there is nothing wrong with the ventilator." At least forty-five minutes went by after respondent calibrated the sensor and was unable to identify what was wrong with the equipment. However, respondent failed to take any action with regard to changing the sensor or any of the respiratory equipment used by Baby B.P.P.

Despite these facts, Judge Miller recommends dismissal of the dereliction of duty charge that has been preferred against respondent. In support of her decision, Judge Miller cites that "all three respiratory therapists credibly testified that the respiratory department has a policy that malfunctioning ventilators should be calibrated and tested to determine whether the problem can be remedied without changing the machine." Her statement overlooks the fact that the Associate Respiratory Therapist Dianne Connelly stated in her testimony that she would let a maximum of 15 minutes lapse while testing the equipment in question before concluding that the ventilator needed to be changed out. Ms. Connelly also stated that if she could not resolve issue herself, she would call another co-worker to examine the equipment. If the issue was still unresolved, she would change out the ventilator.

In respondent's testimony, she claimed that she contacted Associate Respiratory Therapist Earl Bailey and that the both of them were in the NICU attempting to resolve the issue with this ventilator. Respondent's testimony is particularly suspect since she was the only one at hearing who referenced this individual. Clearly, this is a defense that was manufactured for purposes of the hearing and therefore is not credible. The logical conclusion is that respondent failed to have another respiratory therapist examine the ventilator, causing undue delay in the resolution of this particular issue and the provision of care to Baby B.P.P.

Indeed, the matter was only resolved after Nurse Torre contacted Ms. Connelly and Ms. Connelly and Respiratory Therapist Donna Mills arrived on the NICU and examined Baby B.P.P's ventilator unit. Notably, when Ms. Mills and Ms. Connelly arrived on the unit, Baby B.P.P's cardiac monitor reflected that Baby B.P.P.'s heart rate was fast and he was saturating at 62%, whereas the normal range would be from 90%-100%. It was only after Ms. Connelly instructed respondent to obtain a new flow sensor, that it was replaced at 9:30 p.m. Shortly thereafter, Baby B.P.P.'s numbers returned back to normal.

The evidence leads to the conclusion that respondent was not able to resolve the issue with Baby B.P.P's respiratory equipment and failed to take any actions to change any of the equipment, thus causing a delay in the care of patient B.P.P. As such, the facility finds that respondent was derelict in the performance of her duty on October 22, 2009, when she refused to change the equipment on patient B.B.P. at the request of the Staff Nurse and Nurse Practitioner, causing a delay in patient care.

Respectfully,
Jeannith Gangemi-Sosa, Esq, MPA
Senior Associate Executive Director
Network Human Resources

PERSONNEL REVIEW BOARD
THE NEW YORK CITY HEALTH
And HOSPITALS CORPORATION
.... X

In the Matter of the Appeal of

DECISION No. 1434

JOSEPH TOVAL

DATE: December 16, 2011

Respiratory Therapist (HHC)

DOCKET NO.: 3089/11

Disciplinary Proceeding

.... X

DECISION AND ORDER

This is an appeal by Joseph Toval, Respiratory Therapist (HHC) (“Appellant”), from the April 28, 2011 determination by Queens Health Network, Queens Hospital Center, to suspend him for fifteen days without pay for dereliction of duty. Appellant appealed this decision to the Personnel Review Board (“Board”) of The New York City Health and Hospitals Corporation “HHC”) on May 24, 2011. A hearing was held by the Board on November 9, 1011. Sandra Aung, Esq. represented HHC and Appellant was represented by Stuart Litchen, Esq.

BACKGROUND

HHC (Queens County Hospital brought disciplinary proceedings against Appellant pursuant to Rule 7, Section 7.5 of its Personnel Rules and Regulations, relating to an incident that occurred the night of October 21, 2009. Appellant, a Respiratory Therapist with twenty years of experience, was on duty that night in the Neonatal Intensive Care Unit when he was called to examine a ventilator. Nurse Amandina Torre reported that the ventilator that the baby was attached to was continuously “alarming,” and flashed “apnea;” this would indicate that the

baby was not getting enough oxygen. Nurse Torre thought that there was something wrong with the ventilator; when Appellant could not remedy the problem, the nurse insisted that the ventilator be changed. Appellant disagreed; he thought that the ventilator was not malfunctioning and he refused to change it. After quite some time, and a number of interventions by hospital personnel, it was determined by the lead respiratory therapist that there was a short in the wire to the sensor on the ventilator. After instruction from the lead respiratory therapist Appellant changed the sensor and the wire, and the problem was rectified. On October 22, nurse Torre filed a report charging Appellant with being "obstinate, argumentative and uncooperative," to the detriment of the baby and the hospital's goal of providing best medical care. The hospital charged Appellant with three specifications of misconduct:

1) Insubordination, for refusing to change equipment at the request of the Staff Nurse and directive of the Nurse Practitioner;

2) Conduct Unbecoming of a Corporate Employee, for speaking disrespectfully to a co-worker;

3) Dereliction of Duty, for refusing to change the equipment resulting in a delay in patient care.

On October 14, 2010 a hearing was held before the Office of Administrative Trials and Hearings ("OATH"), Administrative Law Judge Kara Miller, presiding. On December 23, 2010, Judge Miller issued a Report and Recommendation dismissing all of the charges. However, on April 28, 2011, Queens Count Hospital, informed Appellant that the hospital disagreed with Judge Miller's recommendation and upheld Specification 3: Dereliction of Duty, resulting in a delay in care to the patient. The hospital imposed a penalty of fifteen days suspension without pay.

DECISION

After careful review of the transcript of the OATH hearing, the letter determination by Queens County Hospital, upholding the charge of Dereliction of Duty, resulting in delayed care to the patient, and the transcript of the hearing before the Board, it is the Board's Decision that the charges against Appellant should be dismissed and the Appeal granted. The Board does not find that the Oath Reports and Recommendations provided by HHC are persuasive as these cases are factually distinguishable.

The charge against Appellant, dereliction of duty, is defined as: "willful or negligent failure to perform assigned duties; culpable inefficiency in performing assigned duties." Black's Law Dictionary, 475 (8th ed. 2004). The hospital states: "(t)he evidence leads to the conclusion that (Appellant was) not able to resolve the issue with (the) respiratory equipment and failed to take any actions to change any of the equipment, thus creating a delay in the care of (the) patient."

The ALJ concluded that the evidence does not support a charge that Appellant willfully or negligently failed to perform his duties or was culpable of causing any delay of care to the patient. As the ALJ found, nurse Torre heard the alarm sounding from about 7:00 or 7:15 p.m. when she began her shift, but that she did not call Appellant until between 8:30 and 9:00 (Tr 44). During the intervening time nurse Torre removed the baby from the ventilator two or three times to check if there were secretions in the intratracheal tube that could have been affecting his breathing. After suctioning the baby's airway three times, the nurse determined that the ventilator was faulty and called for assistance. Appellant checked the ventilator, but could not find anything wrong with it. Ms. Torre requested that the ventilator be changed, but Appellant said that there was nothing wrong with the machine and that he would not change it. The

ventilator continued to alarm. After some time the nurse practitioner on duty was called and she also requested a change of equipment.

ALJ Miller credited, and the evidence supports, Appellant's testimony that there was nothing wrong with the machine (OATH transcript (hereafter "Tr") 151, 162, 173) and that he is not allowed to change a ventilator except at the request of a physician (Tr 153-54) or if he believes that the ventilator is malfunctioning (Tr 154). The lead respiratory therapist also concluded that the ventilator was functioning; she testified that the ventilator was alarming because of a problem with the wiring to the sensor and not the ventilator itself (Tr 74). The lead therapist also testified that respiratory therapists only take orders to change a ventilator from a physician (ninety percent of the time) or a nurse practitioner (Tr 91) because the baby may be on a preferred machine (Tr 90, 92-94). Here, a physician was not contacted and the nurse practitioner testified that she "suggested" changing the ventilator (Tr 118). See also, OATH Exh. 5. Appellant tried for some time to ascertain what was wrong with the machine. Although he could not remedy the problem, he remained convinced that the respirator was not faulty. Accordingly, the Board agrees with ALJ Miller's conclusion that Appellant did not willfully or negligently fail to perform his duties.

Further, the evidence does not support a conclusion that Appellant was culpable in causing delay to treatment of the baby. There is no evidence in the record that anything that Appellant did, or did not do, caused any harm to the baby or resulted in any problem with the baby's care. The hospital maintains that the baby's heart rate was elevated and that he was not sufficiently saturating because of Appellant's actions. Understandably the staff nurse was concerned about the baby's well-being but, as the ALJ concluded, it may be that the problem was caused by removing the baby from the ventilator so frequently. Fortunately, according to the nurse practitioner, on October 22, the morning after the commotion with the baby and the ventilator, the baby was "alert, responsive & active." OATH Exh. 5.

The Board does not believe that the record supports the Specification of Dereliction of Duty. Although it may have been possible to resolve the issue with the ventilator in a more efficacious manner, the record does not support the conclusion that Appellant was intentionally derelict in performing his duties, “creating a delay in the care of (the) patient,” as asserted by the hospital.

ORDER

For all of the foregoing reason's and the reasons set forth in the December 23, 2010 Report and Recommendation of Judge Miller, the Appeal is granted.

Gayle A. Gavin
Chair

Nelson A. Denis
Board Member

Pamela G. Ostrager
Board Member