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

OATH Index No. 1372/14 (May 28, 2014)

Respiratory therapist was derelict in his duty by failing to answer multiple telephone calls from the emergency room relating to a trauma patient and by failing to respond to the emergency room in a timely manner. Related charges of insubordination and conduct unbecoming were dismissed. Penalty of sixty days suspension is recommended considering nature of misconduct as well as minimal disciplinary history.

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

FAYE LEWIS, *Administrative Law Judge*

This employee disciplinary proceeding was referred by petitioner, the Health and Hospitals Corporation ("HHC"), pursuant to section 7.5 of the Personnel Rules of the Corporation. Petitioner alleges that on May 1, 2013, respondent Joseph Toval, a respiratory therapist employed at Queens Hospital Center ("the hospital"), failed to respond to the emergency department in a timely manner to attend to a trauma patient, and failed to respond to calls on his wireless phone relating to that patient, jeopardizing patient safety. Petitioner further contends that in so doing, respondent was insubordinate, neglected his duty, and engaged in conduct unbecoming (ALJ Ex. 1).

At a one-day hearing, petitioner presented three witnesses, all hospital employees: Sterling Williams, the director of Respiratory Care Services, Luc Paulemon, a respiratory supervisor and respondent's direct supervisor, and Grace Okolonji, a registered nurse.

Respondent testified on his own behalf. The record was left open for the submission of nursing notes relating to the patient, which were submitted and received into evidence (Pet. Ex. 5).

As set forth, I find that the charge is sustained and recommend that respondent be suspended for 60 days.

ANALYSIS

Respondent was assigned to work the evening shift on May 1, 2013. He began his shift late, because of pre-approved leave. Respondent testified he began working at 9:00 p.m. (Tr. 113), while Mr. Paulemon, who was also on duty, testified it was closer to 9:30 p.m. (Tr. 70). Respondent was assigned to cover patients on the fourth floor (B4 West and B4 East), and was also assigned to the emergency room ("ER") on the ground floor (Toval: Tr. 113). Shortly after his arrival, respondent went to the ER because there was a trauma patient who needed respiratory treatment (Paulemon: Tr. 59; Toval: Tr. 113). Mr. Paulemon had already placed the patient on a ventilator and went upstairs to make his rounds when respondent arrived (Paulemon: Tr. 60). Respondent remained in the ER for a while but left to make rounds of his fourth floor patients because the medical staff was performing a procedure on the patient that did not involve respondent and that looked like it might take some time (Tr. 114-115). Respondent testified that he left the ER about 9:30, that he had about ten patients, and that his rounds took about half an hour to finish (Tr. 119).

It is not disputed that at some point after respondent left the ER, he received a telephone call from the ER that he was needed to help move the trauma patient to the CT ("computed tomography") scan unit. Respondent, like all respiratory therapists at the hospital, is assigned a dedicated cell phone to the ER, so that the ER can contact him directly without the need for an overhead page (Tr. 68). Respondent testified that he answered this call (Tr. 119), and that he went to the ER as soon as he could after he gave a fourth floor patient a respiratory treatment which a doctor had ordered (Tr. 119, 120). Respondent acknowledged getting about five subsequent calls from the ER which he did not answer. He testified that the calls came in quickly, in less than a two-minute interval (Tr. 146), and that he did not answer the calls because he had already told the ER that he was on his way and he felt the ER has a "very bad habit" of making repeated telephone calls to the therapists to tell them "the same thing" (Tr. 151).

Respondent denied hearing any overhead pages, but testified that he would not have heard overhead pages while he was on the elevator from the fourth floor to the ER (Tr. 146). Respondent testified that it took him ten to fifteen minutes to arrive at the ER, from the time that the ER first notified him that he was needed to respond (Tr. 148).

Petitioner's witnesses disputed that it took respondent only ten to fifteen minutes to respond and asserted that they had to wait approximately thirty minutes for him to arrive (Paulemon: Tr. 69, 73-74; Okolonji: Tr. 82, 91). Petitioner contends that this delay was inexcusable and that respondent should have gone directly to the ER, without giving the fourth floor patient a respiratory treatment. Petitioner also asserts that respondent initiated an argument in the ER, which respondent denies.

The charges are discussed below.

Failure to respond to calls on the wireless phone (Dereliction of Duty)

This specification is sustained. Respondent admitted that he answered the first call from the ER, but did not answer about five subsequent calls. Ms. Okolonji, who was the registered nurse on duty in the intensive care unit on the night of May 1, testified that she called respondent more than four times and that the ER clerks also called and paged him (Tr. 83, 83). Respondent admitted that he finds repeated telephone calls from the emergency room "very annoying" (Tr. 151). This is not a defense. By not answering the calls, respondent thwarted the purpose of the cell phones, which was to facilitate direct communication between the ER and the therapists. Indeed, Mr. Williams credibly testified that it was important for respondent to answer his telephone because the patient was a trauma patient and his condition could have changed or deteriorated (Tr. 31). Mr. Paulemon stressed that the overhead pages should not have been necessary, since the respiratory therapists are expected to answer their telephones and beepers (Tr. 68). Moreover, given the testimony of petitioner's witnesses that they repeatedly tried to contact respondent when he did not arrive at the ER, I did not credit respondent's testimony that the calls came in within two minutes. While they were waiting for respondent to arrive, the ER staff, which needed to transport a trauma patient to CT scan, did not know where respondent was or when he would be arriving. Respondent's failure to answer the telephone calls constituted dereliction of duty.

Failure to Respond to the ER in a Timely Manner (Dereliction of Duty)

This specification is also sustained. Respondent's failure to respond in a timely fashion to the ER was not justified. Mr. Paulemon testified credibly that he returned to the ER when he heard ER paging respiratory "stat" (Tr. 60). Before he reached the ER, he heard a second overhead page for respiratory (Tr. 61). When he reached the ER, respondent was already there. One of the doctors, Dr. Okechukwu, told Mr. Paulemon that the ER had been calling for respiratory assistance for over half an hour, without anyone responding (Tr. 69-70). Ms. Okolonji, the nurse, similarly testified that it took about half an hour before respondent arrived. She testified that she recalled the time because another ER doctor, Dr. Echezona, had asked her to call respiratory staff to help transport the patient to CT scan, so she was aware of the time (Tr. 84). Further, she recalled that when respondent arrived, she asked respondent where he had been, and that Dr. Echenoza told respondent that they had been waiting for 30 minutes (Tr. 85, 91). Medical record notes (Pet. Ex. 3), which were documented by Dr. Adeleke, the ER attending physician (Tr. 103-04) also indicate that there was a "30 minute delay" before respondent arrived:

> … There was a 30 minute delay in transporting patient to CT scanner because respiratory therapist was not available. Respiratory therapist called multiple times to expedite patient's transport to CT scanner. Respiratory therapist was called overhead and AOD was called to contact respiratory therapist…

(Pet. Ex. 3).

Respondent asserts that the delay was more in the nature of ten to fifteen minutes (Tr. 148). More specifically, respondent contends that, just before he was finishing his rounds, close to 10 p.m., he received a telephone call from a nurse indicating that another respiratory patient would be transferred to the fourth floor and required a BiPAP machine (bi-level positive airway pressure machine) as well as a bronchodilator treatment (Tr. 118, 161). Respondent testified that he retrieved the BiPAP machine, which is a large machine on wheels, from the ground floor, brought it to the fourth floor patient's room, checked the computer to determine what medication was needed for the treatment, and then obtained the medication from a locked medicine box (Tr. 119, 160). At some point in this process respondent received a call from the ER that he was needed to help move the trauma patient. However, respondent vacillated on precisely when this

occurred. Respondent initially testified that he was in the process of retrieving the medication when the ER called (Tr. 119), but he later testified that he had already started the treatment when the call came in (Tr. 158).

Respondent contended that he administered the treatment to the fourth floor patient because there was a doctor's order for the treatment (Tr. 162-63), although he acknowledged that the request for the treatment was not a "stat" or emergency order (Tr. 140). Respondent denied that he could have asked another respiratory therapist to administer the treatment, while he responded to the ER. He said that this was not the practice (Tr. 141). Respondent testified that it took him about five minutes to give the treatment, after which he took the elevator to the ground floor and the ER, which probably took another five minutes (Tr. 120). Further, respondent testified that when he reached the ER, the doctors were still readying the patient for transport and that he had to place a respiratory tank under the stretcher before the patient could be moved (Tr. 123-24).

I did not find respondent's testimony compelling, both as to the length of time it took him to respond to the ER and the justification for the delay. While he later changed his testimony, respondent initially testified that he had not even started the treatment for the fourth floor patient when the ER called. Further, respondent was interviewed by Mr. Williams on May 16 about the incident, and, according to Mr. Williams's memorandum, said that he was in the process of delivering the BiPAP to the patient when the ER called. While the memorandum is hearsay, Mr. Williams testified and appeared fully credible. There is no reason to believe that he erroneously transcribed what respondent told him. And there is little reason to believe that respondent's near-contemporaneous statement would be less accurate than his trial testimony almost a year later. *See Dep't of Education v. Brust*, OATH Index No. 2280/07 (Sept. 29, 2008), *adopted*, Chancellor's Decision (Oct. 22, 2008) (finding hearsay statements in investigator's report to be sufficiently probative and reliable to provide a contemporaneous record of his investigation, which captured the recollections of the witnesses closer to the time of the relevant events than the time of trial; ALJ credited report "containing contemporaneous, reliable witness statements, albeit hearsay, over their sworn, contradictory and dubious trial testimony.")

On this record, it is more likely than not that respondent was in the process of delivering the BiPAP machine to the patient when the ER called him and that, notwithstanding the call, he

positioned the machine at the patient's bedside and began the bronchodilator treatment. Mr. Williams testified that this process would have taken 15 to 17 minutes, from checking the order to administering the medication (Tr. 27). This is more in line with the 30 minute delay reported by Dr. Adeleke, Ms. Okoloni, and Mr. Paulemon than the ten to fifteen minute delay reported by respondent, considering that an additional few minutes was also needed to get from the fourth floor to the ER (Williams; Tr. 23, 28; Toval: Tr. 120).

I credited Mr. Paulemon's and Ms. Okolonji's testimony that respondent's delay was lengthy. Their testimony was consistent and was corroborated by contemporaneous medical record notes. Moreover, Mr. Paulemon wrote a memorandum about the incident on May 14, 2013, shortly after the incident, in which he noted that Dr. Okechukwu had been calling for respiratory assistance for thirty minutes (Pet. Ex. 4). Plainly, Mr. Paulemon was perturbed about the delayed response by one of the therapists under his supervision. Ms. Okolonji also seemed exasperated by the length of the delay. The incident may have been particularly memorable for her, and all the witnesses, by virtue of the fact that the patient later died in the CT unit, after attempts at cardiopulmonary respiration ("CPR") failed (Williams; Tr. 20-23; 41-42; Paulemon: Tr. 76-77; Okolonji: Tr. 94; Toval: Tr. 126-27).[1] What stands out from her testimony, however, is that she had been charged with getting respiratory staff to respond and her repeated efforts to do so had been stymied. The fact that multiple calls were made, as well as overhead pages, lends substantial credence to petitioner's assertion that a lengthy delay occurred.

Counsel for respondent asserted in summation (Tr. 169-171) that a 30-minute response delay was not plausible given the chronology of events, as documented in the medical record progress note. In particular, counsel highlights that on the medical record, the time of death was 11:12 p.m., and that CPR prior to that time took 70 minutes, commencing shortly after 10 p.m. (Pet. Ex. 3). Further, a CT scan preceded CPR, which, according to counsel, would have taken about 20 minutes, beginning about 9:40 p.m. (Pet. Ex. 3). Thus, counsel posits that the trauma patient would have been transported to CT scan by about 9:30 or 9:35 a.m., shortly after respondent left the ER to make his rounds, making a 30-minute delay implausible.

Respondent's argument, however, overlooks that medical staff interrupted the CT scan to perform CPR, because the patient did not have a pulse, and that the nursing progress note (Ex. 5)

[1] Petitioner did not allege, or offer any evidence to demonstrate, that respondent's delay in arriving at the ER played any role in the patient's death.

indicates that the patient "coded" while in CT scan at 10:05 p.m. and was returned to the ER with CPR in progress (Pet. Ex. 5). It appears, therefore, that the trauma patient reached the CT unit shortly after 10 p.m., not half an hour earlier, as counsel posited.

Moreover, respondent's testimony that it was not common practice to ask another respiratory therapist to cover the fourth floor patient while he responded to the ER was belied by Mr. Williams' credible testimony that respondent could have gotten someone else to deliver the BiPAP machine, if he felt that was important (Tr. 30). The call from the ER was a "stat" or emergency call and respondent should have prioritized it (Williams: Tr. 30). Respondent's testimony that the patient was not ready to be moved when he arrived in the ER is of little significance. First, it is not clear that respondent's testimony was accurate. While Mr. Paulemon testified that it took more than five minutes before the patient was ready to be moved (Tr. 72), Ms. Okolonji testified that the patient was ready to go to CT scan when respondent arrived (Tr. 86). Second, it is clear that it took a long time, twenty to thirty minutes, for respondent to respond to an emergency call for a trauma patient. While it is not clear that the delay actually jeopardized the safety of the patient, as petitioner charged, the delay was unjustified. Accordingly, petitioner has established that respondent failed to respond to the ER in a timely manner, as alleged. This constituted dereliction of duty.

Failure to Respond in a Timely Manner (Insubordination)

This specification is not sustained. Insubordination requires proof that a clear and unambiguous order was communicated to an employee, that the employee heard and understood the order, and that the employee willfully refused to obey the order. *Health & Hospitals Corp. (Jacobi Hospital Ctr.) v. Cooper***,** OATH Index No. 1748/12 at 3 (Sept. 17, 2012); *Health & Hospitals Corp. (Queens Health Network) v. Smith*, OATH Index No. 2019/08 at 3 (Oct. 17, 2008).

In this case, while petitioner established that the ER called and paged respondent numerous times, the pages came from a registered nurse, Ms. Okolonji, and from other ER staff. There was no evidence that Mr. Paulemon or any other supervisor paged respondent to respond to the ER. Accordingly, while respondent was derelict in his duty by not responding in a timely

fashion to the ER, petitioner has failed to establish that he was given an order by a supervisor which he failed to obey. The insubordination charge is not sustained.

Initiating an Argument with Staff (Conduct Unbecoming)

This specification is also not sustained. Respondent acknowledged having a "disagreement" with one of the emergency room doctors (Tr. 143). However, petitioner failed to establish that this constituted misconduct.

An employee may disagree with a supervisor or a co-worker without committing misconduct so long as the disagreement remains within the bounds of decorum and discretion. Factors to be considered include whether the disagreement disrupted operations or whether the employee was loud or used profanity. *Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Anatua-Bichotte* OATH Index No. 1947/11 at 6 (Oct. 13, 2011); *Health & Hospitals Corp. (Lincoln Medical & Mental Health Ctr.) v. Thomas*, OATH Index No. 531/04 at 6 (May 4, 2004). Factors to be considered in determining whether a disagreement rises to the level of misconduct include whether the respondent was disruptive, threatening, or using profanity. *Anatua-Bichotte*, OATH 1947/11 at 6; *Thomas*, OATH 531/04 at 5; *Human Resources Admin. v. Bichai*, OATH Index No. 211/90 at 13-14, 16 (Nov. 21, 1989), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 90-54 (June 15, 1990) (noting, "A subordinate may disagree with his superior, even vehemently . . .").

Petitioner's proof fell short of establishing that respondent's disagreement with one of the doctors constituted misconduct. Respondent testified that when he arrived at the ER, one of the doctors asked why he had left the ER in the first place, and he replied that he left because the doctors were doing a procedure which did not involve him (Tr. 121, 122).

Mr. Paulemon corroborated this testimony. He said that when he arrived at the ER after hearing the overhead pages, he heard respondent arguing with one of the doctors about whether this was really an emergency; however, when he asked respondent to stop arguing, respondent complied (Tr. 62-63). Ms. Okolonji, who was the only other of petitioner's witnesses who was present in the ER, recalled a discussion with respondent over whether he should have remained in the ER, but did not recall respondent discussing that issue with any of the doctors (Tr. 92-93).

I credited Mr. Paulemon's testimony that he directed respondent to stop arguing over respondent's denial that no such directive was given (Tr. 144). Mr. Paulemon was credible and he noted in his May 14, 2013 memorandum (Pet. Ex. 4) that he told respondent to stop arguing. However, Mr. Paulemon did not testify that respondent was overly aggressive or loud. There was no allegation that he used profanity. Moreover, Mr. Paulemon was not present when the argument commenced and thus did not say who initiated the argument. It is plausible that the argument began when Dr. Echezona told respondent that they had been waiting for 30 minutes or Ms. Okolonji asked respondent where he had been.

At the most, therefore, petitioner established that respondent had a brief disagreement with a doctor and stopped when Mr. Paulemon told him to do so. In the absence of any aggravating factors, this does not rise to the level of misconduct. Accordingly, the charge that respondent engaged in conduct unbecoming by initiating an argument in the ER is not sustained and should be dismissed.

FINDINGS AND CONCLUSIONS

1. On May 1, 2013, respondent was derelict in his duty by failing to respond to the emergency room in a timely manner to attend to a trauma patient and by failing to respond to calls on his wireless telephone from the emergency department.

2. Petitioner failed to establish by a preponderance of the credible evidence that respondent committed insubordination by failing to respond to the emergency room in a timely manner.

3. Petitioner failed to establish by a preponderance of the credible evidence that respondent failed to exercise self-control by initiating an argument with staff during a trauma alert in the emergency room.

RECOMMENDATION

Upon making these finding, I requested and reviewed information relating to respondent's prior disciplinary history. The information submitted indicated that respondent began with HHC on December 11, 1978. Over his 36-year career, he has only had one instance

of adjudicated prior discipline, when he entered into a stipulation of settlement on October 20, 2003 for a five-day suspension. The 2003 charges were for dereliction of duty for failing to respond to a physician's order to change the ventilation for a patient and by addressing his supervisor in an unprofessional way.

Respondent's last two performance evaluations, covering the period from October 2012 through October 2013, and October 2013 through January 2014, were unsatisfactory. His performance evaluations for the two prior years were satisfactory, and his performance evaluation for September 2009 through September 2010 was "needs improvement."[2]

Petitioner has requested that respondent's employment be terminated. This request is worthy of serious consideration. Respondent was needed to help transport a critically ill patient from the ER to the CT scan unit. He ignored a stat telephone call from the ER to deliver a non-emergency treatment to a patient and thus failed to respond in a timely fashion to the ER. Indeed, it appears that he failed to respond for twenty to thirty minutes. Respondent also failed to answer repeated telephone calls from the ER, which kept calling him. As a result, the ER staff was left in the dark as to when they would be able to transport the patient to the CT unit. Respondent's admission that he found the repeated telephone calls to be annoying was distressing because it suggests that in this instance, he let his personal feelings about the ER get in the way of doing his job.

Respondent's most recent evaluations are also problematic. The 2012-2013 evaluation, which covered the incident in question, stated that respondent was argumentative, used profanity oward co-workers, and was insubordinate. The 2013-2014 evaluation stated that respondent was not willing to assist others in the Department and was not courteous to co-workers. Although respondent provided a written rebuttal to the 2013-2014 evaluation, asserting that he was being "disrespected" and "abused," there is a consistency between the two evaluations which suggests that respondent has difficulty working with co-workers and other medical personnel.

---

[2] The 2009-2010 rating of "needs improvement" should be disregarded as it appears to be based solely upon an alleged incident of misconduct that was not proven. *See Health & Hospitals Corp. (Queens Hospital Ctr.) v. Toval,* OATH Index No. 500/11 (Dec. 23, 2010), *rejected*, Hospital's Dec. (Apr. 28, 2011), *rev'd*, HHC Personnel Review Bd. Dec. No. 1434 (Dec. 16, 2011) (Personnel Review Board upheld ALJ's dismissal of the charges of insubordination and dereliction of duty).

On the other hand, in numerous evaluations, including the 2012-2013 evaluation, respondent has been recognized for his knowledge of respiratory care and the quality of his patient care. Respondent's 2010-2011 evaluation said that he was "very reliable in the delivery of care" and praised the "superb quality" of his work. Respondent's 2011-2012 evaluation indicated that he was "extremely knowledgeable" about respiratory techniques and procedures and "very concerned" about proper patient care. The 2012-2013 evaluation indicated that respondent was "well versed in all aspects of respiratory care." Reading these evaluations, there is no doubt that respondent has rendered excellent service over the years.

Moreover, while a substantial penalty is without doubt warranted, respondent's lengthy tenure and limited disciplinary record suggest that he should be given an additional opportunity to conform his behavior to hospital rules and procedures. *See Dep't of Transportation v. Jackson*, OATH Index No. 299/90 at 14 (Feb. 6, 1990) ("It is a well-established principle in employment law that employees should have the benefit of progressive discipline wherever appropriate, to ensure that they have the opportunity to be apprised of the seriousness with which their employer views their misconduct and to give them a chance to correct it").

Accordingly, I am recommending that a 60-day suspension, just short of termination, be imposed upon respondent. This should be sufficient to impress upon respondent that he is under an absolute obligation to answer telephone calls from the ER and to respond to stat calls immediately. Respondent should understand that future conduct of a similar nature is likely to lead to termination of his employment.

Faye Lewis
Administrative Law Judge

May 28, 2014

SUBMITTED TO:

JULIUS WOOL, MPA
Executive Director
Queens Hospital Center

APPEARANCES:

JOHN O'DEA, ESQ.
Attorney for Petitioner

LICHTEN & BRIGHT, P.C.
Attorneys for Respondent
BY: STUART LICHTEN, ESQ.