Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Kahn

OATH Index No. 1051/15 (July 15, 2015)

Petitioner proved that respondent, an ultrasound technologist, failed to follow hospital rules for identifying patients and, as a result, performed the wrong procedure on the wrong patient. In light of respondent's disciplinary record, including a recent 60-day suspension for misconduct and incompetence, termination of employment recommended.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION (KINGS COUNTY HOSPITAL CENTER)
Petitioner
- against -
JEHAN KAHN
Respondent

REPORT AND RECOMMENDATION

KEVIN F. CASEY, *Administrative Law Judge*

This employee disciplinary proceeding was referred by petitioner, the New York City Health and Hospitals Corporation, under section 7:5 of the Personnel Rules and Regulations of the Corporation. Petitioner charged respondent, ultrasound technologist Jehan Kahn, with failing to properly identify a patient and performing an examination on the wrong patient (ALJ Ex. 2).

At a two-day trial, which ended on June 17, 2015, petitioner relied on testimony from two witnesses and documentary evidence. Respondent testified in his own behalf, recalled petitioner's witnesses, presented another witness, and also offered documentary evidence.

For the reasons below, I find that petitioner proved the charges and recommend termination of respondent's employment.

ANALYSIS

Preliminary Matter

Trial was originally scheduled for February 24, 2015. At petitioner's request, the trial was adjourned to accommodate a witness's schedule and re-scheduled for Monday, April 13, 2015. On the afternoon of Friday, April 10, respondent requested an adjournment because two unidentified witnesses had not been located. Thirty minutes after a phone conference to discuss the adjournment request, petitioner's counsel identified the witnesses and provided their contact information to respondent. Both sides were notified by e-mail and phone that the trial would go forward on April 13 (ALJ Ex. 1). Respondent's counsel later confirmed that, as of 4:45 p.m. on Friday, she had been notified that I had ordered the trial to go forward on Monday, but she made no effort to contact respondent all weekend (Tr. 16, 25).

On the morning of April 13, respondent and his counsel did not appear for trial. At 10:00 a.m., I spoke with respondent's counsel, Ms. Onua, by phone and directed her to report to this tribunal. Shortly afterwards, Ms. Onua arrived and I stated that the trial would begin at noon. She refused to participate and walked out (Tr. 43, 45). The trial continued in respondent's absence. Petitioner presented documentary evidence and testimony from two witnesses.

On April 14, 2015, out of an abundance of caution and a desire to avoid undue prejudice to respondent because of his attorney's error, I invited respondent's counsel to move to re-open the record. On May 5, 2015, over petitioner's objection, I granted respondent's motion to re-open the record. The hearing resumed and concluded on June 17, 2015.

As discussed more fully on the record, respondent's adjournment request was never granted (Tr. 8-14). Last-minute adjournment requests are disfavored and "subject to the most rigorous scrutiny." *Dep't of Correction v. Vassel*, OATH Index No. 267/93 (Nov. 18, 1992); 48 RCNY § 1-32 (b) (2015) ("good cause" required for an adjournment). Here, respondent offered no credible explanation for waiting until the eve of trial to request the adjournment.

Even if respondent's counsel disagreed with the denial of an adjournment and the order to go forward with trial, she was not permitted to disregard those orders. *See Balter v. Regan*, 63 N.Y.2d 630, 631 (1984) (public defender lawfully ordered to continue to represent defendant, even though his office represented prosecution's primary witness; belief that continued representation would be unethical was not a basis for disobeying the court's order); *see also Maness v. Meyers*, 419 U.S. 449, 458 (1975) ("If a person to whom a court directs an order

believes that order is incorrect the remedy is to appeal, but, absent a stay, he must comply with the order pending appeal"). Sanctions, including suspension from practice at this tribunal, are authorized for failure to comply with orders and directives. 48 RCNY § 1-13(a) (2015). Ms. Onua is warned that repeated failure to follow this tribunal's procedures may result in sanctions. *See Dep't of Sanitation v. Garcia*, OATH Index No. 1140/98 at 4-5 (May 1, 1998) (counsel, who walked out on trial after adjournment and motion to be relieved were denied, warned that such misconduct could lead to sanctions, including suspension of practice from this tribunal).

The Evidence at Trial

Respondent is an ultrasound technologist in the radiology department (Tr. 118). The charges stem from allegations that he committed misconduct on May 5, 2014, when he failed to follow hospital procedures for checking a patient's identity. As a result of that error, respondent allegedly performed an ultrasound on the wrong patient (ALJ Ex. 2).

The material facts are not in dispute. It is uncontested that patient W.A., a 63 year old man, was scheduled to receive an ultrasound and patient J.A., an 81 year old man, was scheduled for an MRI (Pet. Exs. 2; 5; Tr. 56, 58). Shortly after 3:00 p.m., respondent returned from his lunch hour and performed an ultrasound on patient J.A. (Schwartz: Tr. 53-54; Respondent: Tr. 167-68, 180). Respondent conceded that he performed the wrong procedure on the wrong patient (Schwartz: Tr. 55, 60-61; Respondent: Tr. 171-72).

Ms. Schwartz, manager of the ultrasound unit, testified that hospital policy and nationwide standards require staff to confirm a patient's identity using at least two "patient identifiers" before performing any procedures (Tr. 123-24, 131; Pet. Ex. 6). Each patient's identity should be confirmed by asking the patient his or her name and checking the medical record number on the wrist band (Tr. 124). A patient's identity can also be checked by date of birth or social security number (Pet. Ex. 6).

On the day of the incident, respondent told Ms. Schwartz that there was only one patient who had been waiting for a procedure, he picked up an order for an ultrasound examination on top of the patient's chart, he called the patient's name, and the patient responded (Tr. 119, 121). After performing the examination, respondent checked the patient's wristband and realized that he had performed the wrong exam on the wrong patient (Tr. 125-26). According to Ms.

Schwartz, even if there was only one patient and one chart, respondent was still required to use two methods to verify the patient's identity (Tr. 121).

Ms. Schwartz notified Mr. Aime, the executive director who oversees the radiology department (Aime: 74-75; Schwartz: Tr. 122;). After they cancelled the incorrect test result and obtained new orders, respondent performed the correct procedure on the correct patient at about 5:00 p.m. (Pet. Ex. 5; Tr. 63, 146). Mr. Aime initially told Ms. Schwartz to draft a warning memo, but later decided to refer the matter for disciplinary action (Aime: Tr. 76-77, 149-50; Schwartz: Tr. 122, 139).

Respondent testified that he earned a medical degree in Pakistan and he has worked for petitioner as an ultrasound technician for 13 years (Tr. 166, 177). He conceded that he was required to use different means of verifying a patient's identify, even if there was only one patient waiting for a procedure (Tr. 179, 186). According to respondent, when he saw only one patient waiting, he called the patient's name and the patient responded that was his name (Tr. 168, 180). Only after performing the ultrasound on the patient did respondent check the wristband and realize that he performed the wrong procedure on the wrong patient (Tr. 168, 182).

At trial, respondent suggested that a co-worker's blunder may have contributed to the mix-up. According to respondent, the ultrasound patient was also scheduled for a PVR (pulse volume recording) procedure (Tr. 168-69). Normally, one technician would perform both procedures (Tr. 169-70). On this day, however, Mr. Knight took the patient for only one procedure, the PVR (Tr. 169-70). Respondent faulted Mr. Knight for failing to alert clerical staff that he was only performing one of two scheduled procedures (Tr. 169-70).

No other witnesses testified that Mr. Knight had done something wrong. And, even if Mr. Knight had erred, that did not excuse respondent's misconduct. As respondent admitted, he had an independent duty to use two different means to verify his patient's identity. Respondent failed to do that. As a direct result of respondent's failure to follow standard procedures he performed the wrong procedure on the wrong patient. That was misconduct. *See Health & Hospitals Corp. (Elmhurst Hospital Ctr.) v. Huggins*, OATH Index Nos. 587/14 & 1545/14 at 1, 9 (June 23, 2014) (sustaining charges of dereliction of duty where lab technician sent a patient's specimen for testing with documentation for a different patient and on another occasion entered wrong test code on a requisition form that resulted in the incorrect test being performed).

FINDINGS AND CONCLUSIONS

1. Petitioner established by a preponderance of the credible evidence that respondent did not follow hospital rules for verifying a patient's identity before performing a procedure.

2. Petitioner established by a preponderance of the credible evidence that respondent performed the wrong procedure on the wrong patient.

RECOMMENDATION

Upon making the above findings, I requested and received respondent's personnel history. Petitioner hired respondent in 2002. In 2007, he accepted a 30-day suspension for the record, with 19 calendar days served, in satisfaction of charges that endangered the welfare of a patient and her unborn fetus by refusing to perform a sonogram. In 2012, respondent accepted a 60-day suspension without pay, in satisfaction of charges alleging incompetent job performance.

Respondent's performance evaluations for the past four years range from unsatisfactory to satisfactory. His 2011 evaluation noted that "many of his studies are suboptimal" with "poor quality non-diagnostic images, missing views, and unlabeled views, particularly in respect to obstetrical studies." In March 2012, radiologists reported that they "lacked confidence" in respondent's images and his poor interaction with pediatric radiologists caused delays. In June 2013, respondent showed improvement and received an overall rating of "satisfactory." However, it was noted that pediatric radiologists "had major concerns" about the quality of respondent's images. Respondent was removed from pediatric rotation but then restored and permitted to perform pediatric studies "with close oversight."

In June 2014, respondent received an "unsatisfactory" rating due to the present charges. But that evaluation also noted: in one study involving a patient with testicular cancer, respondent mislabeled a right testicle as a left testicle; a vascular surgeon asked for a repeat study performed by someone other than respondent; respondent had failed to document that he had taken ultrasound courses; respondent did not provide evidence that he passed an industry-standard proficiency exam; and the attending physicians lacked confidence in his abilities.

Petitioner now seeks termination of respondent's employment (Tr. 194). Respondent seeks a lesser penalty (Tr. 189). Among other things, respondent's counsel argued that

respondent found his own error and accepted responsibility, he is over-qualified for his job, the director of the radiology department initially planned to issue a warning, and respondent hopes to retire in a year (Tr. 192).

There is some mitigation here. In any human endeavor, people make mistakes. Respondent caught his error and brought it to the attention of his supervisor. There was no evidence that any patient suffered actual injury as a result of respondent's error.

However, the aggravating circumstances significantly outweigh those mitigating factors. Respondent has received penalties of 30 and 60 days for neglecting a patient and substandard performance. Petitioner has proved that, despite those substantial penalties, respondent has not corrected his behavior. *See Health & Hospitals Corp. (Woodhull Medical & Mental Health Ctr.) v. Ford*, OATH Index No. 2383/09 at 11 (July 10, 2009) (the goal of progressive discipline is "to modify employee behavior through increasing penalties for the same or similar misconduct, and to give employees full notice that if they do not modify their conduct, they risk termination"); *Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Meyers*, OATH Index No. 1487/09 at 8 (Jan. 26, 2009), *aff'd*, NYC HHC Pers. Rev. Bd. Dec. No. 1349 (July 31, 2009). Moreover, the error in this case was completely avoidable had respondent followed basic procedures. Respondent's failure to take the routine step of verifying a patient's identity resulted in needless testing and a delay in service, and it potentially endangered the safety of two patients – the patient who received the wrong test and the patient who did not receive the proper test.

In view of respondent's history of negligent and deficient performance, it does not matter that he belatedly discovered his error and no patients suffered physical harm. As Ms. Schwartz credibly explained, whenever this type of fundamental error occurs, it undermines patient confidence in the hospital and it causes other staff to question the competence of the radiology department (Tr. 145-46).

Where someone with respondent's record of poor performance violates basic hospital procedures, petitioner is not required to wait for a patient to be injured before taking appropriate action. *See Huggins*, OATH 587/14 & 1545/14 at 10 (termination of employment recommended where laboratory technician mislabeled and misidentified samples after previously receiving a 60-day suspension for similar misconduct and receiving poor evaluations); *Health & Hospitals Corp. (North Bronx Central Hospital) v. Doxen*, OATH Index No. 1577/01 at 18 (May 4, 2001) (termination of employment reflects "the seriousness of the offenses, the risks of harm to patients

and the Corporation's obligation to protect patients from staff who fail to exercise proper standards of care"); *see also*, *Health & Hospitals Corp. (Elmhurst Hospital Ctr.) v. Yao,* OATH Index No. 473/11 (Dec. 29, 2010) (termination recommended for dietician with an unblemished disciplinary record for falsifying a patient's record, which could jeopardize patient welfare).

This was not, as respondent suggests, a minor transgression that only required a warning. Though Mr. Aime initially asked Ms. Schwartz to draft a written warning, that document was never issued to respondent. Instead, after reviewing respondent's entire file, Mr. Aime decided to refer the matter for disciplinary action. I was also not persuaded by respondent's argument that he accepted responsibility for his actions. Though respondent admitted that he violated procedures and performed the wrong test on the wrong patient, he never expressed any sincere regret for his actions. Instead, he attempted to shift blame away from himself to clerical staff and another technologist.

Petitioner has a compelling interest in ensuring that fundamental safety procedures are followed. Respondent's disciplinary record, his history of poor performance evaluations, and the proven charges of misconduct all demonstrate that he is unwilling or unable to meet basic hospital standards. He poses an unacceptable risk to petitioner and its patients.

Accordingly, I recommend termination of respondent's employment.

Kevin F. Casey
Administrative Law Judge

July 15, 2015

SUBMITTED TO:

ERNEST J. BAPTISTE
Executive Director

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