Health & Hospitals Corp. (Jacobi Medical Ctr.) v. Hammond

OATH Index No. 2286/17 (Oct. 26, 2017)

Respiratory therapist's unauthorized removal of a patient's respiratory machine after the patient broke the device does not constitute misconduct. However, his failure to notify the clinical team that he removed the nonfunctioning device and to respond when summoned by the emergency department are sanctionable misconduct. 60-day suspension recommended.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION (JACOBI MEDICAL CENTER)
Petitioner
- against -
DENNIS HAMMOND
Respondent

REPORT AND RECOMMENDATION

ASTRID B. GLOADE, *Administrative Law Judge*

This employee disciplinary proceeding was referred by petitioner, the New York City Health and Hospitals Corporation, Jacobi Medical Center ("Jacobi"), pursuant to section 7:5 of petitioner's Personnel Rules and Regulations. Respondent Dennis Hammond, a respiratory therapist, is charged with misconduct and/or incompetence for removing a respiratory device from a patient, causing the patient to suffer medical and respiratory distress. Respondent is also charged with failing to notify the assigned medical provider or clinical team that he removed the device and with ignoring or failing to respond to overhead pages and/or calls to report to the Emergency Department to provide respiratory care for a level one trauma patient (ALJ Ex. 2).[1]

[1] During the trial, petitioner withdrew specifications two, four, and six of the charges (Tr. 294-95).

During a two-day trial on the charges, petitioner presented the testimony of five witnesses and submitted documentary evidence. Respondent, who was represented by counsel, testified on his own behalf and offered the testimony of two witnesses.

For the reasons set forth below, I find that petitioner established most of the charges and recommend that respondent be suspended without pay for 60 days.

ANALYSIS

Respondent, an Associate Respiratory Therapist, has worked at Jacobi since October 2009 (Tr. 202). It is alleged that on February 19, 2016, respondent removed a Bilevel Positive Airway Pressure ("BiPAP") respiratory device from a patient, which caused the patient to suffer medical and respiratory distress. It is also alleged that respondent failed to notify the medical care provider and/or clinical team that he had done so. Respondent is also charged with failing to respond to pages and overhead calls to report to the emergency department ("ED") to provide respiratory care to a trauma patient on February 20, 2016 (ALJ Ex. 2).

Unauthorized Removal of Respiratory Device from Patient (Specification One)

On February 19, 2016, respondent worked the overnight shift in the ED with a clinical team that included Dr. Christine Cassidy, the attending physician, Dr. Ankita Lal, a fourth-year resident, and two nurses (Tr. 14-15, 16-17, 87-88).

Respiratory therapists work under a doctor's supervision. Once a doctor orders that a patient be placed on a respiratory device, such as a BiPAP machine, the respiratory therapist connects the patient to the device. A BiPAP machine aids breathing by supplying oxygen from a machine to the patient through a hose connected to a tight-fitting mask that is placed on the patient's face and attached to the head with Velcro straps. The respiratory therapist programs the BiPAP machine using air pressure settings provided by the doctor. Those settings can vary depending on the patient's size and underlying medical issue. The therapist is responsible for entering the settings into the machine, placing the mask on the patient, and monitoring the patient to ensure that he or she is tolerating the treatment well. When a doctor orders that a patient be placed on the BiPAP machine, he or she is supposed to provide a plan for the patient that includes oxygenation and ventilation goals. The doctor and respiratory therapist evaluate the patient and when the doctor determines that it is appropriate to remove the patient from the

machine, the respiratory therapist is responsible for removing the patient from the machine (Cassidy: Tr. 18-21; Cabarrubia: Tr. 122-23, 140-41).

Kevin Brinson, Associate Director of Respiratory Care Services at Jacobi, is responsible for the overall operations of the respiratory department and helped create and implement the facility's policies regarding respiratory therapists. He testified that placing a patient on a BiPAP machine requires a doctor's written order, as does removing the patient from the machine. The therapist typically determines whether the BiPAP mask needs to be changed. Although there is no policy that sets forth the steps a respiratory therapist must follow when changing a patient's mask, the respiratory therapist should inform the doctor when doing so because additional support may be needed for the patient, depending on his or her condition. Masks to be used with the BiPAP device come in several sizes depending on the size of the patient's face. The respiratory therapist is responsible for having the correct size mask available at the patient's bedside. If there is a need to change a BiPAP mask, the respiratory therapist should replace the existing mask with a new one simultaneously. If the mask is too tight, the therapist should work with the patient to adjust the mask or loosen the straps on the mask so that it is more comfortable (Tr. 151-52, 155-56, 162-66, 167-68; Pet. Ex. 6).

Dr. Lal testified that several hours into her 8:00 p.m. to 8:00 a.m. shift, when one of her patients appeared to be in respiratory distress, she and Dr. Cassidy determined that the patient needed to be placed on a BiPAP machine. Dr. Lal asked respondent to place the patient on the machine. Later that evening, when Dr. Lal reevaluated the patient, the patient's family informed her that the BiPAP mask was uncomfortable and she observed that it was tight on the patient. Dr. Lal advised respondent of the complaints and asked him to check on the patient (Tr. 91-92, 104-05, 107-08, 110-11).

Dr. Cassidy, who has been an attending physician at Jacobi for 20 years, is responsible for caring for patients and teaching residents who work under her supervision. At approximately 11:00 p.m., Dr. Cassidy was walking by the patient's room when she noticed that Dr. Lal's patient was not attached to the BiPAP machine and was sweating and having extreme difficulty breathing. In addition, an oxygen saturation monitor, which measures the amount of oxygen in the patient's blood, showed that her oxygen saturation level was low. Dr. Cassidy was concerned that the patient was not getting enough oxygen into her body, which could result in a heart attack and death. She asked a nurse who was part of the clinical team why the patient was

not on the BiPAP machine, but the nurse said she had just returned from a break and did not know. Dr. Cassidy asked the nurse to call respondent (Tr. 14-16, 23-26, 43).

According to Dr. Cassidy, when respondent arrived, she asked him why the patient was off the BiPAP machine and he told her that a doctor instructed him to remove the patient from the machine (Tr. 24).

About 15 to 20 minutes after Dr. Lal told respondent to check on the patient's mask, a nurse approached her and reported that the patient was not on the BiPAP machine and was having trouble breathing. The nurse also reported that respondent told Dr. Cassidy that Dr. Lal directed him to take the patient off the machine (Tr. 92, 111).

Dr. Cassidy and respondent were outside the patient's room when Dr. Lal approached them. She asked respondent who told him to remove the patient's mask and respondent stated that no one had authorized him to do so. When questioned further, respondent said it was done pursuant to his medical evaluation (Tr. 93, 97).

Later in her shift, Dr. Cassidy wrote an e-mail to her supervisor summarizing the incident. In that e-mail, she stated that after the patient was found off the BiPAP machine, she had the nurse contact respondent, who told the nurse that Dr. Lal instructed him to remove the machine. She wrote that Dr. Lal confronted respondent and denied having directed him to remove the BiPAP machine. At this time, Dr. Cassidy spoke to respondent while the nurse and Dr. Lal were present and he "admitted that he decided to remove the BiPAP himself." She noted that after removing the device, respondent left the patient without informing any other staff members (Pet. Ex. 1).

Similarly, Dr. Lal wrote a memorandum dated February 25, 2016, detailing her version of the events. According to the memorandum, respondent falsely told the nurse that Dr. Lal instructed him to remove the patient from the BiPAP machine, but retracted his statement when Dr. Lal confronted him. He then stated that no one told him to remove the BiPAP device and admitted to Dr. Cassidy that he took the patient off the machine "after 'performing medical evaluation' and did not tell anyone about it" (Pet. Ex. 3).

Respondent maintained that the patient removed the mask herself and claimed that he only tried to replace the mask after she broke it.

Respondent was the only respiratory therapist assigned to the ED during the 7:00 p.m. to 7:40 a.m. shift on the evening of February 19. In contradiction to Dr. Lal's testimony,

respondent denied that Dr. Lal ordered him to place the patient on the BiPAP machine that evening. Instead, respondent testified that while he was on the third floor of the building in which the ED is located, an ED doctor whose name he could not recall paged him and instructed him to place the patient on a BiPAP machine because she was in some distress. Respondent went to the ED on the first floor, where he spoke to the doctor who had paged him. That doctor reiterated that the patient was in distress. He then obtained a BiPAP machine from where they are kept in the ED and went to the patient. The doctor did not provide written orders for settings on the BiPAP machine, so he asked the patient if she used a machine at home. The patient provided the settings that she used for her BiPAP machine at home, which he used to set up the machine (Tr. 204, 209-12, 246-48).

Respondent described the patient as noncompliant with the BiPAP treatment. She did not want to use the BiPAP machine and resisted his efforts to put on the mask. The patient complained that she did not like to use the BiPAP machine she had at home. Respondent told the patient's daughter, who was with her at the time, that the patient needed to use the machine and coaxed the patient to put on the mask. However, she repeatedly removed it and put it back on. Respondent eventually set up the BiPAP machine and left the patient, but checked on her several times. The first time he returned, the patient had removed the mask from her face, including the straps used to attach the mask to her head. Respondent readjusted the straps on the mask for proper fit and placed it back on the patient's face. Respondent returned to the patient's room and noticed that the mask was attached to her head, but had been moved to the side of her face so that she was not receiving the full treatment from the BiPAP machine. He again readjusted the mask on her face and spoke to a family member about the need for the patient to wear the mask (Tr. 212-14, 253-56, 259).

Respondent informed the nurses who were sitting in the nurses' station that the patient was not wearing her mask, but he did not inform anyone in particular. There were doctors present in the vicinity of the nurses' station, but respondent did not specifically tell any of them that the patient was noncompliant with the BiPAP treatment. Respondent went to the patient's room three times, but he did not alert any of the doctors in the ED that the patient was not keeping on the mask (Tr. 257-58, 260).

Respondent testified that later that evening, he was in the asthma booth caring for a sick colleague when Dr. Lal approached him and told him to remove the BiPAP machine because the

team did not want the patient on the machine for more than two hours. Before Dr. Lal approached him, respondent had not known that she was treating the patient. He described himself as happy that someone else was taking an interest in the patient's care. Respondent went to check on the patient after he spoke to Dr. Lal because he was unsure what Dr. Lal had instructed him to do. When he entered the patient's room the mask was in two pieces: part of the mask was on her face and the second piece was dangling from the hose that was attached to the machine. Oxygen was flowing from the machine, which was still on, but because it was not attached to the mask, the patient was not getting any oxygen (Tr. 214-15, 225-26).

Respondent removed the patient's mask when he entered the room and saw that it was broken, and he turned off the BiPAP machine. He did not alert a doctor that the mask was broken and had to be replaced. He went to the basement of the building in which the ED is located to get a replacement mask for the machine, but could not find the size the patient needed. He then went to a storage area where respiratory equipment is stored on the 12th floor of building one, which is adjacent to the building in which the ED is located. He obtained the mask and returned to the ED. Respondent did not go to the patient's room, but instead went to the treat another patient in the asthma booth, which is where a nurse approached him and accused him of removing the patient from the BiPAP machine (Tr. 227-28, 230, 262-64).

According to respondent, the nurse summoned Dr. Cassidy. He tried to explain that he had not removed the patient from the machine and that, in any event, Dr. Lal told him that she did not want the patient on the machine for more than two hours. As he spoke to Dr. Cassidy, he had a BiPAP mask in his hand, as he was returning to the patient to replace her broken mask (Tr. 229-30).

Respondent admitted that when Dr. Cassidy and the nurse confronted him about the patient, he stated that he had removed the patient's mask. However, Dr. Cassidy did not permit him to explain the circumstances under which he did so. Respondent acknowledged that no one told him to remove the mask (Tr. 265-66).

Respondent's contention that the patient initially removed the BiPAP mask herself and broke it is supported by credible evidence. Specifically, Jai Patel, a respiratory therapist and supervisor who has worked at Jacobi for 14 years, testified that the patient admitted as much when he interviewed her shortly after the incident (Tr. 173).

On the morning of February 20, 2016, Dr. Cassidy's e-mail concerning the incident was forwarded to Mr. Callinan, who was a director of respiratory care at the time, with a request that he investigate the allegations against respondent. Mr. Patel testified that while he was working the day shift on February 20, Mr. Callinan asked him to interview a patient about who took her off the BiPAP machine. Since he was conducting rounds with Salem Al Hijazin, another respiratory therapist, Mr. Patel asked Mr. Al Hijazin to accompany him (Pet. Ex. 1; Tr. 174-75, 178, 182, 188).

Mr. Patel interviewed the patient, who was in the intensive care unit accompanied by a family member, about the events in the ED the preceding evening. According to Mr. Patel, the patient stated that she could not breathe when connected to the BiPAP device and had called for someone to take the mask off, but no one helped her. She then removed the mask herself, breaking it in the process. The patient's relative expressed concern that they would be charged for breaking the mask and insisted that they would not pay for it. The patient repeatedly denied that someone else had removed the mask and stated that she took it off herself. The patient told Mr. Patel that she has a similar mask at home and that she does not wear that one either. He later testified that the patient stated that she had "ripped" the mask off because she felt as though she was suffocating and when she called for help and no one responded. Mr. Patel stated that he wrote a summary of the patient's statements and provided it to Mr. Callinan, who has since retired from his position at Jacobi (Tr. 175-76, 182-83, 188-89).

Mr. Al Hijazin corroborated Mr. Patel's account. He testified that he accompanied Mr. Patel to interview the patient, who was with a relative. When Mr. Patel asked the patient what happened the night before, she told him that she was unable to breathe with the BiPAP mask on and felt as though she was suffocating, so she removed it from her face. At no time did the patient state that respondent removed her BiPAP mask (Tr. 194-96).

Respondent's testimony that the patient removed the mask is consistent with the account he gave his supervisor shortly after the incident occurred. Edmund Cabarrubia, who supervises respiratory therapists on the night shift, testified that when he was alerted about the incident a few hours after it occurred, he spoke to respondent, who told him that the patient had removed the mask herself. Mr. Cabarrubia's summary of the incident, which he wrote a few days later, is consistent with his testimony (Tr. 121-22, 137; Pet. Ex. 4).

Mr. Patel's notes of his interview were not offered into evidence. Notwithstanding the absence of those notes, Mr. Patel and Mr. Al Hijazin were credible. Their testimony was clear and consistent, and they appeared to be disinterested witnesses with no discernible bias. *See Dep't of Sanitation v. Menzies,* OATH Index No. 678/98 at 2 (Feb. 5, 1998), *aff'd,* NYC Civ. Serv. Comm'n, Item No. CD 98-101-A (Sept. 9, 1998) (factors such as witness demeanor; consistency of witness' testimony; supporting or corroborating evidence; witness motivation, bias, or prejudice; and the degree to which a witness' testimony comports with common sense and human experience are to be considered in making credibility determinations).

In some respects, respondent's version of these events is puzzling. He maintained that after Dr. Lal told him to remove the patient from the BiPAP machine, he went to the patient's room and observed that she had already broken the mask on the BiPAP machine. He turned off the machine and went to obtain a replacement mask, leaving the patient without a functioning mask and failing to notify Dr. Lal, who he claimed told him to take the patient off the machine. According to respondent, even though he had been ordered to take the patient off the machine, and the patient had already removed herself from the machine by breaking the mask, he went to get a replacement mask. Respondent said that he did so because the patient was still on the BiPAP machine pursuant to a doctor's order when she broke the mask (Tr. 264). Yet, he did not think it necessary to notify the doctor that the mask was no longer functional and had to be replaced. This makes little sense. Having been ordered by Dr. Lal to take the patient off the machine, and discovering that the patient had already removed herself from the machine before he arrived, there was no need to get a replacement mask. Respondent's contention that Dr. Lal told him to remove the patient from the machine is not credible. Instead, it is more likely than not that Dr. Lal told him to go check on the patient and, discovering the broken respiratory device, respondent turned off the machine and went to get a new mask.

Moreover, Dr. Lal credibly denied instructing respondent to remove the patient from the BiPAP machine. She insisted that she wanted him to check the mask to see if was fitted properly and to loosen the straps if necessary. She did not want him to remove the mask because when a patient is removed from the BiPAP machine, it must always be done in the presence of a doctor because a patient could decompensate rapidly, which could make it necessary to intubate him or her. Dr. Lal testified that in her practice she has never ordered a patient removed from the BiPAP machine without being present (Tr. 97, 108-10, 114).

Nonetheless, although respondent's contention that Dr. Lal told him to remove the patient from the BiPAP machine is not credible, there is support for other aspects of his account. Notably, the credible evidence established that the patient tried to remove the BiPAP mask, damaging it in the process. By the time respondent arrived, the mask was already broken and could not effectively deliver oxygen to the patient. He then removed the mask and turned off the BiPAP machine.

Accordingly, the evidence establishes that respondent removed the BiPAP respiratory device from the patient in that he removed a broken mask and turned off the machine without authorization. However, at the time he did so, the BiPAP machine was not able to deliver oxygen to the patient because the patient had already rendered the device inoperable. Thus, at the time respondent removed the device, the patient was not receiving respiratory treatment because of her own actions in disabling the device.

Under these particular circumstances, respondent's removal of the inoperable BiPAP device from the patient without authorization does not constitute misconduct and specification one should be dismissed.

Failure to Notify Clinical Team (Specification Three)

Petitioner established that respondent failed to notify the clinical team that he removed the patient's respiratory device, as charged in specification three.

Mr. Brinson testified that removing a patient from a BiPAP machine requires a doctor's order and that a respiratory therapist should inform the doctor when he is changing a BiPAP mask as the patient may require additional respiratory support while the mask is being changed (Tr. 162-64, 167-68).

Respondent admitted that after he observed the broken mask, he removed it from the patient and turned off the BiPAP machine because it was not delivering treatment to the patient. He also admitted that he had not received a doctor's authorization to turn off the machine and that he did not alert the clinical staff that the mask was broken and had to be replaced (Tr. 262-64). His failure to notify the medical staff that he had removed the respiratory device constitutes misconduct.

Misconduct may be premised on carelessness or negligence, as well as willful or intentional conduct. *See, e.g., McGinigle v. Town of Greenburgh*, 48 N.Y.2d 949, 951 (1979);

Reisig v. Kirby, 62 Misc. 2d 632, 635 (Sup. Ct. Suffolk Co. 1968), *aff'd*, 31 A.D.2d 1008, (2d Dep't 1969). This tribunal has held that "the degree of carelessness must be more than *de minimis*, since minor and inconsequential errors do not rise to the level of misconduct." *Dep't of Sanitation v. Nieves*, OATH Index No. 1683/07 at 2 (Sept. 19, 2007); *see also Dep't of Sanitation v. Richards*, OATH Index No. 529/06 at 3 (Feb. 3, 2006); *Dep't of Sanitation v. Frank*, OATH Index No. 465/03 at 8 (Feb. 28, 2003). However, a single error may constitute negligence where the agency has a particular interest in accuracy or there is a potential for adverse consequences. *See, e.g.*, *Dep't of Environmental Protection v. Majors*, OATH Index No. 1024/10 at 4 (Mar. 10, 2010), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 11-35-A (May 11, 2011) (respondent guilty of negligence for his failure to include his truck's breakdown on his daily log sheet since the Department had an interest in accounting for its heavy equipment for liability and repair purposes); *Richards*, OATH 529/06 at 7 (finding respondent's failure to fuel a truck was negligent as it was an important task and the failure to perform it had adverse consequences).

Here, the evidence establishes that respondent was negligent in performing his duties as a respiratory therapist, and that his negligence constitutes misconduct. Dr. Lal instructed respondent to check on the patient, so he was well aware that she was the clinician to whom he should report any issues with the patient's respiratory care. He knew that this particular patient was not adhering to the BiPAP treatment because he had checked on her several times over the course of the evening and she had repeatedly removed the BiPAP mask. Respondent was on notice that patient was not receiving the prescribed course of treatment because she broke the BiPAP device. He knew that Dr. Lal was treating the patient and was happy that someone had taken an active interest in the case. Yet, instead of advising Dr. Lal or another physician that he had turned off the BiPAP machine and that the patient may not have received full benefit of the treatment, he went in search of a replacement mask. He left the patient unattended as he wandered from one building to another trying to find the mask. He also stopped in an asthma room to treat another patient, yet failed to notify anyone that he had removed the patient from the BiPAP machine. That the patient may have disabled the BiPAP mask does not relieve respondent of his responsibility to inform the doctor that he had turned off the machine and the patient was no longer getting prescribed treatment.

Accordingly, specification three should be sustained.

Failure to Respond to Pages and Overhead Calls (Specification Five)

Several hours after the incident with the BiPAP machine, respondent failed to respond when he was summoned to the ED because a level one trauma patient was in need of respiratory care.

Mr. Cabarrubia testified that respiratory therapists are required to carry a beeper and a Nextel phone, which are used for regular communications with the therapist and in emergency situations. When there is a level one trauma patient in the ED, the Nextel phone, which sends a message to everyone on the trauma team, says "trauma in the ER" (Tr. 133). To contact the respiratory therapist by beeper, one would enter the hospital telephone extension for the person or department that was trying to reach the therapist. That telephone extension would appear on the beeper, signaling the therapist to call that number. In addition to the beeper and the Nextel phone, staff can be summoned using an overhead public address system that broadcasts messages heard throughout the facility (Tr. 69, 100, 128-30, 135).

A critically injured patient arrived in the ED after midnight on February 20, 2016. Dr. Cassidy testified that the patient had to be placed on a ventilator, also referred to as a respirator, which is the responsibility of the respiratory therapist. The ED paged the respiratory therapist to report to the area several times, but there was no response. Dr. Lal had intubated the patient, meaning that a breathing tube was inserted down the patient's throat to facilitate breathing, and the medical staff was using an "ambu bag" to deliver oxygen to the patient through the tube. Placing the patient on the ventilator is preferable to using an ambu bag because the ventilator provides a higher level of consistent assistance with breathing. When the trauma team could not reach respondent, Dr. Cassidy contacted his supervisor, Mr. Cabarrubia (Tr. 27-30, 47, 118).

Dr. Lal testified that the ED staff tried to reach respondent several times. Dr. Lal sent someone to look for respondent in the asthma room, which is where the respiratory technician can usually be found. However, he was not there. The trauma team had respondent paged at least three times on the overhead paging system, which meant that the page was broadcast throughout the hospital, but he did not report to the ED (Tr. 99-101).

Dr. Lal described herself as becoming increasingly frantic because once a patient is intubated, he is paralyzed and the medical staff must use an ambu bag to help the patient breathe until he is placed on a ventilator. According to Dr. Lal, a delay in providing respiratory care could have jeopardized the patient, who must be attached to the ventilator before he can be

transferred out of the ED for further diagnosis and treatment. Gladstone Wilson, an ED nurse who is a registered respiratory therapist, placed the patient on the ventilator. After the patient was on the ventilator, but before he was transferred to get a CAT scan, respondent arrived in the ED. The patient had already been in the ED for about ten minutes before Dr. Lal intubated him. From the time the patient arrived in the ED to when respondent came to the ED, 15 to 20 minutes had elapsed (Tr. 99-100, 104, 117-18).

In a memorandum dated February 25, 2016, Dr. Lal noted that respondent's failure to respond to the pages delayed getting a head CAT scan of the patient, who was found to have "profound intracranial hemorrhage" (Pet. Ex. 3).

Nurse Wilson, an Assistant Head Nurse in the ED, has worked at Jacobi for 12 years. He testified that early in the morning of February 20, 2016, a Fire Department dispatcher alerted the ED that emergency medical service technicians would be bringing a trauma patient to the emergency room in five minutes. Upon receiving the call, Nurse Wilson contacted the Jacobi operator to alert her that a level one trauma patient would be arriving and that she needed to notify the trauma team, which consisted of Dr. Cassidy, several residents, staff from the radiology and orthopedics departments, and the respondent. Respondent was paged before the patient arrived in the ED, but did not respond (Tr. 51-54, 57-60, 67, 69).

Nurse Wilson made several unsuccessful efforts to notify respondent of the trauma patient's arrival to the ED between 2:10 a.m. and 2:30 a.m. In addition to asking the operator to notify the trauma team, Nurse Wilson used the Nextel phone to contact the team. According to Nurse Wilson, the trauma team is designated as a discrete group on the phone, so when it is necessary to reach the team, he dials that group designation, holds down the button that corresponds to the group, and speaks into the Nextel, which functions like a walkie-talkie. His message goes to everyone on the trauma team who has a Nextel device. When he notified the trauma team on the Nextel, he gave them information about the nature of the emergency and the patient's medical status, and told them that the patient had not been intubated. Respondent did not reply to Nurse Wilson's Nextel message (Tr. 54-61, 68).

After respondent failed to respond to the Nextel message, Nurse Wilson asked a clerk to page respondent using the hospital's overhead paging system. Respondent was paged two or three times on the overhead system, but he did not contact the ED (Tr. 61, 69).

The trauma patient was being assisted with breathing through use of an ambu bag, which was not the optimal method for getting oxygen to the patient, and had to be placed on a ventilator. Because the patient required immediate respiratory care and respondent was not present, Nurse Wilson secured the patient's airway with an endotracheal tube and placed the patient on the ventilator. After the patient was ventilated, respondent was paged again. He arrived in the ED 10 to 15 minutes after Nurse Wilson placed the patient on the ventilator. This was 20 to 25 minutes after Nurse Wilson's first attempt to reach respondent. Nurse Wilson submitted a written memorandum about the incident to his supervisor because it was unusual for him to have had to place the patient on the ventilator because respondent took an unusually long time to respond when summoned to the ED (Tr. 61-64, 76-77, 80; Pet. Ex. 2).

Mr. Cabarrubia heard respondent being paged via the overhead system. He testified that sometime after midnight on February 20, he heard an overhead page stating "respiratory therapist to the ER" several times (Tr. 125-26). Mr. Cabarrubia then heard a page summoning him, as the respiratory therapy supervisor, to the ED. When he learned that the department needed a respiratory technician in the trauma bay, he went there immediately (Tr. 126-27).

On his way to the ED, Mr. Cabarrubia tried to contact respondent. Mr. Cabarrubia called respondent on his personal cell phone, which he thought would be the easiest way to reach him, and told respondent that he was needed in the ED as soon as possible. By the time Mr. Cabarrubia arrived in the ED, respondent was already there and was about to take the patient for a procedure. Dr. Cassidy informed Mr. Cabarrubia that they had paged respondent multiple times, but he appeared only after the patient had been intubated (Tr. 124, 127-28, 130-31, 133, 135).

Respondent acknowledged that at the start of his shift on February 19, he received pager and Nextel devices, which he is required to have on his person when he is on duty. Nonetheless, he denied having received any messages on those devices or hearing any overhead pages about the trauma one patient in the ED (Tr. 235, 238, 266-67).

According to respondent, the Nextel phone was working when he received it. However, approximately an hour into his shift, at about 8:00 p.m., he noticed that it had lost power. He placed the Nextel on a charger in the ED. When he removed it from the charger 20 minutes later, the phone again lost power and had to be charged again. Respondent testified that he continued to have trouble charging the Nextel phone during his shift. Respondent maintained

that he did not receive a message on the Nextel phone about the trauma one patient arriving in the emergency department because the Nextel was being charged (Tr. 267-69, 271-72).

Respondent first learned that the trauma team was trying reach him when Mr. Cabarrubia called him as he exited an elevator on the 12th floor of building one. He had been on his way to get some equipment when Mr. Cabarrubia telephoned him. Respondent told Mr. Cabarrubia that he had just left the ED and asked what was happening, but Mr. Cabarrubia did not know. Respondent returned to the ED, where he observed a level one trauma patient on a ventilator. He assumed control over the patient's respiratory care (Tr. 235-36).

Building one, where respondent was located when his supervisor reached him, is attached to building six, where the ED is located, and one can move between the buildings using internal passageways. Before going to the 12th floor in building one, respondent had used a staff restroom on the fourth floor in the same building. Respondent used the restroom in building one instead of using a restroom in building six, because the restrooms in building one are cleaner. He was in building one for about 10 minutes when Mr. Cabarrubia called, and it took him about five minutes to get to the ED after they spoke (Tr. 236-37, 275, 279-80).

Respondent's claim that the Nextel was not working was not compelling. Had he experienced persistent problems with the device as he described, it would have made sense for him to report those difficulties to his supervisor given that his duties in the emergency room required that he be available to provide respiratory care under urgent circumstances where a patient's life may be at risk. This is especially so since, by his own account, respondent became aware that the Nextel device was malfunctioning at 8:00 p.m., about five hours before the trauma patient's arrival to the ED. Yet, he did not report the purported difficulties he was having with the Nextel phone (Tr. 271-72). His uncorroborated claim that the device was not working is not credible.

Similarly, respondent's contention that he did not hear the overhead pages is not convincing. Respondent's counsel suggested that respondent did not hear the overhead pages because they were never made (Tr. 287). However, this argument fails as respondent's supervisor credibly testified that he heard repeated overhead pages summoning the respiratory therapist to the ED (Tr. 125-26).

Respondent also contended that he could not hear the pages because the overhead system does not function well in building one (Tr. 287). Granted, Mr. Patel testified that is difficult to

hear overhead pages in the staff bathrooms in building one, where respondent testified he was located just before Mr. Cabarrubia telephoned him (Tr. 179). However, even if it is difficult to hear overhead pages in the building one bathroom, this does not explain respondent's failure to respond to the multiple overhead pages.

Nurse Wilson credibly testified that he repeatedly tried to contact respondent using the Nextel phone and overhead pages between 2:10 a.m.and 2:30 a.m. This is largely consistent with a memorandum he wrote shortly after the incident, noting that it took respondent about half an hour to respond to the ED pages (Pet. Ex. 2). Similarly, Dr. Cassidy testified that the trauma team paged respondent three to four times over at least half an hour (Tr. 28, 48). Mr. Cabarrubia heard several of these pages, although he did not recall over how long of a time period (Tr. 125). Their testimony was largely consistent and is supported by the written statements prepared shortly after the incident.

Moreover, Drs. Cassidy and Lal and Nurse Wilson's credibility is bolstered by their detailed account of the circumstances surrounding respondent's failure to respond to the ED pages. They described a situation in which a critically injured patient was transported to the ED and required immediate care. Their heightened need for the services of a respiratory therapist, coupled with respondent's prolonged failure to respond, likely enhanced their recollection of their futile efforts to reach him.

Respondent was in building one for ten of the 20 to 30 minutes during which he was being paged. Therefore, even if the overhead page did not work in that building, it is highly implausible that respondent did not hear any of the overhead pages summoning him to report to the ED to assist with the trauma patient.

In sum, petitioner established that respondent failed to respond to overhead pages and calls to report to the ED to provide respiratory care to a level one trauma patient.

FINDINGS AND CONCLUSIONS

1. Respondent's removal of a BiPAP machine from a patient after the patient rendered the device's mask inoperable does not constitute misconduct and specification one should be dismissed.

2. Petitioner proved that respondent failed to notify the medical team that he removed the patient's respiratory device, as charged in specification three.

3. Petitioner proved that respondent ignored or failed to respond to overhead pages and calls to report to the Emergency Department to provide respiratory care to a trauma patient, as charged in specification five.

RECOMMENDATION

Upon making the above findings and conclusions, I obtained and reviewed copy of respondent's disciplinary abstract for purposes of recommending an appropriate penalty. Respondent was appointed to his position in October 2009. He has had one incident of prior discipline, in August 2015, when he accepted a 15 calendar-day suspension for falsely reporting that he had performed certain procedures on a patient. The performance evaluations provided for respondent, covering the period from October 2009 through October 2013, were satisfactory.

Petitioner argued that respondent should be terminated from his employment for the charged misconduct. However, all of the charges were not sustained. Nonetheless, the proven misconduct is serious. In the first instance, respondent failed to notify the clinical team that he had removed the broken BiPAP mask from a patient and turned off the machine. He did so despite knowing that the patient, who he placed on the machine because she experienced difficulty breathing, had been noncompliant with the treatment. He knew which doctor was responsible for the patient because she had ordered him to check on the patient. Yet, instead of reporting to the doctor that the patient was not receiving treatment, he went off on a search for a new mask for the BiPAP machine. It is unclear how long respondent left the patient unattended, but she was having trouble breathing when one of the ED doctors saw her.

In the second instance, respondent failed to respond to multiple pages from the ED when he was needed to provide respiratory care to a seriously injured patient. Indeed, it appears that the trauma team tried to reach respondent for 20 to 30 minutes, to no avail. It is fortunate that a nurse, who is also a registered respiratory therapist, was able to step into the breach created by respondent's absence and perform the critical respiratory procedures that were necessary before the patient could be transported for essential assessment and treatment.

Coming on the heels of his charged confrontation with members of the trauma team who challenged his handling of the patient on the BiPAP machine a few hours earlier, it is reasonable to infer that respondent's failure to answer the ED's calls for his assistance was motivated by petty

annoyance. In an emergency room setting, where swift, competent medical care can make the difference between life and death, such misconduct could have dire consequences.

Penalties for hospital employees whose misconduct has been found to impact patient safety have been relatively severe. *See Health & Hospitals Corp. (Harlem Hospital Ctr.) v. Bryant*, OATH Index No. 2493/15 (Oct. 19, 2015) (30-day suspension for a dietician who failed to assess high risk patients within 24 hours as required by hospital rules and engaged in disruptive behavior); *Health & Hospitals Corp. (Queens Hospital Ctr.) v. Toval,* OATH Index No. 1372/14 (May 28, 2014), *aff'd*, HHC Pers. Rev. Bd. Dec. No. 1560 (Apr. 23, 2015) (60-day suspension for respiratory therapist who failed to respond to the emergency room in a timely manner); *Health & Hospitals Corp. (Jacobi Medical Ctr.) v. Goldfayn,* OATH Index No. 2100/12 (Nov. 21, 2012) (30-day suspension for an ultrasound technician who failed to follow proper procedures in performing an echocardiogram on a patient, resulting in the patient having to return to the hospital to retake the exam. Here, respondent twice engaged in conduct that put the safety of the facility's patients at risk. Thus, a significant penalty is appropriate.

Accordingly, I recommend that respondent be suspended for 60 days, with credit for time served in pre-hearing suspension.

Astrid B. Gloade
Administrative Law Judge

October 26, 2017

SUBMITTED TO:

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