Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Anatua-Bichotte

OATH Index No. 1947/11 (Oct. 13, 2011)

Charges of patient abandonment and insubordination dismissed in part and sustained in part. Penalty of ten days suspension recommended.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION (KINGS COUNTY HOSPITAL CENTER)
Petitioner
-against-
CAROL ANATUA-BICHOTTE
Respondent

REPORT AND RECOMMENDATION

FAYE LEWIS, *Administrative Law Judge*

This is a disciplinary proceeding brought by petitioner, the Health and Hospitals Corporation (Kings County Hospital Center), pursuant to section 7:5 of the Personnel Rules of the Corporation. The charges allege that on June 16, 2010 and June 30, 2010, respondent, a respiratory therapist, was insubordinate toward a supervisor, physician's assistant, and doctor, and engaged in patient abandonment and disruptive behavior.

At a two-day trial, petitioner presented four witnesses while respondent presented four witnesses and testified on her own behalf. The record was left open until August 16, 2011, for the submission of legal memoranda relating to the patient abandonment charges.

For the reasons below, I find that the charges relating to June 16 are not sustained and should be dismissed. The charges relating to June 30 are sustained in part. I recommend that respondent be suspended for ten days.

ANALYSIS

June 16, 2010

Petitioner alleges that at about 10:00 a.m. on June 16, 2010, in a room in the medical intensive care unit ("MICU"), respondent was verbally abusive, disrespectful, and insubordinate towards her supervisor, Barri Stallworth. More specifically, petitioner alleges that respondent refused to comply with a direct order from Mr. Stallworth to do bedside rounds, stating, "Forget it, I will never discuss this topic with you again" (specifications one, two). Also alleged is that respondent refused to answer a page from Mr. Stallworth to report to the office after she had finished her treatment rounds (specification three). Finally, petitioner contends that respondent disrupted patient care, was insubordinate, and abandoned her duty when she refused to follow a directive from a physician's assistant, Mr. Gay, to extubate a patient in MICU and left the area without authorization (specification four).

MICU treats critically ill patients. There is usually at least one patient in MICU who requires a ventilator to breathe (Tr. 66, 67). Usually, in MICU, respiratory therapists such as respondent monitor patients who are on ventilators and play a major role in extubating them, or taking them off the respirators (Tr. 68). A respiratory therapist may extubate a patient whether or not a physician is present (Tr. 69).

The parties agree that on June 16, 2010, respondent was assigned to the MICU and also to the critical care unit ("CCU"). Her shift was from 8:00 a.m. to 8:00 p.m. (Tr. 309-310). Mr. Stallworth, the Associate Director of the Respiratory Department, was her supervisor. He is responsible for giving assignments to the respiratory therapists and makes rounds of the areas to assess coverage and patient care needs (Tr. 151, 155, 377, 378). It is undisputed that some time that morning -- which Mr. Stallworth estimated as between 9:30 a.m. and 10:00 a.m. (Tr. 154) and respondent said was shortly after she was finishing up her first round with her patients (Tr. 311) -- Mr. Stallworth and respondent met in MICU and had a conversation. Mr. Stallworth asked how respondent was doing (Stallworth: Tr. 179), or if everything was okay (Bichotte: Tr. 311, 382). Respondent then asked Mr. Stallworth if he could assign another therapist to assist her later in the day (Stallworth: Tr. 155; Bichotte: Tr. 311). Respondent testified that she told Mr. Stallworth that it was "very busy" (Tr. 312), and she also testified that it was an "exceptionally . . . busy day" (Tr. 310).

By all accounts, Mr. Stallworth did not immediately accede to respondent's request for help. Mr. Stallworth testified that he asked respondent if they could "go through the patients" or "do rounds of the patients" to assess the needs of the unit and determine whether she needed assistance (Tr. 155). Respondent denied that Mr. Stallworth specifically asked her to do "rounds," but acknowledged that he said, "let's walk around" (Tr. 317). He also questioned her need for help, saying that he did not think that it was so busy (Tr. 312, 389).

According to Mr. Stallworth, respondent replied to his request to walk around or do rounds, by saying, "I will never ask you again. Just forget about it," and walking away. He told her that "this is what we need to do." She replied that she did not feel well and that if Mr. Stallworth continued to "bother" her she would go to the emergency room and go home (Tr. 156). He told respondent that this was not "the place" to have this conversation, and told her to come to the respiratory office to discuss the matter once she had completed her rounds. He then left the area (Tr. 156-57).

Respondent had a somewhat different recollection of the conversation. She testified that after Mr. Stallworth questioned her need for help, she asked why he was questioning her, along the lines of, "Mr. Barri, why would you question me? I don't see the reason for you to ask me in the first place because I need your help . . ." (Tr. 312), or, "I don't see the reason for you to ask me why I need help, when I asked you and you cannot give it to me" (Tr. 389). She recalled telling Mr. Stallworth that she was just trying to finish up her work and that as soon as she finished her work, they could walk around but that she could not "do it right now" (Tr. 317). She denied that Mr. Stallworth ever ordered her to do rounds and indicated that if he had, she would have complied with his directive (Tr. 317).

Respondent testified that she was upset and felt as if she was being "played" (Tr. 313). She had been suffering from work-related stress in the recent past, with symptoms of heart palpitations and chest tightness, for which she had sought medical help (Tr. 315). She acknowledged telling Mr. Stallworth that she did not feel well, and alluding to perhaps having to go to the emergency room. Specifically, she testified that she said, "it would be better if I had to [go to] the emergency room because I'm not feeling good as of this" (Tr. 314). According to respondent, Mr. Stallworth told her he wanted to see her in the office immediately. She replied that she could not do so because she was very busy and had to finish her rounds, but would come

as soon as possible (Tr. 316, 389, 392-93). Mr. Stallworth left and respondent continued doing her first round of visiting patients who were on ventilators (Tr. 318).

By all accounts, Mr. Stallworth paged respondent about half an hour later to remind her to come to his office. Respondent testified that Mr. Stallworth paged her and left a voice message saying that thirty minutes had elapsed and she still had not come to see him (Tr. 319, 393). She called back and spoke to someone in the respiratory office and said she would be there shortly (Tr. 395-97). Mr. Stallworth replied, less affirmatively, "yes, maybe," when asked if he had paged respondent with that message (Tr. 188). Sonthonax Gay, a physician's assistant at the hospital, who is licensed to practice medicine under the supervision of a physician (Tr. 65), testified that he was working at MICU on a team with respondent, evaluating a patient on a respirator in preparation for extubation, when respondent received a page on her beeper. Respondent told Mr. Gay after the page that she had to report to her supervisor (Tr. 79, 80). Similarly, Alexandra Prophete, a staff nurse assigned to MICU, testified that she was with respondent and Mr. Gay when respondent was paged. Respondent said it was her supervisor (Tr. 249-50).

Prior to Mr. Stallworth's page, Mr. Gay had told respondent of the decision to extubate the patient and respondent had replied that she would set up for the extubation (Gay: Tr. 71-72; Bichotte: Tr. 319). After respondent's pager sounded, respondent left the area to report to Mr. Stallworth rather than continue setting up for the extubation. Mr. Gay and the fellow physician who was also on the team (Dr. Gupta) stayed by the bedside until respondent returned some seven to fifteen minutes later. Respondent and Ms. Prophete testified that respondent asked Mr. Gay for permission to leave and that he said, "okay" (Bichotte: Tr. 319, 394, 399); Prophete: Tr. 250). Mr. Gay testified on direct examination that respondent approached and said that she had to report to a supervisor (Tr. 72). However, on cross-examination, Mr. Gay replied, "yes," when asked if he recalled respondent asking to be excused to go to the office (Tr. 80). In his report on the incident, written July 22, 2010, Mr. Gay wrote that respondent came in to the room "to excuse herself" and said that she would return "shortly" (Pet. Ex. 2).

Respondent testified that she thought that she had time to go to the respiratory office because she had already stabilized the patient and the extubation could not proceed immediately, as the nurse needed to remove the sedation and the sedation needed a little time to wear off (Tr. 397). Kings County Hospital Center has multiple buildings: MICU is located on the third floor

of building D, while the respiratory office is on the seventh floor of building C (Tr. 398). The buildings are connected by hallways (Tr. 24, 36).

Some time after respondent left the area to report to Mr. Stallworth, MICU telephoned the respiratory office looking for respondent (Gay: Tr. 85). Mr. Stallworth testified that MICU requested assistance because respondent had left the area (Tr. 159, 189). After taking the call, Mr. Stallworth proceeded to the MICU to assist with the extubation, taking the elevator down to the second floor of the C building so he could cross over to the D building. The elevator doors opened on the fifth floor and he saw respondent, who told him that she was on her way to meet him (Stallworth: Tr. 160, 189-190; Bichotte: Tr. 321, 399; Tr. 13). Mr. Stallworth told respondent to come with him to MICU; she complied and they both successfully extubated the patient (Gay: Tr. 75; Stallworth: Tr. 160; Prophete: Tr. 250; Bichotte: Tr. 322, 401).

Specifications one and two allege that respondent was insubordinate, and verbally abusive and disrespectful, towards Mr. Stallworth on June 16, 2010, by refusing a direct order to perform bedside rounds and by stating, "Forget it, I will never discuss this topic with you again." The evidence was insufficient as to both specifications.

An employer must prove three elements to establish a charge that an employee willfully committed insubordination: (1) that a supervisor communicated an order to his or her subordinate and that the subordinate employee heard and understood the order; (2) the contents of the order were clear and unambiguous; and, (3) the employee willfully refused to obey the order. *Health & Hospitals Corp. (Woodhull Medical & Mental Health Ctr.) v. Muniz*, OATH Index No. 1666/05 at 8 (Oct. 17, 2005). The supervisor need not use the word, "order," or "direct," but the supervisor's language must be clear and unambiguous, so that the employee knows that he or she is being directed to perform a task. *Compare Dep't of Environmental Protection v. Schnell*, OATH Index No. 2262/00 at 7-8 (Oct. 25, 2000) (respondent's claim that he was under no obligation to comply with order to turn off tape recorder because his supervisor did not use the words "direct order" was unavailing) *with Health & Hospitals Corp. (Queens Hospital Ctr.) v. Toval*, OATH Index No. 500/11 at 11-12 (Dec. 23, 2010) (testimony by nurse practitioner that she "suggested" to a respiratory therapist that he change a ventilator insufficient to prove that she gave him an order to do so).

The conversation in question happened more than a year ago. There is no evidence that a contemporaneous memorandum or other document was made to record the brief exchange. I

concluded that neither Mr. Stallworth nor respondent totally recalled the precise language that was used. What is clear is that respondent asked if she could have assistance later in the day and that there was a brief exchange between respondent and Mr. Stallworth about how to resolve the situation. In essence, Mr. Stallworth told respondent that they should walk around and look at the patients, so he could decide whether to give her the help she requested. Respondent became upset because she felt that Mr. Stallworth was questioning her need for help, even though it was very busy, and she withdrew her request for assistance. Respondent was in the middle of her rounds and still had work to do. The conversation ended when Mr. Stallworth told respondent to come to his office to discuss the situation once she had completed her rounds. Under these circumstances, petitioner fell short of establishing that respondent willfully committed insubordination by withdrawing her request for assistance rather than walking around the floors with Mr. Stallworth as initially requested. Thus, specification one, alleging insubordination, was not proven and should be dismissed.

Regarding specification two, the charge of disrespect and verbal abuse, it is well-settled that an employee may disagree with a supervisor so long as the disagreement "remains within the bounds of decorum and discretion." *Toval*, OATH 500/11 at 12 (Dec. 23, 2010); *Health & Hospitals Corp. (Lincoln Medical & Mental Health Ctr.) v. Thomas*, OATH Index No. 531/04 at 6 (May 4, 2004); *Triborough Bridge & Tunnel Auth. v. Simms*, OATH Index No. 1303/97 at 18 (May 30, 1997), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 98-123-SA (Dec. 30, 1998). 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. *Toval* at 12; *Thomas* 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 . . .").

As discussed above, it is not clear that respondent actually said, "Forget it, I will never discuss this topic with you again," as alleged in specifications one and two. Respondent acknowledged, however, asking Mr. Stallworth why he was questioning her or asking why she needed help. Whatever comments respondent made, they did not appear to be "deliberately disrespectful," but rather remarks uttered in frustration, whether or not justified, at Mr. Stallworth's reaction to her request for assistance. *See Health & Hospitals Corp. (Kings County Hospital Ctr.) v. Meyers,* OATH Index No. 1182/11 at 8 (Mar. 28, 2011) (employee's comment,

in response to supervisor's threat that he would not be paid, was that supervisor should do what she had to do was not deliberately disrespectful but the "resigned lament" of an employee who felt he was being unfairly treated).

Moreover, there is no evidence that respondent was disruptive, threatening, or profane in her comments to Mr. Stallworth. At most Mr. Stallworth testified that respondent has "a very strong tone of voice" and "a tendency to seem confrontational" (Tr. 156). I do not conclude that this testimony establishes that respondent raised her voice to Mr. Stallworth during this encounter. But even if I were to draw that conclusion, the fact that an employee spoke loudly to a supervisor during an argument does not, standing alone, establish that the employee was being disruptive or otherwise committing misconduct. *Meyers*, OATH 1182/11 at 7 (Mar. 28, 2011); *Human Resources Admin. v. Traylor*, OATH Index No. 168/07 at 4 (Jan. 31, 2007); *Human Resources Admin. v. Delgado*, OATH Index No. 833/03 at 10 (Mar. 24, 2003), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 06-91-SA (Aug. 24, 2006). The record falls short of establishing the aggravating factors that would transform a permissible argument or disagreement with a supervisor into something that constitutes disciplinable misconduct under the Civil Service Law. Accordingly, specification two, alleging verbal abuse and discourtesy, was also not proven, and should be dismissed.

It is not entirely clear what the basis is for specification three, which alleges that at about 10:00 a.m. on June 16, 2010, respondent refused a directive and refused to answer a page from her supervisor, Mr. Stallworth, to report to his office after she finished her treatment rounds. More specifically, petitioner alleges that respondent said, ""I'm not feeling well, I'm not in the mood for you today," and later said, "I will go to the emergency room and go home if you continue to harass me." As noted, both respondent and Mr. Stallworth testified that respondent made a comment relating to not feeling well and perhaps having to go to the hospital. However, this related to respondent's initial request for assistance and Mr. Stallworth's reaction to it. There is no evidence that respondent failed to comply with Mr. Stallworth's directive to report to his office after she finished her rounds. Indeed, the evidence is to the contrary. It was undisputed that Mr. Stallworth paged respondent about half an hour after their initial conversation to tell her that half an hour had elapsed and that she needed to report to his office. Respondent then left the MICU area to report to Mr. Stallworth's office. Mr. Stallworth, in the interim, had left his office

to go to MICU. The two met in route. Mr. Stallworth acknowledged that respondent was complying with his order to report to his office (Tr. 190).

Accordingly, specification three should be dismissed.

Petitioner also failed to establish the misconduct alleged in specification four, which charges that respondent was insubordinate, engaged in disruptive behavior, and abandoned her duty by leaving the MICU area without authorization, refusing to follow a directive from Mr. Gay to extubate a patient, and stating that she was going to the respiratory office when in fact she did not do so. There is no evidence that respondent was insubordinate to Mr. Gay. Rather, the record established that after Mr. Stallworth paged respondent to order her to report to his office, she either asked to be excused or said that she had to leave to report to a supervisor and would return shortly. There is no evidence that Mr. Gay told her or even suggested that she could not leave the area. The fact that MICU called the respiratory office looking for respondent some time later does not establish that respondent left the area without authorization. All it goes to show was that MICU was placed in a difficult situation by respondent's attempt to comply with her supervisor's directive on the page to report to his office.

Moreover, there is insufficient evidence that Mr. Gay, the physician's assistant, gave respondent an order or directive to extubate the patient. Mr. Gay testified only that the decision to extubate a patient is made by "the team," which includes the respiratory therapist and primarily by the attending physician, and that respondent was told that the patient be extubated and said she would set up for the procedure (Tr. 67, 71).

Even if it could be inferred that respondent knew that she was responsible for extubating the patient, respondent left MICU in response to Mr. Stallworth's directive to report to his office. Petitioner contends that Mr. Stallworth had ordered respondent to report to his office after she finished her rounds. Thus, petitioner contends, Mr. Stallworth did not require respondent to report to his office while her work was ongoing and respondent can not rely upon this order as a defense to the charge that she failed to complete an extubation of a patient. I disagree. There would be merit to petitioner's argument if the only order in question was Mr. Stallworth's in-person verbal command to respondent after their discussion about whether respondent could get assistance later in the day. This argument ignores Mr. Stallworth's page, which appeared to have been an urgent directive for respondent to report to his office.

It may well have been better practice, as petitioner urges, for respondent to have notified Mr. Stallworth that she was about to extubate a patient and could not come to see him at that very moment (Pet. Post-Trial Brief at 7). Indeed, petitioner notes Mr. Stallworth's testimony that "patient care always comes first" (Tr. 161, 189), that he considered extubation to be part of respondent's rounds (Tr. 211), and that it was not "proper" for respondent to report to him prior to performing the extubation (Tr. 212). However, the fact remains that respondent left MICU in response to Mr. Stallworth's directive to report to his office. A finding of misconduct requires a showing of fault, either intentional or willful, *Reisig v. Kirby*, 62 Misc. 2d 632, 635 (Sup. Ct. Suffolk Co. 1968), *aff'd*, 31 A.D.2d 1008 (2d Dep't 1969), or negligent, *McGinigle v. Town of Greenburgh*, 48 N.Y.2d 949, 951 (1979). It would be incongruous to find respondent at fault here, when she left the MICU in an attempt to comply with Mr. Stallworth's directive to report to his office.

Petitioner failed to prove that portion of specification four that alleges that respondent failed to go to the respiratory office after leaving MICU. As discussed above, the evidence was to the contrary.

Petitioner also failed to prove that respondent abandoned her duty because she left her assigned area, MICU, instead of continuing to extubate the patient. Petitioner asserts that respondent left without reasonably arranging for proper coverage for the patient who needed to be extubated. Petitioner contends (Pet. Post-Trial Brief at 5-6) that this constituted patient abandonment, citing the Rules of the Board of Regents of the New York State Education Department, which define unprofessional conduct in the profession of respiratory therapy as including: "abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care." 8 NYCRR §29.2 (a) (1) (Lexis 2011). By contrast, respondent asserts (Resp. Post-Trial Brief at 2) that respondent left her work area to comply with her supervisor's page and that respondent did not leave the patient unattended: Mr. Gay, Dr. Gupta, and a nurse all remained by the patient.

It is true that respondent did not leave the patient unattended. Mr. Gay testified that he and the fellow physician stayed by the bedside for the seven to fifteen minutes that respondent was gone, and continued evaluating the patient in preparation for the extubation (Tr. 82). There was no evidence that the extubation was needed urgently: indeed, respondent testified without rebuttal that the extubation could not proceed until the nurse removed the sedation and the

sedation wore off. Ultimately, respondent returned in time to extubate the patient. Clearly, it would have been better had respondent remained in MICU, as she was needed to extubate the patient, or had she made some attempt to tell Mr. Stallworth that she could not report until the extubation was completed. This was an unfortunate situation. However, respondent left MICU in response to a directive from Mr. Stallworth. Under these peculiar circumstances, petitioner has failed to sustain its burden of establishing that respondent abandoned her duty.

In sum, charge one, specifications one through four, were not proven and should be dismissed.

June 30, 2010

Petitioner alleges that at approximately 9:00 a.m. on June 30, 2000, respondent was insubordinate by failing to comply with a directive from Dr. Anika Backster to transport a critically ill ventilated patient to MICU and instead going to retrieve a beeper, and by subsequently failing to respond to three overhead pages to transport the patient (specification six). Petitioner contends that by going to get the beeper, respondent also engaged in patient abandonment (specification five). Petitioner also asserts that respondent failed to comply with an order from an Associate Director Joanna Portee to respond to one of these pages, and that she instead continued talking to a co-worker (specification seven). Finally, petitioner alleges that at about noon on the same day, respondent engaged in disruptive behavior by trying to question Dr. Backster about the incident after she had been relieved of duty (specification eight).

On June 30, 2010, respondent was working the 8:00 a.m. to 8:40 p.m. shift (Tr. 328). She was assigned to cover an area including various wards, the recovery room, and the emergency room. Her duties also included responding to any emergency codes (Stallworth: Tr. 163; Bichotte: Tr. 328). More specifically, Mr. Stallworth assigned respondent to relieve a respiratory therapist whose night shift was ending. Respondent was needed to transport a patient to the CAT (computerized axial tomography) scan area (Stallworth: Tr. 166; Bichotte: Tr. 330, 402). The patient had suffered a heart attack and was on a ventilator. Respondent helped Dr. Backster move the patient to the CAT scan area (Backster: Tr. 19, 20: Bichotte: Tr. 402, 403). Prior to moving the patient, respondent disconnected him from the ventilator; she then manually ventilated him using a hand-held bag until he reached the CAT scan area. She connected him to a ventilator in the CAT scan area (Backster: Tr. 19, 20, 21). A number of people were present in

the CAT scan area, including respondent, Dr. Backster, Marilyn John-James (a patient care technician), and Howard Passat (a radiation technician) (Backster: Tr. 22; John-James: Tr. 230; Bichotte: Tr. 404).

Dr. Backster informed her team, including respondent, that the patient would be moved to MICU once the scan ended (Backster: Tr. 25). This would mean disconnecting the patient from the ventilator in the CAT scan area and placing him on a manual resuscitation bag for the trip to MICU. As the respiratory therapist, respondent was responsible under the hospital's ventilator transport procedure (Pet. Ex. 3) for the manual ventilation of the patient during the transport (Portee: Tr. 93-94).

It was undisputed that respondent left the CAT scan area to retrieve her beeper from the respiratory office. Ordinarily, a respiratory therapist gets a beeper from the respiratory therapist that he or she is relieving from the prior shift. At this time usually the person going off duty briefs the person coming on duty regarding the ventilator patients (Portee: Tr. 113-14). On this occasion, respondent was not able to retrieve her beeper because Nicole Gathers, the therapist who had the beeper on the prior shift, had been assigned to another area (Stallworth: Tr. 167).

It was also undisputed that, prior to leaving the CAT scan area, respondent asked Mr. Passat how long the scan would take. Respondent also said that she could be reached on the overhead page, which is generally audible throughout the hospital, if the scan concluded before she returned (Backster: Tr. 26-27; Bichotte: Tr. 334). The witnesses differed, however, on what Mr. Passat said regarding how long the scan would take. Dr. Backster testified that Mr. Passat said the scan would take about ten minutes (Tr. 21-22), and she testified that CAT scans are automated and pre-set for a certain amount of time, depending on the area being scanned (Tr. 27, 54). She also testified that the patient was on the CAT scan bed and the scan was ready to proceed when respondent said that she had to leave to get her beeper. All that remained to start the scan was for the technician to press a button (Tr. 26, 28).

By contrast, both respondent and Ms. John-James testified that when respondent asked Dr. Backster for permission to leave to retrieve her beeper, the CAT scan was not ready to begin (John-James: Tr. 231; Bichotte: Tr. 333-34). Indeed, respondent testified that she had been sitting in the CAT scan area for about fifteen minutes when she saw everyone else getting up and going to the patient bedside. They were doing something to adjust the patient's head and said that they needed to do more tests. She felt "very annoyed" that she did not have her beeper; her

assignment was “all over the place” and it did not “make sense” for her not to have the beeper (Tr. 333). She asked to be excused because she thought she had time to leave to get her beeper before the CAT scan ended (Tr. 334). She asked Mr. Passat how long the scan would take, and Mr. Passat said it would take approximately 20 minutes (John-James: Tr. 231; Bichotte: Tr. 334).

The parties differed over whether it was Mr. Backster or Ms. Gathers who had physical possession of the beeper. They also differed over how important it was for respondent to get her beeper at this juncture. It was stipulated that Mr. Stallworth verbally directed respondent to personally retrieve the beeper (Tr. 14). Mr. Stallworth testified that although respondent could not get the beeper when she came on duty, she telephoned the respiratory office and spoke with Ms. Gathers about the ventilator patients. Mr. Stallworth told Ms. Gathers to tell respondent that he would hold the beeper for her until she could come to get it (Tr. 168). Respondent asked if he could arrange to have her beeper delivered to her, but he did not do so. He testified that he had asked two therapists if they would deliver the beeper and both had said they did not want to get involved. Rather than order them to deliver the beeper, he told respondent that he would hold on to the beeper for her (Tr. 199). Mr. Stallworth thought it was acceptable for respondent not to have the beeper, as he is a working respiratory therapist and would have answered the beeper if it went off (Tr. 168, 199).

By contrast, while respondent acknowledged asking Mr. Stallworth to arrange for the beeper to be brought to her, she testified that Ms. Gathers retained physical possession of the beeper (Tr. 332, 336, 407). She also stressed that she needed the beeper because she had such a large area to cover. This was corroborated by Ms. Portee’s testimony that respiratory therapists “just don’t” work without a beeper; the beeper is needed because that is how they are contacted for assistance (Tr. 113).

The parties also differed on what happened once respondent arrived at the respiratory office to get her beeper. Mr. Stallworth testified that respondent retrieved the beeper from him some time between 9:00 a.m. and 10:00 a.m. He heard an overhead page for a respiratory therapist to report to the CAT scan area, “stat.” Ms. Portee came to his office and asked who was covering the CAT scan area. He told her it was respondent. Ms. Portee testified that she had seen respondent sitting in the adjacent conference room talking to a coworker when the page sounded but she had not known that the page was for respondent. She proceeded to the conference room to talk to respondent. A second page sounded for a respiratory therapist to

report "stat" to the CAT scan unit. Respondent was talking to a co-worker. Ms. Portee asked respondent if she had heard the page. Respondent said she had and walked towards the telephone. Ms. Portee told respondent not to call CAT scan, but to go directly there. Respondent complied and left the area (Portee: Tr. 103, 104, 112, 142, 143; Stallworth: Tr. 172-73, 204).

Respondent acknowledged that she was sitting with Ms. Gathers, who was debriefing her, when she heard an overhead page, which she knew was for her, to respond to the CAT scan area. She denied, however, that there had been an earlier page to report to CAT scan. Respondent testified that she told Ms. Portee that she did not have her beeper and had told the doctor to page her. Ms. Portee told her to call the CAT scan unit so they did not keep paging her. Respondent said she would do that and called the operator to connect her to CAT scan. Instead she was connected with the emergency room. She decided this was wasting time and instead proceeded quickly to the CAT scan area so she could transport the patient (Tr. 338, 339, 340, 413, 414).

However, by the time respondent returned to the CAT scan area, the patient was no longer there, having been taken to MICU. Dr. Backster testified the team had paged respondent as the scan was completing after ten minutes. The team then transferred the patient from the CAT scan bed to the transport gurney, leaving the patient connected to the ventilator while on the gurney. This took another ten minutes, during which the nurse paged respondent at least two more times. When the patient was ready for transport, Dr. Backster paged respondent again. Respondent did not return to the area. They waited another three to five minutes and then Dr. Backster decided that they needed to move the patient, because he needed cooling therapy to preserve the heart muscles (Tr. 28-32). As respondent was not there, Dr. Backster disconnected the patient from the ventilator and began to manually ventilate the patient. Along with the nurse and nurse's assistant, she transported the patient to MICU. MICU has a separate respiratory therapist assigned to it, who was waiting with the ventilator. The patient was connected to the ventilator (Tr. 31, 32). Mr. Stallworth was in the MICU and he asked why there was no respiratory therapist accompanying them to MICU; Dr. Backster told him what happened (Tr. 32). Mr. Stallworth corroborated Dr. Backster's account of their conversation (Tr. 175).

It was not disputed that Mr. Stallworth later called respondent to his office and verbally relieved her of duty, telling her to go home (Stallworth: Tr. 202; Bichotte: Tr. 341-42). Respondent testified that she felt "stunned" and "shocked" and that she was also afraid to leave the hospital without written authorization to leave for the day (Tr. 343). Indeed, while Ms.

Portee testified that an employee is not entitled to receive a written directive relieving him or her of duty (Tr. 142), Mr. Stallworth acknowledged that he should have given respondent a letter relieving her of duty, instead of telling her verbally (Tr. 202). Respondent testified that she felt that she should talk to Dr. Backster (Tr. 418).

Accordingly, respondent approached Dr. Backster, who was sitting by the nurse's station. Respondent wanted to talk about what had happened to the patient. Dr. Backster testified that she was busy going over medication orders but that she could talk for a few moments. However, Mr. Stallworth appeared and told respondent she did not need to talk to Dr. Backster and that hospital police would be called if she did not leave the area. The entire conversation took about two or three minutes (Backster: Tr. 32, 33, 41, 42, 45; Bichotte: Tr. 354, 345, 353-54, 418). According to respondent, Mr. Stallworth also said she had no right to be at the hospital once she had been sent home, and picked up the telephone to call the hospital police. Respondent left the area (Tr. 345).

Respondent did not leave the hospital after this encounter with Mr. Stallworth. Instead, she went to the administrative offices seeking assistance. An individual from administration accompanied her to the respiratory offices, where she was given a written directive relieving her from duty for the day. Respondent also approached Dr. Backster a second time, accompanied by Marie Etienne, the head nurse in charge of the emergency room at the hospital. Respondent was unsure whether she approached Dr. Backster for the second time before or after receiving the written relief of duty directive (Tr. 346-47, 365, 418-21, 422). Ms. Etienne began to ask Dr. Backster for assistance, but Dr. Backster said she was busy and was not really the person to speak to; respondent then left the area (Backster: Tr. 33; Bichotte: Tr. 351-52, 353). The conversation was extremely brief (Bichotte: Tr. 354). Dr. Backster acknowledged that respondent did not use harsh language or swear; nonetheless, she felt it was a "little bit" disrespectful for respondent to have come back a second time after having been told the first time by Mr. Stallworth to leave (Tr. 40).

Petitioner's proof on the June 30 charges was mixed. Petitioner failed to prove that respondent committed insubordination as alleged in specifications six and seven except to the extent it established that respondent failed to comply with one of the overhead pages to respond to the CAT scan unit. Petitioner also established that respondent engaged in patient abandonment by leaving the CAT scan area to retrieve a beeper and failing to return in time to

transport the patient, as alleged in specification five. Petitioner did not prove that respondent engaged in disruptive behavior by attempting to talk to Dr. Backster later in the day, as alleged in specification eight.

Specification six alleges, in part, that respondent failed to comply with an order from Dr. Backster to transport the patient to the MICU. A finding of insubordination requires proof that an employee willfully failed to obey a clearly communicated order. Here, petitioner did not establish that Dr. Backster gave respondent a direct order to transport the patient. Dr. Backster testified, credibly, that she told the team, including respondent, that the patient would be transferred. Indeed, respondent also acknowledged that the "normal procedure" is to transport a ventilator patient directly from the CAT scan area to MICU (Tr. 405). The hospital's ventilator transport policy requires that a respiratory therapist transport a patient with a manual ventilation bag. The fact that respondent asked Dr. Backster to page her if she did not return before the scan ended demonstrates respondent's knowledge that she would be needed for the transport. There is a difference, however, between respondent knowing that her duty would be to transport the patient, and respondent having been ordered to perform the transport. Petitioner did not establish the latter.

Moreover, to the extent that the insubordination charge is premised upon respondent leaving the CAT scan area to get her beeper, there is no evidence that Dr. Backster told respondent that she could not leave the area, or even intimated that it would be improvident. Ms. Portee testified that the hospital's ventilator transport policy does not require that a respiratory therapist remain in the CAT scan area during a scan, although respiratory therapists generally do so because of the short duration of the scan, usually ten minutes or less (Tr. 105-07). It was also undisputed that it is important for a respiratory therapist to have a beeper and that Mr. Stallworth had told respondent to come to his office to get her beeper, even though he had not ordered her to do so at this precise time.

Thus, it can not be said that by leaving the CAT scan area, respondent intended to fail to comply with any directive or duty to transport the patient. Insubordination requires proof of intent; failure to comply with an order because of negligence, error, or poor judgment does not constitute insubordination. *See Human Resources Admin. v. Swaminarayan*, OATH Index No. 302/04 at 4 (Oct. 30, 2003) (where evidence is more consistent with a misunderstanding than with intentional insubordination, disciplinary charges dismissed); *Dep't of Sanitation v.*

Figueroa, OATH Index No. 670/96 (May 1, 1996) (insubordination implies intentional and knowing disobedience). Accordingly, that portion of specification six which alleges that respondent was insubordinate by failing to comply with a directive by Dr. Backster was not proven and should be dismissed.

Specification six also alleges that respondent failed to respond to three overhead pages. While petitioner failed to meet its burden as to all the pages, petitioner established that respondent was insubordinate by failing to respond to one of the overhead pages and instead continuing to talk to her colleague, Ms. Gathers, until questioned about the page by Ms. Portee.

There was mixed evidence regarding the number of overhead pages. Respondent said she heard only one page. Ms. Portee testified that she heard two pages. Dr. Backster said she paged respondent four times, once as the scan was ending and three more times during and immediately following the patient's transfer to the transport gurney. However, unlike respondent and Ms. Portee, Dr. Backster was not in a position to know when or if respondent complied with any of the overhead pages, only to know that she did not return to the CAT scan unit in time to transport the patient. Thus, the testimony of Ms. Portee and respondent is more dispositive than Dr. Backster's regarding this charge. I found Ms. Portee to be a disinterested witness and credited her testimony that she heard an overhead page for respiratory to report to the CAT scan area, discovered from Mr. Stallworth that respondent was covering the CAT scan area, and spoke to respondent, who was still sitting in the conference room talking to a colleague. I also credited Ms. Portee's testimony that respondent acknowledged that the page was for her and tried to telephone the CAT scan area to answer the page, that Ms. Portee then told her not to call but to instead proceed directly to CAT scan, and that respondent complied and left the area. Thus, I find that respondent failed to respond to the first "stat" page but instead kept talking to her co-worker.

Respondent explained that Ms. Gathers was trying to debrief her about the patients, even though she told Ms. Gathers that she had a patient in CAT scan and could be paged at any time (Tr. 336). While I credit respondent's explanation about the debriefing, Ms. Portee's testimony established that she kept talking to Ms. Gathers even after the first overhead page sounded. Respondent acknowledged that the page was for her and knew that it was Dr. Backster, or someone acting on Dr. Backster's behalf, who was paging her to return to CAT scan. Her decision not to respond immediately to this directive but to instead continue talking to Ms.

Gathers was insubordinate, even though it was mitigated by her immediate departure from the unit once Ms. Gathers instructed her to leave.

Regarding the other pages, Ms. Portee testified that respondent left the area after the second page. Thus, the evidence established that she complied with these directives to report to the CAT scan area, even though she did not get there in time to transport the patient. By all accounts, it takes a long time to get from the respiratory office to the CAT scan area. The CAT scan area is located on the first floor of the S building, while the respiratory office, as noted above, is located on the seventh floor of the C building. From the S building, one has to pass through the D building to get to the C building (Bichotte: Tr. 408). Respondent testified that the whole trip could take ten or fifteen minutes (Tr. 412). Thus, respondent's failure to reach the CAT scan unit prior to the time the patient was transported does not establish that she failed to comply with the page to report to the CAT scan area, as alleged in specification six.

Specification seven alleges that respondent was insubordinate by failing to follow Ms. Portee's directive to respond to an overhead page, and instead continued her conversation with a coworker. Petitioner failed to prove this charge. As discussed, Ms. Portee testified that respondent tried to answer the page by telephone. When Ms. Portee directed her to instead respond to the CAT scan area, respondent complied. Ms. Portee did not testify that respondent continued to talk to a co-worker rather than follow her directive to respond to the page.

Specification five, which alleges that respondent abandoned her patient in order to retrieve her beeper, is sustained. There is no doubt that respondent's duty was to accompany the ventilator patient to MICU and to manually ventilate the patient during the transport. The hospital's ventilator transport policy requires that a respiratory therapist accompany a ventilator patient in transport. Ms. Portee testified that a doctor is not permitted to move a patient without a respiratory therapist and a nurse present (Tr. 134).

Respondent did not fulfill this duty because she left the CAT scan room under circumstances not reasonably calculated to assure her return in time to transport the patient. Respondent was not required to remain in the room during the procedure, as Ms. Portee testified, but she needed to be in the room in time to assume responsibility for the manual ventilation of the patient upon the completion of the scan and the transfer of the patient to MICU.

I credited Dr. Backster's testimony that the CAT scan was about to start when respondent left and that the radiation technician told respondent that the scan would take ten minutes, over

respondent's and Ms. John-James's testimony to the contrary. I did so even though respondent wrote a somewhat lengthy memorandum dated July 8, in which she stated that the scan was not ready to start and the technician, Mr. Passat, said it would take twenty more minutes to do the test (Resp. Ex. E). It was striking that Dr. Backster used the word "precise" at least three different times in referring to the timing of the scan (Tr. 27, 28) and said that it "definitely" took ten minutes to complete (Tr. 27). Moreover, Dr. Backster wrote an e-mail dated July 2, 2010, just two days after the incident, in which she recalled that the radiation technician said there were ten minutes of scan time left when respondent said that she was going to leave to get her beeper (Pet. Ex. 1).

Overall, Dr. Backster presented as an unbiased witness with no motive to prevaricate or embellish her testimony to harm respondent. Indeed, Dr. Backster was quick to admit that respondent was polite when she left to get her beeper (Tr. 40, 46) and did not use any harsh language or profanity when she approached Dr, Backster later that day (Tr. 39). Dr. Backster's testimony regarding the length of the scan also was consistent with her explanation that it took twenty minutes before she left the CAT scan area with the patient, ten of which were spent transferring the patient to the gurney and readying for the move. While Ms. John-James corroborated respondent's testimony that the CAT scan was not ready when respondent left and that the radiation scan said it would take approximately twenty minutes, it was unclear how Ms. John-James independently recalled these details, which occurred almost a year before she testified at trial. For example, it appears that Ms. John-James did not recall that Dr. Backster was in the room. While she testified that she recalled the "face" of the doctor who was present in the CAT scan room, she also testified that she did not remember "his" name (Tr. 233). Dr. Backster is female.

Moreover, respondent did not simply retrieve her beeper and return to the CAT scan area. The parties dispute whether she retrieved her beeper directly from Mr. Stallworth or from Ms. Gathers, but it is undisputed that respondent sat down at a conference table with Ms. Gathers and had a conversation with her prior to returning to the CAT scan unit. Ms. Portee acknowledged that debriefing from a respiratory therapist going off-duty to the therapist replacing him or her is important to continuity of care (Tr. 115). However, she also testified that the manual ventilation of a patient is "high priority, very important" (Tr. 134). Indeed, Dr. Backster noted that "time was of the essence" in concluding the CAT scan of this particular patient, because cooling

therapy was needed to try to preserve his heart (Pet. Ex. 1). Under these circumstances, where respondent left the CAT scan unit to get her beeper, her obligation was to return as quickly as possible so she would be able to perform the important and time-sensitive function of manually ventilating the patient during transport to MICU. By sitting at the conference table and speaking to Ms. Gathers, she failed to do so. Respondent compounded the problem by not responding immediately to the first overhead page and continuing to speak to Ms. Gathers until directed by Ms. Portee to respond to the page.[1]

There is some mitigation here. Respondent did not leave the CAT scan area to talk to a friend or engage in matters unrelated to her work. Rather, she left to get her beeper. There is no dispute that a beeper is an important tool for a respiratory therapist to have. Without a beeper, it is more difficult for the therapist to be summoned to work in different parts of the hospital. A beeper is particularly important in a large institution like Kings County Hospital, which has multiple buildings. Mr. Stallworth had declined to have the beeper delivered to respondent and had told respondent to come to get it. However, the record is devoid of any evidence that Mr. Stallworth directed respondent to come to retrieve the beeper at this time, or even suggested that she do so expeditiously or within a certain time frame.

The end result of respondent leaving the CAT scan unit to get her beeper is that respondent could not fulfill her duty of accompanying a ventilator patient and assuming responsibility for the ventilation because she did not return from the respiratory offices quickly enough. Dr. Backster testified credibly that she could not wait any longer for respondent because the patient needed cooling therapy to preserve the heart muscles. Because respondent was not there, Dr. Backster had to assume responsibility for the manual ventilation of the patient. Dr. Backster acknowledged that this was not the first time she had had to move a patient without a respiratory therapist present and that the patient had remained stable throughout the transport (Tr. 45). However, Dr. Backster also testified that when a respiratory therapist is present during a transport, she is "a little bit more free" to engage in the "overall supervision" of the transport, including "keeping a closer eye on [the patient's] vital signs" (Tr. 58). The transport of this patient was unremarkable. Had any problems developed, however, they might have been more difficult for Dr. Backster to handle because she was assuming respondent's duties in

[1] Even if respondent thought she had twenty minutes before the scan was going to end, she still should have refrained from having a conversation with Ms. Gathers in the conference room. Her obligation was to retrieve the beeper and return to the CAT scan unit as quickly as possible.

respondent's absence. Thus, while it can not be said that respondent's absence jeopardized the health of the patient, it resulted in a less than optimum level of service to the patient.

Finally, specification eight alleges that respondent engaged in disrespectful behavior when she approached Dr. Backster later in the day. As noted, this specification is not sustained. There is no evidence that respondent was "disruptive" in her conversations with Dr. Backster. She had spoken to Dr. Backster for only two or three minutes when Mr. Stallworth interjected and threatened to call hospital police. When respondent came back a second time, she was accompanied by Ms. Etienne, the head nurse, who spoke on her behalf. It was undisputed that she left immediately when Dr. Backster said she was busy and was not the person to talk to. It is true that respondent had been relieved of duty, at least verbally, prior to these two conversations. I also credited Dr. Backster's testimony that she felt it was "a little bit" disrespectful for respondent to approach her a second time after having been told by Mr. Stallworth the first time to leave the area. Nonetheless, respondent did not use profanity or harsh language. There was no evidence that her voice was loud or antagonistic or that she was disruptive, other than distracting Dr. Backster from her duties for, at most, four minutes in total. This does not rise to the level of misconduct under the Civil Service Law.

FINDINGS AND CONCLUSIONS

1. Petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate and disrespectful toward her supervisor, Mr. Stallworth, on June 16, 2010, as alleged in specifications one through three.
2. Petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate or disruptive or abandoned her duty on June 16, 2010, as alleged in specification four.
3. Respondent abandoned a ventilated patient she was responsible for transporting by leaving the CAT scan area on June 30, 2010, to retrieve a beeper under circumstances not reasonably calculated to assure her return in time to transport the patient, as alleged in specification five.
4. Petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate on June 30, 2010, by failing to follow a directive by Dr. Backster to transport a critically ill patient, as alleged in specification six.

5. Petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate on June 30, 2010 by failing to respond to three overhead pages to transport the patient, as also alleged in specification six; however, petitioner established that respondent was insubordinate by failing to respond to one of these pages.
6. Petitioner failed to establish by a preponderance of the credible evidence that respondent was insubordinate on June 30, 2010 by failing to follow a directive from Ms. Portee to respond immediately to a page, as alleged in specification seven.
7. Petitioner failed to establish by a preponderance of the credible evidence that respondent engaged in disruptive behavior on June 30, 2010 by approaching Dr. Backster, as alleged in specification eight.

In sum, specifications one, two, three, four, six, and eight were not proven and should be dismissed. Specification seven was not proven except as to failure to respond to one overhead page. Specification five was sustained.

RECOMMENDATION

Upon making these findings, I requested a copy of respondent's disciplinary abstract. It indicates that respondent was appointed to her position in January, 1994. She has no record of previous formal discipline, although her personnel file reflects a warning notice in August 2005 for patient abandonment and an employee counseling session in 2009 for failure to perform her duties.

Petitioner has requested a 30-day suspension for the misconduct that was charged. However, none of the charges relating to June 16 were sustained and only a portion of the charges relating to June 30 were sustained. A lesser penalty is therefore appropriate.

The proven misconduct, relating to going to get her beeper and not returning in time to accompany a critically ill patient to the MICU, is serious. However, at no time was the patient left without medical care. The patient was manually ventilated and transported without incident. Moreover, while not a defense to the patient abandonment charge, the fact that respondent told the team where she was going and arranged to be paged if she was not back in time is a significant mitigating factor. *Cf. Health & Hospitals Corp. (Metropolitan Hospital Ctr.) v. Swakeen,* OATH Index No. 269/04 (Feb. 11, 2004), *aff'd,* 39 A.D.3d 287 (lst Dep't 2007) (30-

day suspension recommended for operating room technician who could not be located for nearly two hours when needed in operating room; penalty exacerbated by respondent's submission of altered document at trial); *Health & Hospitals Corp. (Jacobi Medical Ctr./North Bronx Central Hospital) v. Doxen*, Health & Hospitals Corp. Personnel Rev. Bd. Dec. No. 903 (May 19, 1998), *aff'g* OATH Index No. 630/97 (Apr. 16, 1997) (Personnel Review Board affirms a 13-day suspension for respiratory therapist who left her work area and the hospital for a period of time without notifying anyone, obtaining permission, or arranging for proper patient coverage; ALJ had initially recommended a 45-day suspension).

Additionally, respondent is a long-term employee who has worked for the hospital since 1994. The head nurse in charge of the emergency room, Ms. Etienne, described her as "a very knowledgeable and responsible respiratory therapist" who is "a very hard worker and does her work in a very efficient manner" (Resp. Ex. G).

Considering all the circumstances, including respondent's lack of a formal prior disciplinary record, I conclude that a ten-day penalty is appropriate. *See Health & Hospitals Corp. (Metropolitan Hospital Ctr.) v. Shea*, Hosp. Dec. (Jan. 28, 2009), *rev'g* OATH Index No. 687/09 (Dec. 17, 2008) (imposing 10-day suspension for social worker found to have failed to maintain patient safety and committed insubordination by delaying the assessment of two children in the psychiatric emergency room).

Faye Lewis
Administrative Law Judge

October 13, 2011

SUBMITTED TO:

ANTONIO D. MARTIN
Executive Director

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