ARBITRATION SUMMARY AND AWARD LOG

OCB AWARD NUMBER: 639

OCB GRIEVANCE NUMBER: 24-02-910111-0381-02-11

GRIEVANT NAME: LEE, DR. TING-YANG

UNION: 1199

DEPARTMENT: MR/DD (APPLECREEK DEV CENTER)

ARBITRATOR: KATZ, JONAS

MANAGEMENT ADVOCATE: GALL, DAVID

2ND CHAIR: SAMPSON, RODNEY

UNION ADVOCATE: KEPLER, RICK

ARBITRATION DATE: MAY 1, 1991

DECISION DATE: JULY 30, 1991

DECISION: MODIFIED

CONTRACT SECTIONS AND/OR ISSUES: THREE DAY SUSPENSION FOR "FAILURE TO ACT/CLIENT NEGLECT"

HOLDING: AGENCY FAILED TO PROVE THE "FAILURE TO ACT" CHARGES. SINCE GRIEVANT DID NOT IMMEDIATELY PERSONALLY RESPOND TO A PATIENT WHO WAS UNDERGOING AN UNUSUAL TYPE SEIZURE, EMPLOYER DID HAVE JUST CAUSE FOR A SUSPENSION IN THIS INSTANCE. THREE DAY SUSPENSION IS REDUCED TO A SUSPENSION OF ONE AND ONE-HALF DAYS.

COST: $763.00

BEFORE THE ARBITRATOR #639

In the Matter of:

STATE OF OHIO, DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (APPLE CREEK DEVELOPMENTAL CENTER)

and

SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1199

SUSPENSION OF TING-YANG LEE, M.D.

24-02-910111-0381-02-11

DECISION AND AWARD

This arbitration arises by reason of a three-day suspension given to the Grievant for "failure to act/client neglect."

FACTS

The Grievant is employed as a physician at the Apple Creek Developmental Center operated by the State of Ohio, Department of Mental Retardation and Developmental Disabilities ("MRDD"). Apple Creek is a residential facility for individuals with mental retardation and developmental disabilities. The individuals residing at this center are severely handicapped, unable to care for themselves, and require supervised care twenty-four hours a day.

On October 22, 1990, Grievant received a verbal reprimand from the medical director for failing to come in and examine resident Lucille S. on October 20, 1990, when he was on call. The matters at issue are set forth below.

Failure to Act

On October 22, 1990, some two hours after the above-

mentioned reprimand, the Grievant was in the presence of three nurses when examining resident Pearl M; he found that her right nipple was chafed and abraded. The Grievant ordered a topical medication to relieve the condition and left the room. Pearl M. then seemed agitated and requested the nurses to examine her vaginal area, which she claimed hurt. Upon examination by the nurse, it was discovered that Pearl M. had a small laceration to the posterior vaginal wall. At that time, Pearl said that it was her boyfriend who had caused the injury, and upon further questioning implicated an employee of the center as the perpetrator. In view of the foregoing, the nurses called Dr. Lee back into the room, and upon his examination, he found the laceration and ordered another medication for that condition. At this point the remaining version of the incident is in conflict.

Susan Wallach, an RN who was present during the foregoing and who was working at the Center for the first time, testified as follows:

> ". . . And at that time, Jeanette told Dr. Lee that she had accused an employee of doing this. And, Jeanette asked Deborah Hill if it should be reported and Deborah said she didn't know. And that's when Dr. Lee said no, I don't want to get involved. And he walked out of the room. And then there was one more discussion between the three nurses about whether or not it should be reported. We decided it should be. And when we walked out of the room, there's another small examining room, that's where Dr. Lee was. And, we told him that it was going to be reported. And he said if that's what they want, then send her to the Emergency Room for investigation.

On the other hand, Jeanette Kornhaus, another RN in attendance at

the time of the incident, testified as follows:

> "Okay. Dr. Lee came into the room. I informed him that an employee was involved supposedly. That we weren't sure if she was going to change her story or if she was telling the truth because she does have a habit of either "telling stories" or she's a hypochondriac and she has a lot of symptoms that never are really there. So. Dr. Lee checks her without hesitation. We apply what he says. While they were still in the examination room, I went to make a call to let the IPC know. I had asked Dr. Lee who do you think we should report to. And he said the IPC.
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> . . . He recommended, I asked him. I said who do you think we should call. And he said the IPC. I do not recall Sue having anything to do with telling us we ought to go report and I never had a feeling the whole time I was in the room that we would not report it. We did discuss we did not want to get an employee in trouble. That was just between Debbie Hill and I. And that was for the simple fact that who wants to get, excuse me. Another employee in trouble.
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> . . . The reason we wanted to call the IPC was because the IPC had a closer working relationship with Pearl and we thought perhaps she could get more information from Pearl as to find out whether she was telling the truth.

(Tr., p. 40)

The Grievant denied he said, "I don't want to get involved," and further testified that he wanted the Individual Program Coordinator ("IPC") to look into the case because it was more reliable. IPC is directly involved with and responsible for each resident, including the medical treatment, occupational therapy and background of similar incidents.

Client Neglect

The second incident for which Grievant was suspended occurred on November 12, 1990. At approximately noon on that

day, a resident, Jerry M., who had a history of seizures, had what appeared to be another seizure while in the dining room. He was brought to the clinic and was observed by the nursing coordinator, Joan Shamp, and two other nursing staff to be unconscious, unresponsive, with a nosebleed and muscular contractions up and down his arm. Ms. Shamp tried shaking Jerry's shoulders and pinching his earlobes but he failed to respond. Ms. Shamp then asked Jane Curry, an RN who was in attendance, to call the Grievant, who was on call at home and notify him of his situation.

At approximately 12:30, a call was made to Dr. Lee's residence. He was not home, and a message was left on his answering machine. When Dr. Lee did not respond to the message, he was "beeped" on his pager, and at approximately 12:50 Grievant responded to the beeper. At that time, Shamp described Jerry M.'s symptoms and observed that he was having a strange type of seizure, not typical of the ones he generally has, in that the seizure was of a substantially long duration whereas his ordinary seizures are from one to four minutes. Shamp also told Grievant that Jerry M. had dusky nail beds (cyanotic), meaning he was not breathing as well as he should and there was a lack of oxygenation. Grievant responded by ordering ten milligrams of valium by mouth. When Shamp explained that the medication could not be given by mouth since Jerry was unconscious, the Grievant ordered the medication to be given by intramuscular injection.

At that time he advised Shamp to call him back with the results of the injection of the medication.

Grievant did not wait to be called back but at 1:10 called in to ascertain how the patient was doing. Shamp told Grievant how Jerry M. was doing. Shamp told the Grievant that Jerry M. was still unresponsive but his tremors seemed to be decreasing. She asked him to come in and examine the patient, and when he responded, "Why?" Shamp advised that all of the nurses were concerned about the resident, that this was not his typical seizure, and that "we" were worried about him. Shamp also advised the Grievant that Jerry had just opened his eyes slightly but that was his only response. Grievant responded that he would come in later. Shamp further testified that Jerry's normal seizures last one to four minutes, while this one lasted over forty minutes. She also testified that at the time she spoke to the Grievant, that not only did she ask Grievant to come in, but that one of the other nurses said to tell Grievant, "We want him to come in." Thus, he was requested to come in at least twice.

The evidence is undisputed that Dr. Lee then finished his lunch and arrived at about 2:00 o'clock, causing a delay in responding of anywhere from 10 to 20 minutes.

The Center's medical director testified that in her appraisal of the facts as related to her, she would have ordered oxygen and would have come in as soon as possible. She also testified that on October 22 she had given Grievant a verbal

reprimand because on October 20 when it was reported to him that a resident, Lucille S, had had a forty-five minute seizure, he failed to come in and examine the individual immediately.[1] She also testified that the Grievant had been counseled twice concerning similar types of instances of failure to personally respond.

The testimony of the Union witness, a nurse with 37 years experience who was present at the time, differs slightly, but in important respects from the testimony of Shamp. Her testimony is as follows:

> ". . . So I don't recall Joan telling Dr. Lee that his fingernails were cyanotic. That was not really a major concern. His facial color and respirations and everything -- he wasn't in a compromising situation at that time. She Dr. Lee ordered valium 10 mg. -- she said she didn't think Jerry would be able to swallow it right then, so he ordered the 100 mg. of phenobarbital IM. So we gave that to him. Apparently, Dr. Lee said to call him and let him know how he was responding to the medication. Before we could even do that, at 10 after 1:00 Dr. Lee called back in. It was reported to him that Jerry was improving, his eyes were opening, he had less muscular twitching. He still wouldn't respond to us and the fact that he wouldn't answer when he called his name. But I wouldn't call him unconscious.
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> And then June Jacobs said to tell Dr. Lee that we think he ought to come in and check him. June and I felt that there were hard feelings between Dr. Lee and Dr. Slaga and that it just might be a good idea. In no way did we ever convey to Dr. Lee that it was an emergency, that he needed to hurry in there. We just felt, for his own sake, he better come in and look at him. June

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[1]Grievant became infuriated and stormed out of the medical director's office. For this latter act, he was given another verbal reprimand by the medical director, which was subsequently removed from his record. Neither of these incidents are at issue here.

said that to Joan who was on the phone, and I said yes, it's a good idea. . . ."

Q. "Did at anytime did you convey to Joan or anytime that any of these other people in attendance over this situation have a different opinion that this may be an emergency?

A. "No. And Joan didn't tell him that he needed to hurry and come in. Just come in and check him out."

Q. "Are you saying then, Jane, that your concern for having Dr. Lee come to this patient is not because of any emergency, but because of some concern about the relationship that you saw developing between Dr. Lee and Dr. Slaga as a result of these incidents that I referred to earlier? Was the LPN under the same impression?"

A. Yes. She would testify to the same thing. In fact, we have written input."[2]

The Grievant himself testified as follows:

A. My beeper was on as I was going home. I go home and call immediately. Nurse Shamp told me that Jerry was having some sort of seizure, but he wasn't responding. I asked if the color was good and told her to give him valium him by mouth. Normally you can take the valium by mouth, but in that stage, he cannot. Then I gave him 100 mg. IM and hold the PM medication. My impression at that point was that he was postictal, not in seizure. I asked them to call me after the results of the medication. About 20 minutes later I called in because they did not call me. Joan asked the nurse at the bedside and he was opening his eyes. There was no more twitching and his color was good. One of the nurses said to call Dr. Lee to come in. Medically, I didn't think I needed to be there since he was in a recovery stage now. The other nurse felt that I should come in. I asked Joan why I needed to come in and she said because the nurses would feel more comfortable if I did. I said, "Okay, I will be there, it will take me about 40 minutes to come in." When I came in he was okay. So I said to give him another dose of valium. He was alert enough to take it. I then told the nurse she needed to observe him and I went home. After I got home I called back and asked how he was doing.

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[2]The statement was written by the Union witness and signed by the LPN. It is, therefore, accorded little weight.

She told me he was happy and laughing.

The Position of MRDD

It is the position of the department that the evidence amply proves the failure to report sexual abuse, a very serious offense which alone warrants the full suspension. The department further urges that the failure of the doctor to respond to requests of the nursing coordinator to examine resident, Jerry M., was a serious neglect of duty and considering previous warnings of the same nature, the suspension is more than justified.

The Union Position

The Union takes the position that the whole series of events leading to the suspension was created by the medical director because of what could be termed "personality conflicts" between them and because of the medical director's lack of respect for the Grievant's professional ability. The Union further urges that there is no basis for finding that the Grievant was guilty of failure to report a possible sexual abuse or neglect of a resident in failing to respond immediately in person; that Grievant has a high degree of respect among his peers, and an unblemished record which should not be soiled by the events leading to this arbitration.

DISCUSSION

The Arbitrator is mindful of the Grievant's enviable record and reputation and is also cognizant of what appears to be the medical director's lack of respect for the Grievant. The

Arbitrator mentioned this "conflict of personalities" because of the concern that in this incident and in future dealings between the two, this attitude may cloud fair treatment of the Grievant. This observation, therefore, will memorialize the fact of the existence of this situation. Having made this observation, however, the Arbitrator must view the incidents leading to the instant suspension in the light of the evidence presented by both sides.

Failure to Report

The evidence in this case is conflicting, and while I do not discredit the testimony of Susan Wallach, I likewise do not discredit the testimony of R. N. Jeanette Kornhaus or of the Grievant himself. For this reason, the Arbitrator finds that the Agency having the burden to establish the neglect to report a possible sexual abuse has not met that burden. I therefore sustain the Grievance as to the failure to report.

Neglect of Patient

The resolution of this issue is not as simple. The testimony of the MRDD witness and that of the Union witnesses are not materially in dispute. It is the implications of that testimony which determine whether or not neglect occurred.

The evidence is uncontradicted that Grievant was given a verbal reprimand for not responding to examine a resident on October 20, 1990, which the medical director testified without contradiction was not the first such incident. While it is

apparent that the Grievant vehemently objected to this verbal reprimand, no facts in the record indicate that it was not justified. However, putting aside for the purpose of this case whether or not the reprimand relating to October 20 has merit or not, it was apparent from the reprimand that the Grievant was on notice that the medical director was critical of his failure to personally respond to a patient with a forty-five minute seizure. In that context, and with the verbal reprimand as a guide to future conduct, the Grievant in this case did not immediately personally respond to a patient who was undergoing an unusual type seizure lasting for over forty minutes at the time when he last checked on the patient's condition. It is clear that Nursing Coordinator Shamp requested the Grievant to come in, and while she did not explicitly characterize the situation as an emergency, the facts related to him, together with the "concerns" of all the nurses should have prompted a more immediate response.

In addition, R.N. Jane Curry, a witness for the Union, testified that her request for the Grievant to respond was not motivated by her concern for the resident's immediate condition but rather a concern that his failure to respond could lead to a possible problem with the medical director, given the previous verbal warning and the relations between them. While this testimony is an indication that she might not have believed an immediate response by the Grievant was necessary, it indicates that she did believe that others, especially the medical

director, might view the situation otherwise. In other words, Curry had some serious concern that others would judge the patient's condition differently. Therefore, she especially requested the Grievant for the second time to respond. Under these circumstances, even if there were doubts about whether or not an emergency existed, prudence required that the doubts be resolved in favor of the resident's welfare. Accordingly, the Arbitrator finds that the Agency has sustained the burden of proof relating to the Jerry M. incident and that, in fact, Grievant was under the circumstances neglectful

In view of all the foregoing, it is the Arbitrator's opinion and decision that the three-day suspension be reduced to a suspension of one and one-half days.

AWARD

Grievance is granted in part and denied in part. Grievant's discipline is reduced to a suspension of one and one-half days. Grievant is entitled to back pay for one and one-half days.

Issued at Cincinnati, Ohio
this 30th day of July, 1991

JONAS B. KATZ, Arbitrator