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Giving Voice to Values
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Apologizing at Community Hospital (A)[1, 2]

Karen was a skilled and experienced CPA with an MBA. She had spent her early career in public accounting and had later delved into hospital management as COO at West Lake University Hospital: a very highly regarded teaching hospital. She had a genuine concern for the well-being of others and was motivated by the humanitarian good her skills could yield in the health care sector.

After a few successful years as COO at West Lake Teaching Hospital, Karen took the next logical step up the career ladder and accepted an offer to be the CEO of Community Hospital. Community Hospital was a less prominent, community hospital with a patient satisfaction and outcome track record in need of serious improvement. She knew it would be a challenge; and now, getting into her fifties, reaching the peak of her career, she felt ready for it.

Soon after assuming her new position as CEO at Community Hospital, the board and legal counsel briefed Karen about a lawsuit the hospital was defending. The suit was not singled out as extraordinary. In fact, it was treated as a routine externality to the hospital's business. Lawsuits happen at hospitals, they reminded her.

The family of Tom Beach, a patient who had died of a heart attack while in the emergency room of Community Hospital, was alleging that Community Hospital, and some of its staff, had acted negligently, and were to blame for Tom's death. The legal team defending Community Hospital was confident that they could successfully fight the claims – focusing on holes in the plaintiff's case alleging the legal element of causation. The defense planned to show that Community Hospital's actions or inactions were not, in fact, the cause of the patient's death.

Karen was aware that some of the allegations brought by the deceased's family against Community Hospital included claims that protocols were not properly followed. Specifically, allegations were made that the heart attack victim was left to wait on a stretcher in a hallway outside of the ER for far too long before he was assessed. The family also claimed that, once the patient had been assessed, the conclusions and diagnoses were inaccurate, and not addressed in a sufficiently timely manner.

The usual course of action for the hospital CEO is to stay out of the details of the court battle and let the legal team do its job. The Community Hospital CEO was expected to manage the hospital, not delve into tasks that were routinely delegated to other experts. Karen, however, wanted to know the details of the lawsuit. Her instinct was to ask questions, not to simply rely on second or third hand reports from the legal team. Without

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[2] Developed by Thomas M. Madden, Adjunct Professor of Law, Northeastern University Law School; Adjunct Professor of Business Law and Ethics, Providence College. This case was inspired by an actual experience but names and other situational details have been changed and interview sources left uncredited with permission for confidentiality and teaching purposes.

This field-based case is part of the *Giving Voice to Values* curriculum collection. Names and other situational details have been disguised. It was written as a basis for class discussion rather than to illustrate effective or ineffective handling of an administrative situation. Copyright © 2010 by Mary Gentile. All rights reserved. *To order free copies, send an e-mail to* sales@dardenbusinesspublishing.com. *No part of this publication may be altered without permission.*

having become accustomed to a protocol that might otherwise have inhibited her, Karen wanted to know the intimate details of the case. She wondered whether Community Hospital, even if not at legal fault in the case, could take away something beneficial from the case and its allegations. She wanted to do better. She wanted the hospital to do better. She got emotionally involved. She even attended (against the legal counsel's advice) the early stages of the trial.

It was while attending the early stages of the trial that Karen felt compelled by empathy for the family of the deceased patient to somehow act outside the box. She wrestled with the causation centered legal advice she was getting from the legal team, finding it in conflict with her own sense of empathy. She wanted to do the right thing. She knew she could not bring back the deceased, but she wanted to address the surviving family's loss in a way that recognized their loss and honored their resulting needs. She also wanted to learn from the case and use it as a catalyst to address systemic problems at Community Hospital and prevent future similar occurrences, if possible.

Who should Karen talk to about this situation and how should she go about it?

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