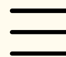

Patient-119

Patient-119 went to Sunrise Hospital. She said Sunrise Hospital completely fails at communication. They don't explain anything to patients or caretakers. Zero communication. Zero accountability. Stay away.

Sunrise Hospital and Medical Center completely fails at communication.

They don't explain anything to patients or caretakers, offer no clear directions, and make it nearly impossible to get the help you need.

Someone I know was medically gaslit here -- told their condition wasn't serious and denied a referral to a specialist, with no explanation.

If I had a heart attack today, I wouldn't trust this place to save me or even refer me to someone who could.

Zero communication.

Zero accountability.

Stay away.

Additional Patient Stories about Failed Communication

Read about **Patient-1** where Sunrise Hospital and Dr. Michael Bradford at Nevada Orthopedic & Spine Center refused to tell the patient what went wrong during surgery and did not inform the patient that she had died during surgery due to being overdosed by the physician who was pretending to be an anesthesiologist. The patient was severely harmed and is continuing to suffer while Sunrise Hospital and Dr. Bradford remain silent and in hiding.

Read about **Patient-10**, an infant suffered serious brain injury at Sunrise Hospital due to untreated anemia, doctors withheld critical information and provided false and misleading information in the discharge summary. Jury awarded $14.5 million to the family.

Read about **Patient-17** where Dr. Michael Bradford at Nevada Orthopedic & Spine Center failed to tell the patient he had bone cancer and only sent the patient for pain management. The patient died a horrible, painful death.

Read about **Patient-21** where Sunrise Hospital failed to tell the patient he had colon cancer and instead put him through numerous horrible tests and surgeries. The coroner refused to do an autopsy, so his family paid for a private autopsy. The family finally got the truth when the private autopsy report showed that Miles died from an aggressive form of colon cancer that had spread to every organ in his abdomen.

Read about **Patient-30** who received very little medical care and said the communication was nonexistent.

Read about **Patient-33** where Dr. Holman Chan at Nevada Orthopedic & Spine Center lied to the patient when he failed to tell her that he broke her femur during surgery.

Read about **Patient-41** who was a patient at Sunrise Hospital for 3 weeks. The patient received no diagnosis, no answers, and poor communication.

Read about **Patient-55** who was mistreated, misdiagnosed and ignored at three hospitals in Las Vegas even though the patient needed surgery.

Read about **Patient-59** who received very little communication from doctors at Sunrise Hospital. Patient was not properly cleaned and was frequently left alone during treatments, including physical therapy.

Read about **Patient-60** who spent 3 days at Sunrise Hospital. His procedure was canceled and rescheduled multiple times, but the procedure never happened. Staff was disorganized and inept and provided very little communication.

Read about **Patient-61** who was treated for "alleged pneumonia" at Sunrise Hospital. Days later, the family learned from a home healthcare nurse who reviewed the medical records that the patient had actually suffered a heart attack and had a blood infection. Sunrise Hospital never told the patient's family. Dangerous lack of communication.

Read about **Patient-70** who received zero communication from Sunrise Hospital regarding his condition or treatment.

Read about **Patient-90** who was a patient at Sunrise Hospital for 11 days. Received very little medical care. Lack of communication and no answers from the doctors.

Read about **Patient-155** who was at Sunrise Hospital in the ICU. There was very little communication between the doctors and nurses. The doctor put a DNR (Do Not Resuscitate) Order in the patient's chart without her permission. When the family learned about it, they had it removed from her record.

Who is Liable for Failure to Communicate a Diagnosis?

A failure to communicate diagnosis occurs when a medical professional does not adequately relay essential diagnostic information to the patient. This can happen at any stage of the healthcare process, from failing to inform a patient of test results to omitting critical updates about a developing condition.

Common examples include:

- Not informing a patient of abnormal lab or imaging results.
- Delaying the delivery of a life-altering diagnosis such as cancer or a chronic illness.
- Communicating test results to the wrong patient.
- Failing to follow up or misinterpreting the need for urgent intervention.

Liability doesn't stop at the doctor. Other healthcare professionals and institutions may also be responsible:

- Primary care physicians
- Radiologists who fail to report findings
- Nurses or medical assistants who don't relay results
- Hospitals that lack proper communication protocols

When a diagnosis is documented in the EHR (Electronic Health Records) but never actually communicated to the patient, both the provider and the system may be held responsible for negligence.

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Just say NO to Sunrise Hospital

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