

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES
NEW YORK BRANCH OFFICE**

HOSPICE COMPASSUS

and

Case No. 28-CA-94375

BRENDA BOOKER, An Individual

David Garza, Esq., Counsel for the General Counsel.

Kevin Mullen, Esq., Littler, Mendelson, P.C., Counsel for the Respondent.

Anita Kelley, Esq., Counsel for the Charging Party.

DECISION

Statement of the Case

Joel P. Biblowitz, Administrative Law Judge: This case was heard by me on May 21 and May 22, 2013 in Albuquerque, New Mexico. The Complaint herein, which issued on February 28, 2013, and was based upon an unfair labor practice charge that was filed on December 6, 2012¹ by Brenda Booker, alleges that Hospice Compassus, herein called Respondent, discharged her on June 7 because she engaged in concerted activities with other employees by complaining, and raising concerns about terms and conditions of employment, in violation of Section 8(a)(1) of the Act. Respondent defends that she was not discharged for engaging in protected concerted activities; rather she was discharged because she refused to follow an order of a doctor to perform a procedure on a hospice patient and substituted her own judgment and treatment, contrary to State rules and Respondent's policy.

I. Jurisdiction

Respondent admits, and I find, that it has been an employer within the meaning of Section 2(2), (6) and (7) of the Act.

II. The Facts

As the name implies, the Respondent is engaged in providing end of life medical care at numerous locations throughout the United States. In the Albuquerque, New Mexico area, Respondent provides these services to individuals located in a number of facilities in the Albuquerque area. These could be the patient's home, at nursing homes or long-term care facilities and the nurses employed by the Respondent visit and treat the patients at these facilities. The principal focus of the employees was to make the patients comfortable in their final weeks or months of life.

A. March 21, 2012 Meeting

Booker is a registered nurse who was employed by the Respondent as a case manager, as were the other four registered nurses employed by the Respondent at the facility. She

¹ Unless indicated otherwise, all dates referred to herein relate to the year 2012.

attended a regular staff meeting at the facility on March 21, along with the other case managers, the executive director, Kathryn Sykes-Sullivan (who did not testify), supervisors Gail Levine and Tom Lofton, the social worker, office manager, team coordinators and the receptionist. There were discussions of finances, how to obtain more patients and ways to improve the operation.

5 She testified that near the end of the meeting Sullivan said, “On a final note, I want the RNs to know that there won’t be any overtime.” Booker then said that they were having a problem with overtime and that because of it, the RNs were charting at home. Sullivan said that they should not be charting at home and one of the other case managers asked, “Where should we chart? Should we sit in our cars in our driveway?” Sullivan then got up to leave, but Booker continued speaking, saying that if the chaplains and social workers would help by discussing death and dying with the families, that would ease their workload and their need to chart at home. 10 Everybody left the meeting and Booker followed Sullivan into her office saying, “We need to talk about this” and Sullivan put up her hand, signifying that she did not want to discuss it further. Booker then asked if that meant that the conversation was over and Sullivan responded, “Don’t yell at me” and Booker left the office. A few weeks later, one of the other nurses, “Lilliana,” told her that she wasn’t going to be paid because she turned in her timecard late, and Booker spoke to Gail Levine, at the time the director of clinical services for the Respondent, and asked her if she could do something about it by setting a uniform time for the nurses to hand in their timecards, because it was a problem all the nurses were having. Levine said that she would discuss it with Sullivan and went into Sullivan’s office while Booker waited outside the office and she heard Levine tell Sullivan that she had a concern about Lilliana not being paid for the day, and overheard Sullivan respond, “Oh, Brenda is making a big deal out of this.” Booker then said, “I can hear you.”

25 On April 20, Booker was given a Monitoring and Mentoring form dated April 2 by Levine, who told her that raising her voice at the staff meeting to talk about overtime was inappropriate. The comments at the conclusion of this form states:

30 You are a role model for your peers. As such your conduct sets a tone that can create a positive or negative working environment. When you are upset, you need to decide if it is best to address your concerns at that moment while you are upset, or if your needs are better served by waiting a few hours or a day so that you can speak clearly and specifically to address your areas of concern. Your comments during IDT of 3/21/12 were unprofessional and bordered on insubordination, this will not be tolerated again without disciplinary action. At this point there is no plan to make a note in your personnel file unless this behavior persists. 35

On April 23, Booker responded:

40 I acknowledge that I was angry at the meeting. I don’t feel I am being heard. Three of the four nurses had input on the topic with the same concerns. The fourth nurse left the meeting. I find it disheartening that my feelings aren’t validated when my feelings reflected those of all the nurses at the time. How is calling an employee insubordinate and threatening disciplinary action productive? How can we prevent this in the future? 45 How can we create a more cohesive communicative understanding team?

In the margin of Booker’s response, Levine wrote, *inter alia*, “Issues done in meetings rather than 1:1 with DCS [Levine] or ED [Sullivan].” Levine testified that what she meant by this comment was that she would have coached Booker to meet with either she or Sullivan, 50 individually, to discuss these issues, rather than bring it up at the meeting, as she did.

On May 11 Booker was given a Pre-Meeting Worksheet, which she characterized as a

“type of counseling notice.” Under “Required Performance” it states:

5 Per job description Brenda must have timesheets with accompanying nurse’s notes in
before 10 AM Mondays. Brenda is expected to exhibit professional and courteous
behavior to all of her Hospice Compassus colleagues. Brenda will manage her time for
patient care to avoid excessive overtime, and will get pre-approval for any anticipated
overtime related to patient care. Brenda will get approval from DCS to participate in
marketing activities, keeping in mind time requirements for case management activities
and hours available in her schedule. Brenda will utilize 30 minutes for her lunch break.

10 The Respondent had an “issue” with Booker’s lunch breaks; she sometimes went to
lunch with Lofton and every other Friday she had lunch with the other RN case managers. They
would schedule it when the patient load was light and take a one or two hour lunch at a
restaurant; Booker testified that she is not aware of any policy at the facility regarding lunch
15 breaks. Sullivan called her into her office and said that she could no longer take two hour
lunches; she asked why since it didn’t cause overtime and her patients were not neglected, but
Sullivan did not respond. After that conversation, she limited herself to one hour lunches and
Sullivan called her in again and told her that she couldn’t continue doing so; Booker again
objected, saying that she was not putting in for overtime, her patient care was not affected, and
20 she had not seen any policy on the subject. Sullivan replied, “It doesn’t matter.”

Lofton, who was employed by the Respondent as director of clinical services along with
Levine from February 2009 to June 19, 2012, and who Levine testified was Booker’s “significant
other,” testified that at the March staff meeting Booker got up and said that the nurses needed
25 overtime because they did not have enough time to chart when they were in the field and had to
do so when they got home, and that they would have more time to chart if the support staff did
more of their job. Her demeanor was direct and calm and she was directing what she said to
Sullivan: “The meeting stopped at that point.”

30 Levine testified that she has been counseling Booker since about August 2011, and has
counseled all of the case managers. She counseled Booker about the illegibility of her
documentation, turning in late timesheets and signing in and out at the correct time. In regard to
what Booker said, and how she said it at the March 21 meeting, Levine testified, *inter alia*:

35 There was a lot of emotion in what was being said. What was being said was said in a
disruptive manner and that...what we were having was a general staff meeting, and
what happened was that this outburst disrupted that staff meeting, pretty much derailed
it and completely took myself and the other manager that was there, Kathryn Sykes-
Sullivan, quite a bit aback because we hadn’t been approached about these topics prior
40 to this time. So it was completely disruptive and it wasn’t presented like a factual case, it
was just disruption...I don’t remember what she said so much as how she said it. I
remember that her voice was extremely loud, and her face got real red and...she cut
through all the conversation that was going on before that, a give and take completely
ceased. There was this loud shrill outburst by Ms. Booker. You could tell she was upset.

45 Levine told Booker that her “concern” was lost because of the emotional way that she presented
them and that she would have been more effective if she had presented them in a controlled
organized manner. Booker received her yearly Performance Review on May 31. There are
twenty categories that are rated from 1, the highest rating, to 3, the lowest rating. She was rated
50 1 in eleven categories, including 1+ in five categories, 2 in eight categories, and 3 in one
category, Budget Adherence & Cost Control, making her eligible for a merit increase.

B. The Treatment of Patient JF

Dr. Preston Matthews has been employed as a medical director for the Respondent for two years, and in that position, he acts as the primary physician for those patients who do not have their own treating physician. In addition, he provides instructions to the nurses employed by the Respondent on how to treat and care for its hospice patients. Initially, that is through standing orders, a pre-approved, generic style form that he completes for the patients. These orders provide initial treatment guidelines for the patients, depending upon their situation. There are different standing orders for pain control, constipation, nausea, vomiting and psychosis, as well as other maladies that hospice patients often exhibit, and the nurses follow these orders in treating the patients, and he signs them, often without carefully examining their contents because of the large number of orders requiring his signature. These orders are guidelines for the nurses to employ in treating the patients until the nurses inform him that the patient's symptoms are not addressed on the standing order, if the treatment is not effective or that the patient has difficulty with some medication. In those situations he, or the treating physician, would change the orders. Any treatment performed under these orders, or changes to the standing orders are documented on Respondent's Physician Orders by the nurses and are eventually signed by him. Any treatment that does not conform to the standing orders has to first be discussed with him or the patient's treating doctor. He discusses the patient's condition and treatment with the nurses by phone, text or at the weekly IDT meetings. He also testified that a nurse cannot treat a patient in a manner that does not conform to orders that he has issued, and that a nurse may not give a patient drugs not specified in the standing order, whether prescription or over the counter, without a physician's authorization.

Levine, who had been employed by the Respondent until she voluntarily left its employ in August 2012, testified that in New Mexico, only physicians and nurse practitioners are authorized to prescribe treatment and medicine for the patients. The nurses are required to follow the treatments prescribed by the doctors or nurse practitioners. If a nurse disagrees with a doctor's order, or believes it is unsafe for the patient, the nurse is required to call the doctor to discuss his/her concerns about the order before changing it or performing an alternate procedure.

Dr. Francisco Torres has been employed by the Respondent as its associate medical director at the facility since August 2012, but his connection with this matter is that JF was his private patient while being cared for by the Respondent at the Beehive Home. On June 1, Dr. Torres received an X-Ray Report for JF that stated, *inter alia*: "Suspect fecal impaction in the rectosigmoid region." On the same day, he faxed the report to Levine and wrote on the fax that he called Levine and told her that JF needed a fecal disimpaction. He testified that JF's diagnosis was end stage multiple sclerosis, which "...is a progressive disorder that weakens. What usually happens is that the patient is not able to bear down with abdominal muscles, so it makes evacuation more difficult." He testified that if a nurse had questions about an order that he issued, or disagreed with it, he expects the nurse to call him to discuss the treatment that he prescribed. He was asked:

Q Would you expect a nurse to follow standing orders for constipation when you have given an order to disimpact a patient?

A No.

Q Why not?

A Because that's not...the order I gave. In my mind, a direct verbal order usually

outweighs standing.

Q If a nurse has any questions about that, what should she do, in your mind?

5 A What they usually do.

Q Which is what?

A They call me.

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He testified that he was available that day, but did not receive a telephone call from Booker about the requested disimpaction of JF.

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After receiving the fax from Dr. Torres, Levine sent a text message to Booker on at 11:53 a.m. on June 1 stating: "Dr. Torres MD of Beehive called and [JF] is impacted, would like a visit for him today to disimpact, he asks for call ½ hour before you arrive so staff can premedicate for pain. Thanks." She testified that after she received the fax from Dr. Torres, she called Booker to make sure that she received the fax and told her that Dr. Torres said the patient was uncomfortable and he wanted the disimpaction done that day or as soon as they could arrange it. In addition to sending the text message to Booker, she believes that she called her or left a voicemail for her to be sure that she could cover all of her patients that day with the additional workload or if another nurse could be of some assistance to her. She never discussed the possibility of not disimpacting JF or alternatives to disimpacting him.

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Booker testified that she first met JF at the Beehive Village, an assisted living facility on May 30, when she spent about an hour with him, trying to put him at ease. At about noon on June 1 she received a text from Levine saying that she had received a fax from Dr. Torres stating that JF was impacted, "and that he would like the nurse to go disimpact." The text also said that he should be premedicated thirty minutes before the disimpaction. Booker then called Beehive and after one building did not answer the phone she called the other building and was told that they probably did not answer because they were helping the patients with lunch. Booker then called Levine and asked her "...how urgent the situation was." Levine asked her if she had called Dr. Torres, and she answered that she didn't, because she didn't have his telephone number. Booker then told Levine that if JF was impacted, she had a plan: to give him Senna, Milk of Magnesia, a suppository and an enema, spread out over two or three hours to help "soften" him. She was going to call the pharmacy to pick up the medicine and deliver them to the Beehive. She testified that Levine replied, "Okay," and that she would call Joan Seward and Brenda Schetnan, the on call nurse, who would be involved later on with JF, to tell them of her plan. Levine also said that she would text her Dr. Torres' telephone number, but she never received it. Booker picked up the stool softener, the Milk of Magnesia, the suppositories and two Fleet enemas at the pharmacy. When she was asked why she got those items, she testified:

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It was just in case I could not disimpact him. If he was in a lot of pain and the impaction was difficult, it is my experience that the stool softeners help soften from the other end. Sometimes if you would give them some pain medicine to help prevent his discomfort, the stool softeners and Fleet enema and suppositories help loosen it, so that anyone, including myself, who would go back later to try to disimpact, the stool would be softer.

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She went to the Beehive right from the pharmacy and arrived at about 1:00 and saw JF sitting in the dining room and he smiled at her and waved. She determined that, "...it looked like he did not have any pain. So, I assessed him. I took his blood pressure, his temperature, I listened to his abdomen...I palpated his abdomen. He had good bowels sounds and, at the

time, his abdomen was soft.” She told the staff at the home that the situation was not as urgent as she had been told and she did not want to remove him from the social setting in the dining room to disimpact him. They had time to soften his stool and she told the staff to give him some warm, chopped prunes and she gave him four Senna tablets. When she left about an hour later, she instructed the staff to give him the Milk of Magnesia in two hours and that when Seward came, she would give him the suppository, while Schetnan would give him 60 ml. of Lactulose, all with the goal that his stool would not be too hard that he would have pain and that he could have a bowel movement or, at least, his stool would be easier to disimpact. Dr. Torres testified that this treatment is not in conformance with treating an MS patient because an MS patient would not have the muscle power to move the stool. Booker called Seward and Schetnan and told them of her plan and what she needed them to do. Seward called her at about 5:30 p.m. that day and told her that his stool was so hard that she was unable to disimpact him, and that Booker’s plan to soften up his stool was a good plan and should be continued. Later that evening Schetnan called her and said that the stool softeners had worked because she was able to disimpact about half of the stool.

Schetnan testified that she received a call from Booker on June 1 asking her to stop by that evening to see JF, who was constipated and that she could help out by giving him a Fleet enema. Booker also told her that she had received an order from Dr. Torres to disimpact the patient, and that she wanted to give him other medications, Senna, Milk of Magnesia and Lactulose instead of disimpacting, and that Seward would be there earlier to give him a Dulcolax suppository, to help clear him, and she completed a Physicians Order to this effect, as required. When she saw the patient that evening, he was “arousable and responsive,” and was in bed. She performed a rectal exam to determine whether a Fleet enema was appropriate, and the exam revealed that stool in his rectum was interfering with her ability to insert the Fleet enema. Due to his “declined state,” and because the stool was so hard, he was not going to be able to evacuate it, and she decided that it was appropriate to do a disimpaction, and she did so.

As stated above, after Booker decided upon her treatment of JF, she completed a Physicians Order form setting forth what she did, and left it for Dr. Matthews to sign, which he did on June 6. He testified that he signs many orders and signs them “fairly rapidly.” On the same day, Sullivan told him that Respondent had concerns about a patient that Booker was caring for, and that there was another physician involved with that patient, and Matthews said that if he had been told that there was another physician, he would not have signed the Physicians Order that Booker gave him. Later that day, Sullivan sent him the Physicians Order in question, together with a note stating: “Please indicate this was signed in error & that you did not speak to either nurse about pt. or protocol that was started as you stated in our conversation.” After receiving this note from Sullivan, Matthews re-signed the Physicians Order with these words included. He testified that when he initially signed the form, he wasn’t aware that JF was Dr. Torres’ patient, that JF had multiple sclerosis and was impacted, and that the patient had not been disimpacted before the order was implemented. He testified that if Sullivan had not told him about the Physicians Order, he probably would never have learned of the situation because he signs so many of them. In addition to Matthews testimony about signing the Physicians Order without reading its contents, there are a series of emails dated June 6 between Synthia Cathcart, a Senior Vice President of the Respondent, Sullivan, Kerry Arp, Respondent’s Regional Clinical Director, and Renee Bradford, a Senior Vice President for Human Resources, where they discuss Matthews’ signature on the form. Some of the comments were: “Did Dr. Matthews really give them these orders, or did he just sign after the fact, whatever they wrote?” “Just for the record, he needs to start looking at what he is signing before he signs it. With signed orders in our hands, that could well complicate our report to the state;” “I spoke with him at length about that. He asked me to send him the order so he can write a statement on it that says it was signed in error and that he did not speak with either

nurse about this patient or the protocol they started.” “I’ll bet he reads all orders from now on;” “I have talked to him 3 times and he feels awful he said he will never let that happen again;”

5 Levine testified that Booker was called into the office on June 4 and was told that she was suspended for acting outside of the scope of her nursing license. During a prior conference call with Cathcart, who made the decisions to suspend, and then to discharge Booker, Levine was “asked for factual information during a conference call,” but did not make a recommendation on whether Booker should be discharged. As part of her investigation into the incident, she asked Booker to prepare a “timeline” of the events of June 1, which she did. There were several conference calls where she and Sykes-Sullivan spoke to Cathcart about this situation with JF and in these calls, Levine never raised the issue of Booker’s speaking up at the March 21 meeting, and does not recall Sykes-Sullivan speaking of it either.

15 Cathcart testified that Booker was fired because she did not follow a direct order from Dr. Torres and, instead, substituted her own treatment for Dr. Torres’ orders. She came to that conclusion after overseeing the investigation as well as the timeline of events that were prepared by Booker and Schetnan, and by speaking to Levine and Sykes-Sullivan, but not with Booker. She testified that Booker’s treatment of the patient on June 1 did not comport with Dr. Torres’ order that was texted to her by Levine on June 1, and her investigation found no support for Booker’s claim that Levine approved of her changing the treatment of the patient, rather than disimpacting. In addition, her initial attempt to soften his stool was improper, because she didn’t put on a glove and first examine his rectum to determine if it was feasible. Cathcart testified further that when she made the decision to discharge Booker, she was unaware of the events of the March 21 meeting, as recited above of Part A of this decision.

25 Schetnan testified that she called Levine on June 2 to inform her of the patient’s condition and Levine told her to make sure that the patient was comfortable and to take very good notes. On the following morning Levine told her to take very good notes about the patient, “because they were watching Brenda Booker.” Later that day she met Levine at the Beehive facility, and Levine told her that they were watching Booker because “they thought she was being cavalier in her decision making,” and they wanted to document it. On the following day, Levine asked her to prepare a timeline of the events up to the patient’s death, she did so, and gave it to Levine.

35 Booker testified that when she reported for work on June 4 she was called into Sullivan’s office and told that JF developed a fever and died on June 3; that she had failed to follow Dr. Torres’ orders and that she had caused the patient’s death; Cathcart testified that Respondent never said or alleged that. They asked what her plan had been on June 1 and she said that she was following the standing orders for the patient in trying to soften his stool, and to make the patient more comfortable, and Sullivan said that there would be an investigation, and that she was free to go. Shortly thereafter, she was told that as she had directly disobeyed an order, she was suspended. On June 7 she was called into Sullivan’s office and with both Sullivan and Levine present, she was told that she had acted outside the scope of her practice, had prescribed medication without authority, and that her actions were reportable to the Board of Nursing and that they had no choice but to discharge her. Booker repeated that she followed the standing orders in attempting to make the patient more comfortable and did not feel that it was warranted to remove him from the social setting in order to disimpact him. She was given the following notice at the meeting:

50 Reason for termination:

Willfully ignoring physician’s order and not following plan of care for patient...

Practicing outside of your scope of practice by instituting a plan of treatment that you do not have the prescriptive authority to do.

5 Chose to go against physician’s orders and proceed with own protocol for patient.

Failure to follow directive from supervisor.

10 Did not follow supervisor’s directive to follow physician’s order for digital disimpaction of patient.

The offense of not following physician’s orders is a reportable offense and we have the obligation to report it to the New Mexico State Board of Nursing.

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III. Analysis

20 The sole issue herein is whether Booker was fired on June 7 in retaliation for her protected concerted activities at the June 21 meeting, as alleged by Counsel for the General Counsel, or because her treatment of patient JF on June 1, did not conform to the treatment that Dr. Torres ordered.

25 It cannot be doubted that Booker’s actions and statements at the March 21 meeting constitutes protected concerted activities. In *Prescott Industrial Products Company*, 205 NLRB 51 (1973), the Board stated:

30 A line exists beyond which an employee may not go with impunity while engaging in protected concerted activities and that if employees exceed the line the activity loses its protection. That line is drawn between cases where employees engaged in concerted activities exceed the bounds of lawful conduct in a moment of animal exuberance or in a manner not motivated by improper motives and those flagrant cases in which the misconduct is so violent or of such character as to render the employee unfit for further service.

35 The question is whether the employee’s conduct is “sufficiently egregious” to remove her/his actions from the protection of the Act. *Stanford New York, LLC*, 344 NLRB 558 (2005). Here, there can be no question that her actions and statements at the March 21 meeting were well within the area of actions protected by the Act. Although she was angry, raised her voice and did not first discuss this issue with Sullivan and Levine, as they would have preferred, her actions clearly did not cross the line constituting flagrant misconduct. The ultimate issue herein
40 therefore, is whether she was discharged because of this activity, or because of the manner that she treated JF on June 1. For that determination, we employ the test set forth in *Wright Line*, 251 NLRB 1083 (1980). Under this test, the initial issue is whether Counsel for the General Counsel has made a *prima facie* showing sufficient to support the inference that protected
45 conduct was a “motivating factor” in the Respondent’s decision to discharge Booker. If that has been established, the burden then shifts to the Respondent to establish that it would have terminated her even in the absence of her protected conduct.

50 On April 20 Booker was given a Monitoring and Mentoring memo, which praised her as a “role model for her peers,” but criticized her “unprofessional” conduct at the meeting which “bordered on insubordinate,” and she was warned that a repeat of this conduct would not be tolerated without disciplinary action. It appears to me that this was an overreaction by Sullivan

and Levine which could best be explained by their being “thin skinned.” In addition, she was warned that she could no longer take two hour lunches and then was warned about taking one hour lunches. Even though the nurses were not paid for their lunch breaks, I can understand Respondent’s displeasure at Booker and the other nurses taking two hour lunches, especially when they were having difficulty completing their charting, as was expressed at the March 21 meeting. One hour lunches appear to be less offensive, however. On the other hand, on May 31, only one day prior to the incident that resulted in her discharge, she was given her yearly Performance Review in which she was given the highest rating in most of the performance categories, and had a 1+ in five of the categories, making her eligible for a merit wage increase. It appears to me that the animus that was present two months earlier at the conclusion of the meeting, was no longer evident at the end of May. The sole exception is Schetnan’s testimony that on June 3 Levine told her to take good notes about the patient as they were watching Booker because they thought that “she was being cavalier in her decision making,” and the events of June 1 establish, to my satisfaction, that she was.

One aspect of the Respondent’s defense herein is that Cathcart testified that she alone made the decision to discharge Booker and she made that decision solely on Booker’s actions on June 1, and that when she made that decision, she was unaware of the events of March 21. In addition, Levine testified that in conference calls with Cathcart, she and Sullivan told her of Booker’s treatment of JF, not what occurred at the March 21 meeting. Cathcart and Levine, who is not presently employed by the Respondent, each appeared to be credible witnesses, and I credit Levine’s denial that she agreed with Booker’s “alternative” treatment of JF in their June 1 telephone conversation. It does not seem reasonable to me that in her position she would agree to a treatment that clearly disregarded a doctor’s order. While Booker also appeared to be a credible witness, I found some of her testimony somewhat disingenuous. While she was forceful in her testimony that her treatment of JF was pursuant to Dr. Matthews’ Standing Orders for the patient, that was not totally true. In fact, she clearly exceeded her authority by prescribing Lactulose, which was not in the Standing Orders, and prescribed different doses of some of the drugs listed in the Standing Orders. I also found disingenuous her testimony, and the argument in Counsel for the General Counsel’s brief that the text message that she received from Levine on June 1 was somehow inadequate because she never received Dr. Torres’ order on a Physician’s Order form, and that the text, somehow, was not specific enough. The text says that the disimpaction is to be performed “today.” That seems clear to me. Further, as argued by counsel for the Respondent, in his brief, Booker never “gloved up” to check the patient’s condition prior to deciding not to disimpact and selecting which medicine to give him, in lieu of the disimpaction.

As I credit the testimony of Cathcart, I find that Counsel for the General Counsel has not satisfied his initial burden under *Wright Line* that he protected conduct, principally her actions on March 21, were a motivating factor in the Respondent’s decision to discharge her. In the alternative, if I had found that he had satisfied his initial burden, I would have found that based upon Booker’s actions on June 1, Respondent has satisfied its burden that he would have discharged her regardless of her concerted actions. I therefore recommend that the Complaint herein be dismissed.

Conclusions of Law

1. The Respondent has been an employer within the meaning of Section 2(2), (6) and (7) of the Act.

2. The Respondent did not violate Section 8(a)(1) of the Act as alleged in the Complaint.

On these findings of fact, conclusions of law and based on the entire record, I hereby
Issue the following recommended²

ORDER

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It is recommended that the Complaint be dismissed in its entirety.

Dated, Washington, D.C. July 23, 2013

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Joel P. Biblowitz
Administrative Law Judge

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² If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and
Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec.
102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed
waived for all purposes.

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