

Baptist Hospital, Orange and Elisa Williamson. Case
16-CA-19047

May 28, 1999

DECISION AND ORDER

BY CHAIRMAN TRUESDALE AND MEMBERS FOX
AND HURTGEN

On August 20, 1998, Administrative Law Judge Howard I. Grossman issued the attached decision. On September 11, 1998, he issued an erratum (which has been noted and corrected). The Respondent filed exceptions, a supporting brief, and supplemental exceptions to the erratum. The General Counsel filed an answering brief.¹

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel.

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings,² and conclusions, as amended below,³ and to adopt the recommended Order as modified below.⁴

AMENDED CONCLUSIONS OF LAW

Substitute the following for present Conclusion of Law 4.

"4. The Respondent discharged the Charging Party on November 25, 1997, because of her concerted protected activities, in violation of Section 8(a)(1) of the Act."

¹ The General Counsel also filed a Motion to Quash those portions of the Respondent's brief which, the General Counsel argues, "are utterly without foundation in the official record." The Respondent filed a Reply. The motion is denied. Secs. 102.46(b)-(c) of the Board's Rules and Regulations require, among other things, that exceptions and briefs provide specific page references to the record, and states that any exception that fails to comply with these requirements may be disregarded. Although we do not condone the failure to comply with the Board's Rules and Regulations, we find that it is not prejudicial in this case.

² The Respondent has excepted to some of the judge's credibility findings. The Board's established policy is not to overrule an administrative judge's credibility resolutions unless the clear preponderance of all the relevant evidence convinces us that they are incorrect. *Standard Dry Wall Products*, 91 NLRB 544 (1950), enf. 188 F.2d 362 (3d Cir. 1951). We have carefully examined the record and find no basis for reversing the findings.

³ The judge concluded that the Respondent's discharge of Elisa Williamson violated Sec. 8(a)(1), (3), and (4) of the Act. We affirm the 8(a)(1) violation. There is no basis in the complaint or record for the 8(a)(3) violation, and we shall delete this mistaken reference from the judge's conclusions of law. In addition, particularly in the circumstances presented here, we find no need to pass on whether Williamson's discharge violated Sec. 8(a)(4).

⁴ We shall modify the judge's recommended Order and substitute a new notice with the Board's traditional narrow cease-and-desist paragraph. We will also modify the judge's recommended Order in accordance with our recent decision in *Indian Hills Care Center*, 321 NLRB 144 (1996). In addition, contrary to the judge's recommendation, we shall leave to compliance proceedings the determination of the percentage amount of wage raise due Williamson to remedy the effects of the Respondent's unlawful low rating of her work.

ORDER

The National Labor Relations Board adopts the recommended Order of the administrative law judge as modified below and orders that the Respondent, Baptist Hospital, Orange, Orange, Texas, its officers, agents, successors, and assigns, shall take the action set forth in the Order as modified.

1. Substitute the following for paragraph 1(c).

"(c) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act."

2. Substitute the following for paragraph 2(a) and reletter the remaining paragraphs.

"(a) Within 14 days from the date of this Order, offer Elisa Williamson full reinstatement to her former job or, if that job no longer exists, to a substantially equivalent position, without prejudice to her seniority or any other rights or privileges previously enjoyed.

"(b) Make Elisa Williamson whole for any loss of earnings and other benefits suffered as a result of the discrimination against her, in the manner set forth in the remedy section of the decision."

3. Substitute the attached notice for that of the administrative law judge.

APPENDIX

NOTICE TO EMPLOYEES

POSTED BY ORDER OF THE

NATIONAL LABOR RELATIONS BOARD

An Agency of the United States Government

The National Labor Relations Board has found that we violated the National Labor Relations Act and has ordered us to post and abide by this notice.

Section 7 of the Act gives employees these rights.

To organize
To form, join, or assist any union
To bargain collectively through representatives of their own choice
To act together for other mutual aid or protection
To choose not to engage in any of these protected concerted activities.

WE WILL NOT give low evaluations to employees because of their concerted protected activity, and WE WILL NOT tell employees that we gave them low evaluations for this reason.

WE WILL NOT discharge or otherwise discriminate against employees for engaging in concerted, protected activity.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed you by Section 7 of the Act.

WE WILL, within 14 days from the date of the Board's Order, offer Elisa Williamson full reinstatement to her former job or, if that job no longer exists, to a substan-

tially equivalent position, without prejudice to her seniority or any other rights or privileges previously enjoyed.

WE WILL make Elisa Williamson whole for any loss of earnings and other benefits resulting from her discharge, less any net interim earnings, plus interest.

WE WILL, within 14 days from the date of the Board Order, remove from our files any references to our low evaluation and unlawful discharge of Elisa Williamson, and WE WILL, within 3 days thereafter, notify her in writing that this has been done and that these actions will not be used against her in any way.

BAPTIST HOSPITAL, ORANGE

Tamara Gant, Esq., for the General Counsel.

John J. Durkay, Esq. (Mehaffy & Weber, P.C.), of Beaumont, Texas, for the Respondent.

Elisa Williamson, appearing pro se.

DECISION

STATEMENT OF THE CASE

HOWARD I. GROSSMAN, Administrative Law Judge. The charge was filed on December 1,¹ 1997, by Elisa Williamson (Williamson). Complaint issued on March 31, 1998, and alleges that Baptist Hospital, Orange (Respondent, or the Hospital), by Supervisor Jean Jackson, told Williamson that her evaluation as to professionalism was so low because she complained to the administration. The complaint also alleges that Jackson gave Williamson a low rating as to professionalism because Williamson engaged in protected activities and in order to discourage employees from engaging in these activities, thereby violating Section 8(a)(1) of the National Labor Relations Act (the Act). The complaint additionally alleges that the Hospital terminated Williamson on November 25, 1997, because she engaged in protected activities, and because she filed a charge and gave testimony in Case 16-CA-18871, in violation of Section 8(a)(1), (3), and (4) of the Act.

This case was heard before me in Port Arthur, Texas, on June 22 and 23, 1998. Thereafter, the General Counsel and the Hospital filed briefs. Based upon my observation of the demeanor of the witnesses and the entire record, I make the following

FINDINGS OF FACT

I. JURISDICTION

Respondent is a Texas corporation with an office and place of business in Orange, Texas, where it is engaged in the operation of a not-for-profit hospital providing inpatient and out patient medical care. During the 12 months preceding issuance of the complaint, Respondent received gross revenues in excess of \$250,000, and purchased and received at its Orange, Texas, facility goods valued in excess of \$5000, directly from points outside the State of Texas. Respondent is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act and a health care institution within the meaning of Section 2(14). *East Oakland Community Health Alliance, Inc.*, 218 NLRB 1270 (1975).

¹ All dates are in 1997 unless otherwise stated.

II. THE ALLEGED UNFAIR LABOR PRACTICES

A. Williamson's Concerted Activities

1. The scheduling dispute

Williamson was a certified respiratory therapist, and started working at the Hospital in March 1989, together with other therapists in the respiratory therapy department. She assisted patients throughout the Hospital who had breathing difficulties.

The Hospital appointed Jean Jackson as manager of the respiratory department in early 1997.² Jackson announced a new method of scheduling work assignments. The previous method had been a rotating schedule. It was basically a schedule that repeated itself and gave the therapists 7 days off each month. It was predictable, and allowed the employees to plan personal activities in the future.

In April or May, Jackson instituted monthly schedules which were not the same among the different therapists and which changed from month to month. According to Williamson, there was a departmental meeting in April, and several therapists complained about the new system, including Williamson. Jackson responded that she would schedule as she saw fit. Susan Hart testified that she was at a departmental meeting within a few weeks from the time Jackson arrived at the Hospital. Hart stated that she protested the scheduling change, and Jackson replied that she was going to make the schedule as she saw fit.

At about the end of April, Williamson and therapist, Ramona Fullerton, gave Jackson a proposed new schedule which was similar to the old one. The schedule repeated itself, and nobody received more weekends off than any other employee. Jackson replied that she had no desire to look at the proposed schedule, and intended to assign work as she was doing.

Personnel Director Lyndia Permenter testified that the Hospital had been overstaffed, and had engaged a consultant, "Pro-Care," to assist it cutting down on staffing, and on "juggling" work assignments to correspond to constantly changing numbers of patients. This policy applied to all departments. However, Permenter did not know whether there was any overstaffing in the respiratory therapy department in the summer of 1997, and did not know Pro-Care's recommended staffing for that department.

2. The defective blood-gas machines, and the visit to Assistant Hospital Administrator Holly Christopher

The Hospital had two blood-gas machines, devices which determine the amount of oxygen in the blood of a patient with breathing problems. One machine was in the emergency room, and the other in the intensive care unit. The machine in the emergency room had been "down" for some time, and the Hospital had spoken with the manufacturer about it. On the evening of May 7, the machine in the intensive care unit also failed, and the Hospital was without any blood-gas machine. Williamson told the staff working that night to get it functioning. However, when she arrived at work the morning of May 8, neither machine was operating.

Supervisor Jackson was out of the city undergoing training at this time. Williamson tried to get the machine to work, without success. She tried to call the manufacturer, but only reached an answering machine. At that point, Medical Director Dr. Maz-

² The pleadings establish that Jackson was a supervisor within the meaning of the Act.

zola came in and asked for a blood-gas test on a patient. Williamson said that no machine was available and Mazzola replied that a courier would have to be sent to another hospital for the test. Williamson attempted to call Assistant Hospital Administrator Holly Christopher, but was told that she was busy. Dr. Mazzola then called Christopher, and the latter set up a courier service to transport the blood.

Williamson and respiratory therapist, Susan Hart, then went to Christopher's office. They discussed the dysfunctional blood-gas machines, and also protested the new scheduling method. Christopher replied that she liked Jackson, and thought that she was doing a good job.

3. Supervisor Jackson's return, and the 16-hour shifts

Jackson returned, and called Williamson on the evening of May 12. She stated that she wanted to speak with Williamson about the latter's going to the administration and talking to Dr. Mazzola about the blood-gas machines. Further according to Williamson, she had a conversation with Jackson on May 15, lasting about 1 hour. Jackson said that there was nothing wrong with her schedules. Since Williamson and Hart had gone to the administration, they were going to work 16-hour shifts. "And see how you like that," Jackson stated. The 16-hour shifts were really Holly Christopher's doing, Jackson asserted. She was also upset about Williamson's "dragging" Dr. Mazzola into the blood-gas machine problem, according to Williamson. The latter responded that, in light of Jackson's attribution of the 16-hour shifts to Christopher, they should talk to her about the matter.

Williamson, therapist Ramona Fullerton, and Jackson then had a meeting with Christopher. The therapists stated that 16-hour shifts were not safe for therapists, who frequently had to make crucial decisions in critical situations. They argued that working from 7 a.m. to 11 p.m., then having to be back at 7 a.m. the next morning, would present a danger in critical care areas. Fullerton corroborated Williamson, and affirmed that Christopher said they had to work 16-hour shifts. Christopher did not testify.

Williamson averred that Jackson held a departmental meeting in mid-May. She said that they were going to 16-hour shifts, and that the reason was the fact that "two techs chose to go to the front office." Susan Hart testified that, a few days after Jackson returned from her training trip, she called Hart into her office. Jackson said that the therapists should have "followed the chain of command," that Hart was a "back stabber," and had "stabbed all of her bosses" in the back. The schedule was going to remain the way it was. The reason the therapists did not like it was the fact that Jackson was "black." "I can't help that," Jackson stated, but the schedule was going to stay the way it was.

There was a departmental meeting a few days later, according to Hart, in which Jackson stated that a note with a "racial comment" had been put into her box. Assistant Hospital Administrator Christopher had the note, and was supposed to have brought it to the meeting. However, Christopher did not appear. Hart and the other therapists denied seeing any such note or knowing who wrote it, if anybody.

Williamson asserted that she, Fullerton, and Hart received more 16-hour shifts than any other therapists. Williamson queried why 16-hour shifts were necessary during the day, since there were more therapists present at that time.

Jackson agreed that the 16-hour shifts covered only the therapists during the day. She stated that this was necessary

because of the absence of therapists at school, and that she returned to the "basic" 12-hour shift after a few weeks. Holly Christopher had received a "lot of complaints" about the schedule, according to Jackson. She denied that she ever told employees that they could not go to Holly Christopher. "I told them that if you're going to do anything, go through the chain of command." If she knew about a problem, she could frequently solve it. Jackson denied that she "set out to get any employee" because the latter had complained to the administration.

4. Jackson's evaluation of Williamson

Williamson received an evaluation in September 1995, from a prior supervisor in which she equaled or exceeded the required standards in all categories. The evaluation states: "Elisa's skills are exceptional. She has far surpassed the expectations of the department. Her interaction with the doctors knows no equal."³ Williamson received similar scores in an evaluation in August 1996. Comments included in that evaluation stated that she was always at work early, did not miss work, and was "good and beyond" in initiative to ensure good patient care.⁴

Jackson gave Williamson an evaluation on August 6, 1997, in which the latter received scores of average or above average in all categories except "professional ethics." In this she received a score of "3," or "below average."⁵ The Hospital's criteria for evaluating performance in "professional ethics" states that a rating of "3" means that the employee "often does not follow professional standards when dealing with others. Difficult to get along with; disrespectful at times."⁶

Williamson testified that she asked Jackson about the low score on professional ethics. According to Williamson's uncontradicted testimony, Jackson replied that the reason was the fact that Williamson "went to the front office. They don't like that, and Holly's going to be looking for poor marks here." Williamson responded that she was supposed to have received counseling in order to get a grade as low as a "3."⁷ Jackson replied that Williamson had counseling—a warning for going to the front office, and asked whether Williamson wanted to sign the warning during that conversation. Williamson declined. On cross-examination, Jackson admitted that Williamson had not received counseling concerning a deficiency in professional ethics.

The respiratory therapists received raises based on their evaluations. The highest increase was 4 percent. Williamson, Susan Hart, and two other therapists received 1 percent; Ramona Fullerton received no raise.⁸

5. Williamson's reprimand and grievance

Williamson's normal shift was 7 a.m. to 7 p.m. During the day on August 12, Jackson called her and said that the "count"

³ G.C. Exh. 25.

⁴ G.C. Exh. 23.

⁵ G.C. Exh. 3.

⁶ Id.

⁷ There is no such statement on the exhibit, G.C. Exh. 3. However, each grade of 2 or 3 in the various categories being rated is preceded by an asterisk, without any reference to its meaning. Respondent's employee handbook states that employees shall receive a verbal warning for their first offense, except for severe misconduct, and that "should be noted in Personnel file." G.C. Exh. 26, p. 12. There is no such warning in evidence.

⁸ G.C. Exh. 13.

(number of patients) was down for the next day, and that Williamson's shift was being changed to 7 to 11 p.m. Williamson replied that she did not have a babysitter for that shift, but would try to find one. She called back at 3 p.m. and informed Jackson that she could not find a babysitter. The supervisor responded it was mandatory for her to come in, and Williamson repeated that she did not have a babysitter. Jackson replied that she would do what she had to do.

Williamson later filed a grievance in this matter as described hereinafter.⁹ In it, she avers that "Frances"¹⁰ had been scheduled to work from 7 p.m. on August 13 to 7 a.m., August 14, but said that her foot hurt, and she wanted time off to see a doctor. Williamson's grievance states that other therapists were not asked to come in at 7 p.m. on August 13. "Barbara" could not come in at 11 p.m. because she did not have a baby sitter.¹¹ Williamson's grievance argues that "Barbara was not written up for not coming in at 7:00 p.m. (she didn't have a baby sitter). . . . How can Jean make mandatory for me and no one else?"¹² According to Williamson, schedule changes of this nature were only made in an emergency.

On the morning of August 14, Jackson gave Williamson a written warning for "refusal to accept job assignment." The warning states that Williamson "threatened" Jackson with a grievance and a lawsuit, and said that a 1-day notice was insufficient to change the schedule.¹³

Williamson then prepared a grievance. In addition to the reprimand, she discussed the scheduling dispute and the blood-gas machine problem. Williamson complained that she was working in a "hostile environment," and asked Permenter to inquire about her with fellow employees, patients (including wives of board members), and other family members.¹⁴ Williamson testified that she gave the grievance, dated August 15, to Jackson on August 18, in the presence of Mary Ann Dryden. According to Williamson, Jackson was required to respond within 3 days.¹⁵

Jackson contended that she first saw the grievance when she "picked it up off the floor" on August 18, "the day I should have responded to it," i.e., within 3 days. As noted, the grievance was dated August 15.

Williamson affirmed without contradiction that she had not received a reply by August 22. She called Personnel Director Lyndia Permenter, who told Williamson that she would call Jackson. Williamson averred without contradiction that Jackson called her at 3 p.m. on August 22, and said that she was sending a response by certified mail. Williamson further testified that she did not receive a response.

On August 25, Permenter called Williamson into her office. She told Williamson that she (Permenter), Jackson, Holly Christopher, and another supervisor "couldn't make heads or tails" of the grievance, and "couldn't figure out what Williamson was grieving." They wanted her to "start all over again and

specifically state her grievance." It would be "fair" to give Williamson the extra time she needed, according to Permenter.

On August 26, Williamson prepared a letter to Holly Christopher, which she characterized as step 2 of her grievance. Enclosed was a copy of her letter delivered on August 18, which listed "all of [Williamson's] grievances of harassment that were discussed with Jean Jackson prior to implementation of this grievance procedure."¹⁶ Williamson was not sure of the exact date she gave this to Christopher. A few days later, Permenter said that she was supposed to give it to Jean Jackson. Williamson attempted to do so, but Jackson was not in. Williamson returned the next day, and gave it to Jackson. Permenter called Williamson again, returned the grievance to her, and said that Williamson "had let her time lapse." No action was taken on the grievance.

6. Williamson's charge against the Hospital in Case 16-CA-18871

Lyndia Permenter testified that Williamson filed a charge against the Hospital in a different case. Permenter was an admitted supervisor, and her testimony constituted an admission against interest *NLRB v. Gardner Construction Co.*, 296 F.2d 146 (10th Cir. 1961), *enfg.* 130 NLRB 1481 (1961). I take judicial notice of the charge in Case 16-CA-18871, which Williamson filed on August 29, and which alleges unfair labor practices based on the 16-hour shifts and the reprimand issued to Williamson by Respondent.

7. The heliox investigation

Heliox is a mixture of helium and oxygen used to assist respiratory patients in breathing. Patients who use this medication occasionally talk in a high-pitched voice. Vocational Nurse Stephen Spears had a patient for whom heliox was prescribed. Williamson, a respiratory therapist, had some questions about this patient and called Spears in mid-August. According to Spears, the person calling spoke in a high-pitched voice in a humorous manner. Spears said, "Oh, get off the heliox." They both laughed and this ended the conversation. Both Williamson and Spears denied that Williamson in fact had ever used heliox.

About 2 days later, Jackson approached Spears and asked him to write a report about the "heliox incident." Spears did so, but did not specify the name of the person who called. He gave this report to Jackson, but felt "uncomfortable" about it, and asked to see the report again. Jackson returned it to him, and Williamson's name "had been added to the top, as well as a statement above [Spears'] signature." Spears became "very angry," and tore up the report "right in Ms. Jackson's face."

About 30 minutes later Spears was directed to report to assistant Hospital Administrator Holly Christopher. She told Spears that she believed somebody was using heliox, and had to investigate it. Spears replied that Williamson was "too smart and too good of a tech" to do that. Spears testified that Christopher became "offended" at a question he asked her, and this ended the conversation.

Jackson also interrogated Registered Nurse Amy Henson about this incident.

⁹ G.C. Exh. 5.

¹⁰ I infer that Williamson refers to respiratory therapist, Frances Crawford, G.C. Exh. 13.

¹¹ I infer that Williamson refers to respiratory therapist, Barbara Haywood. Id. G.C. Exh. 13.

¹² G.C. Exh. 5.

¹³ G.G. Exh. 4.

¹⁴ G.C. Exh. 5.

¹⁵ There is a section in the Hospital's employee handbook entitled "Grievance Procedure." It does not specify any time frames for various steps. G.C. Exh. 26, p. 10.

¹⁶ G.C. Exh. 5. The August 26 letter is the first page of G.C. Exh. 5, and the remaining pages are the grievance delivered on August 18.

8. The birthday party

Williamson testified that she was scheduled to get off work at 4 p.m. on October 17, at which time her grandchild was having a birthday party. Jackson asked her to stay later, and Williamson agreed to remain until 5 p.m. Jackson then told Williamson she had to remain until 6:30 p.m., because Jackson's planned replacement "would be in overtime." Williamson remonstrated that it had been understood that she would remain until 5 p.m. Jackson stated that it was an "emergency schedule," and Williamson would have to remain or be terminated. Jackson then called Ramona Fullerton, and told her to call Jackson immediately if Williamson left for any reason. Williamson remained at work, and missed the birthday party.

B. The Emergency Room on November 24

Williamson was discharged after events which took place in the Hospital's emergency room on the evening of November 24. Williamson started work at 6:45 a.m. that day, and was scheduled to leave at 7:15 p.m. At 6 p.m., she and Susan Hart were on duty. At about 6:30 p.m., Williamson received a call on a pager to go to the emergency room. A patient had been admitted in respiratory distress. Williamson did a blood-gas test on him, and the results showed minimum oxygen content in his blood. The physician on duty at the emergency room was Dr. Michael Perez.¹⁷ He arrived at 6 p.m., and was present when the patient arrived. The latter's condition was deteriorating. Dr. Perez discussed his condition with Williamson, and it was decided that he had to be intubated. This involved the insertion of a tube into his trachea, so that he could be mechanically ventilated. A condition of this nature was life-threatening and was called a "code" by the Hospital.

According to Dr. Perez, he anesthetized the patient and inserted the tube into the trachea. Williamson and two nurses were present. The procedure went without incident; the patient was being oxygenated appropriately, and was breathing with the use of a bag attached to the endotracheal tube. The bag required regular squeezing to force air into the tube, and was preliminary to the use of a mechanical ventilator in the intensive care unit. Dr. Perez had intubated this patient three times in the past, and the latter normally stabilized after intubation. The same condition resulted on this occasion, and Dr. Perez considered the patient to be stabilized.

A shift change was scheduled for 7 p.m. Mary Ann Dryden and Suzette Bilbo were the respiratory therapists for the night shift. They arrived at about 6:45 p.m. and were directed to the emergency room. When they arrived, the patient had already been intubated, according to Bilbo, and Williamson was "bagging" the patient, i.e., squeezing the bag to provide his breathing. Bilbo stated that the patient "was just really waiting for a room in the intensive care unit."

Replacement therapists received reports on patients from the preceding therapist. Bilbo left to go upstairs and get her report from Susan Hart, whom she was replacing. She returned at about 7:20 p.m., at which time Williamson was giving her report to Mary Ann Dryden in the hallway. A nurse was doing the bagging. Dr. Perez testified that a nurse or anybody trained in life support could do this. Bilbo asked Williamson and Dry-

den whether they needed any help, and they said, "No." Bilbo went to the intensive care unit to set up the mechanical ventilator.

Williamson's version of these events corroborates Bilbo's. She was "bagging" the patient after intubation when Dryden and Bilbo arrived. Dryden then took over the bagging. Dr. Perez testified that Williamson asked him whether there was any more need for her. He replied, "No," and testified that there was no need for two respiratory therapists to be there. One therapist was sufficient, and at that time Dryden and two nurses were in the room. Dr. Perez specified that he was merely releasing Williamson from the "code."

Williamson then went to the fifth floor to prepare her detailed instructions to Dryden on the treatment and medication to be administered to patients during the night shift. While on the fifth floor, she clocked out at about 7:34 p.m. She then went back to the emergency room, and gave the report to Dryden in the hallway. This took about 15 minutes. A nurse was then bagging the patient. "You got it?" (or words to that effect) Williamson asked Dryden. "Yes," she replied.

Williamson also gave her pager to Dryden at this time. The pager originally had a clip which permitted it to be fastened to a belt. However, the clip was missing, and Williamson carried it in her pocket. The pager also had a loose switch, and could be turned off accidentally, according to Williamson. The Hospital later replaced this type of pager. Therapists could also be paged with an overhead intercom. Pagers were to be checked during the shift and at shift change.¹⁸ As indicated Williamson was called to the emergency room on her pager at 6:30 p.m.

Dryden's version of these events differs from the foregoing evidence. She contended that Williamson had left before the intubation, and that she was bagging the patient after that procedure. She testified that this activity "occupied both her hands." When Dryden was later questioned by Jackson, Dryden said that the pager was "turned off" when Williamson gave it to her, but admits that she did not check it at the time. Dryden admitted that she told the supervisor that she did not check the pager, contending that her hands were busy bagging the patient. However, Dryden also agreed that Williamson handed Dryden the pager in the hall, and that Dryden was not bagging the patient at that time.

The patient left the emergency room and was transferred to the intensive care unit at about 8:09 p.m. He was then Suzette Bilbo's patient. At about 9:30 p.m. a unit secretary found Dryden and said that they had another "code situation," but had been unable to reach Dryden on her pager. Dryden then examined the pager and "found that it had been turned off." Jackson gave Dryden a warning the next day for not examining the pager when Williamson gave it to her.¹⁹

At about 11 p.m., Dryden called Jackson at home, and reported what had happened. Jackson offered to come in and help, but Dryden said that everything was under control. The next day, Dryden filed a report with the Hospital giving her version of these events.²⁰

On direct examination, Dryden testified that Williamson violated "professional and ethical standards" by not helping Dryden with her rounds, and by giving her a pager that was turned off. (As noted, Williamson had been called on this pager to go

¹⁷ Perez graduated with honors from St. Mary's University in San Antonio, received a doctor of osteopathy degree from the University of Osteopathic Medicine in Des Moines, Iowa, did internship in South Florida, and a family medicine residency in Galveston, Texas.

¹⁸ G.C. Exh. 6.

¹⁹ G.C. Exh. 12.

²⁰ G.C. Exh. 11.

to the emergency room.) Dryden stated she filed the report about Williamson because the pager had been turned off, and because a “code” was happening. She would not have done so if the pager had worked. Dryden agreed that there would have been no problem in Williamson’s leaving if the patient had already been intubated. Dryden admitted that she “quite often” handles codes by herself. She also agreed that Suzette Bilbo was available, and did a blood-gas test at Dryden’s request.

Department Manager Jackson testified that Williamson “left a code,” a life-threatening situation, in violation of Texas law and Hospital policy. Williamson was not justified in getting Dr. Perez’ approval that she leave the code. “That is the therapists’ judgment,” Jackson argued, “because the therapist is responsible for keeping that patient breathing.”²¹ . . . You are not to leave your patients unless you’re properly relieved,” Jackson averred. Doctors are not qualified to do this—they’re “in and out,” taking care of other patients. Jackson testified that she initiated a new policy—a therapist assigned to a code could not leave until the patient was on a mechanical ventilator. However, Jackson admitted that, although this was the policy, it was not the practice.

Williamson testified that “shift change codes happen all the time,” and that the departing therapist does not always stay until the patient is on a ventilator. She stated that she once had three codes at the same time, with only two therapists on duty. Suzette Bilbo testified that one therapist was sufficient after a patient had been intubated. Mary Ann Dryden, herself, testified that she “quite often” handles a code by herself. She also agreed, as indicated, that Suzette Bilbo was also on duty and available for help.

Dr. Perez testified that, as the physician in charge of the emergency room, he decides the number and skills of the medical personnel required, based on the health and status of the patient. In the instant case, the appropriate response was made. This patient was intubated, stabilized, and ready for transfer to the intensive care unit. Williamson performed her job “excellently,” and was “dismissed from the code.” Although two therapists are needed before intubation, one is sufficient thereafter.

On recross-examination, it was pointed out to Dr. Perez that Mary Ann Dryden had filed an incident report about Williamson. Dr. Perez answered as follows:

I don’t want to sound arrogant, but I will be honest. Her opinion of what transpired in that code is limited. . . . When a patient comes in, the ultimate responsibility of that patient, every system involved, is mine. And as far as I am concerned, that code ran without incident . . . I’m telling you exactly what happened, and I’m saying it honestly. There was no problem with that code. Anybody who would have perceived a problem with that code doesn’t know what they’re talking about. You know, I spent four years in medical school, a year in in-

²¹ The Hospital’s “Policies and Procedures” state that a physician’s order must be consistent with the established department and/or hospital policies. A physician’s order does not automatically give authority to disregard medical staff rulings and/or hospital policies. R. Exh. 3. Hospital respiratory staffing patterns require “a minimum of two people on 7 A area 7P.” (R. Exh. 2.)

The Hospital’s “trauma code” policy provided that once a patient was “stable,” one therapist initiated mechanical ventilation in the intensive care unit, while the other therapist did the manual ventilation, or bagging. R Exh. 14.

ternship, two years in residency, and I’ve been practicing for seven years, and that code ran without incident.

Dr. Perez further testified that nobody from the administration asked his opinion of these events.

Cynthia Dixon was called by Respondent, apparently as an expert witness. She taught university courses in various technologies, including respiratory care procedures. Her attention was directed to the Texas “Health Services” statute, which states that “a practitioner shall not leave an assignment without being properly relieved by appropriate personnel.”²² There were no specifics in the statute, according to the witness. Dixon was asked whether an employee who left “during a code situation” would still be in violation of Hospital policy even though the doctor had said the patient was stable. The witness replied that this would be a violation.

On cross-examination, the witness agreed that the therapist in this case had been relieved. The following colloquy then ensued:

Q. When does a code end?

A. Technically, if the patient is still in respiratory arrest, there are still procedures the respiratory care physician has to perform. As far as when a code ends, I’m not really sure.

Q. You’re not sure when a code ends?

A. I would say it’s when the physician says the code ends.

Q. And would the physician when the code ended [sic] in your mind (be) similar to saying, “This patient is now stable?”

A. Yes.

C. Williamson’s Discharge

Personnel Director Lyndia Permenter was about to begin attendance at a managers’ meeting the next morning, November 25. Jean Jackson approached her and said that she had a “very serious incident” to discuss. Permenter replied that Jackson would have to have “documentation,” and agreed to discuss the matter after the managers’ meeting. Permenter, Christopher, and Jackson then met in Permenter’s office, and the latter examined the “documentation,” the complaint against Williamson filed by Dryden. This was the only “documentation” examined by Permenter. She then talked with the Hospital administrator, and secured permission to call the Hospital’s attorney.

Jackson called Susan Hart at about 10:30 a.m., and asked whether she could come to work; Hart agreed. When she arrived, she was told to relieve Williamson, who was in the emergency room maintaining a code patient.

Williamson was told to report to Permenter’s office, and did so. Permenter, Holly Christopher, and Jackson were present. Jackson first said that Dryden had reported that Williamson had given her a pager that was turned off. Williamson denied that she turned off the pager, and Jackson replied that it was off when Dryden received it.

Jackson then said that Williamson had left a code. Williamson replied that her shift was over, and that the therapists routinely leave during a “shift-change code.” Williams then asked a question about the pager, and Permenter stated: “It really doesn’t doesn’t matter. The reason you’re here is to be terminated. You can collect your belongings and go home.”

²² R Exh. 2, sec. O.

Permenter testified that the meeting did not last long, because she was not going to let it last long. Williamson admitted that she “left the patient” and Permenter decided to end the conversation. She told Williamson that she was being terminated because of that action.

Permenter stated that the Hospital has its own standards as to what it expects its employees to do, and does not defer to the medical profession on this issue. She did not know the name of the doctor involved, and did not inquire. Permenter said that the doctor’s opinion on whether Williamson had abandoned the patient would be irrelevant, although it would be relevant on whether the patient was in a life-threatening condition. She would “lean on the manager of the department” as to whether a patient had been abandoned. Permenter did not know the Hospital’s policy on the number of respiratory therapists normally on duty, and did not know that there was a policy. It would “fluctuate.” Also, Permenter did not know the number of therapists required to work a code. “I don’t work codes,” she stated. She knew that Suzette Bilbo was on duty with Dryden. As indicated Permenter testified that she was aware that Williamson had filed a charge with the National Labor Relations Board. Permenter averred that she did not consider it a threat to the Hospital. Her decision to terminate Williamson was not based on this charge, Permenter declared.

The Hospital discharged a respiratory therapist on June 8, 1998, for departing from the Hospital and work area and leaving a patient unattended during his absence.²³ Jackson agreed that the patient in the case at bar was not “unattended” when Williamson left. Jackson also testified that another employee was warned in April 1977 for repeatedly leaving patients without medication, and was then discharged. Jackson also agreed that this was not Williamson’s offense.

The Hospital has a due process policy which provided for counseling and warnings prior to discharge. Due process could be bypassed in the “most severe” types of misconduct upon written authorization of the Hospital administration.²⁴ There is no such authorization in evidence.

D. Williamson’s Unemployment Compensation Award

Williamson filed an application for unemployment benefits with the Texas Workforce Commission and received a favorable decision on December 18. It reads: “We can pay you benefits. Our investigation found your employer discharged you from your last work for a reason that is not misconduct connected with work.”²⁵

E. Factual Analysis

I credit the consistent testimony of Dr. Perez, Bilbo, and Williamson, and reject the contradictory testimony of Dryden where it differs from the testimony of the other witnesses. Thus, the patient had been intubated prior to the arrival of Bilbo and Dryden, and Williamson was bagging the patient. Williamson turned the bagging over to Dryden, and went upstairs to prepare her report. When she returned, Dryden was in the hallway, and a nurse was bagging the patient. Williamson spent 15 minutes describing the procedures for the night. “You got it?” (or words to that effect) Williamson asked Dryden, and the latter replied, “Yes.” This was then past 7:34 p.m., the time

when Williamson had clocked out on the fifth floor. Dr. Perez had already told Williamson that she was not needed, and her scheduled departure time from the Hospital was 7:15 p.m. She left.

Jackson’s assertion that Williamson “left a code” is contradicted by the Hospital’s own expert witness. Cynthia Dixon testified that a code ends when the doctor says that it has ended. The witness was asked whether a doctor’s saying that the patient is “stable” is similar to saying that the code has ended,²⁶ and the witness answered, “Yes.” Since Dr. Perez repeatedly testified that the patient was stable, he affirmed that the code had ended. Accordingly, Williamson did not “leave the code.”

Jackson’s testimony that Williamson left a life-threatening situation, is not supported by credible evidence. There was no life-threatening situation, according to the doctor selected by the Hospital to be in charge of the emergency room. The patient was stable, and was waiting for a room in the intensive care unit.

Jackson’s argument that Williamson’s leaving was contrary to Hospital policy is also unsupported by credible evidence. The testimony of Williamson, Bilbo, and even Dryden establish that one therapist was sufficient to handle a code after intubation, particularly where, as here, there were two therapists (Dryden and Bilbo), plus nurses on duty. Dryden was doing the bagging, and Bilbo was preparing the mechanical ventilator in the intensive care unit, exactly as required by Hospital procedure.²⁷ Hospital policy that a physician’s order does not automatically give authority to disregard hospital policies,²⁸ is too vague to apply to the specific issue in this case. The Hospital itself countenanced only one therapist after intubation, and two in fact were present. The Texas statute requiring a practitioner to remain on an assignment until relieved by “appropriate personnel” does not identify such personnel. Respondent’s expert witness Cynthia Dixon testified that Williamson had been relieved.

Dr. Perez was a truthful and forceful witness. I credit his testimony that he was responsible for the health of each patient. Indeed, it could not be otherwise—the Hospital had selected him and placed him in charge of the emergency room. Jackson’s assertion that the therapists were responsible for maintaining the status of the patients—for “keeping them breathing”—and that the doctors were not so qualified, is contrary to common sense. Permenter simply relied on Jackson.

Dryden’s statement to Jackson that she did not check the pager because her hands were busy bagging the patient when Williamson gave her the pager is patently false—she admitted that Williamson gave her the pager in the hallway. Dryden’s statement that the pager was turned off at the time is not believable—she admitted that she did not examine the device at that time, and, in fact, received a warning for not doing so. The pager was working for Williamson at 6:30 p.m. It was not until 9:30 p.m., after a unit secretary had vainly tried to page Dryden, that she examined the pager. Although it was then turned off, there is no evidence as to when this took place, perhaps by accident. There is thus no evidence for Jackson’s statement to Williamson at the exit interview that the pager was turned off when Dryden received it. Jackson’s discharge was initiated by

²⁶ This is the reasonable interpretation of the somewhat garbled question on cross-examination, quoted above.

²⁷ *Supra*, fn. 21.

²⁸ *Supra*, fn. 20.

²³ G.C. Exh. 14.

²⁴ G.C. Exhs. 22, 26.

²⁵ G.C. Exh. 29.

Dryden's incident report. Yet Dryden—who was reprimanded for failure to examine the pager—admitted that she would not have filed the report if the pager had been working.

F. Legal Conclusions

The complaint alleges that Respondent engaged in unlawful conduct, including termination of Elisa Williamson, because she engaged in concerted activities and in order to discourage employees from engaging in these activities. Such conduct, the complaint alleges, violated Section 8(a)(1) of the Act. The Board has set forth the principles concerning both discrimination under Section 8(a)(3), and violations of Section 8(a)(1) turning on employer motivation. Under these criteria, the General Counsel has the burden of establishing a prima facie case that is sufficient to support an inference that protected conduct was a motivating factor in an employer's decision to discipline an employee. Once this is established, the burden shifts to the Respondent to demonstrate that the discipline would have been administered even in the absence of the protected conduct. The General Counsel must supply persuasive evidence that the employer acted because of unlawful motivation.²⁹

The evidence conclusively establishes that Williamson and other employees complained to the administration about Respiratory Therapy Department Manager Jackson's change in the method of scheduling assignments, and in the assignment of 16-hour shifts. The complaint alleges that Respondent violated the Act by *telling* Williamson that it gave her a low evaluation because of her protests, and by *doing so*. Prior to 1997, Williamson received evaluations which met or exceeded all requirements. One of the evaluations stated that her "skills were exceptional." In August 1997, Departmental Manager Jackson gave Williamson a below-average rating on "professionalism," and told her that the reason she did so was the fact that Williamson had gone "to the office" about the new scheduling and the 16-hour shifts. The new schedule was going to remain, and the nurses were going to work the 16-hour shifts—"and see how you like that," Jackson added. The three nurses who protested received more 16-hour shifts than other nurses. Jackson told one of them, Susan Hart, that she should have followed the "chain of command," and that Hart was a "back-stabber."

Respondent argues that the scheduling changes and 16-hour shifts were mandated by Pro-Care's plan to eliminate overstaffing. But Permenter did not know the Hospital's policy on the number of respiratory therapists on duty, and did not know that there was a policy. And Jackson eliminated the 16-hour shifts after a few weeks.

Jackson also manifested animus against Williamson because she went to the administration in Jackson's absence when the blood-gas machines became dysfunctional—on demand from the medical director. The birthday assignment, the heliox investigation and the reprimand constitute additional evidence of animus.

The Board has concluded with judicial approval that concerted protests by nurses against changes in work assignments constitute protected activity, and that discipline based on such

activity violates Section 8(a)(1). *St. Anne's Hospital*, 245 NLRB 1009 (1979), *enfd.*, 648 F.2d 67 (1st Cir. 1981). The latter case has facts similar to those in the case at bar. The nurses in *St. Anne's Hospital* argued against changes in their work assignments and protested that some of them were dangerous to patients, as did the nurses in the instant case.³⁰

I conclude that the complaint allegation pertaining to Williamson's evaluation is meritorious.

The same animus was manifested in the exit interview. Jackson told Williamson that the latter had given Dryden a pager that was turned off despite the fact that Jackson had no evidence for this allegation—she herself gave Dryden a reprimand for not examining the pager when the latter received it from Williamson. Jackson also accused Williamson of leaving a code—an accusation which had no merit for the reasons given above.

Permenter functioned merely as a reflection of Jackson's opinions. She had little knowledge of Hospital procedure in cases like this, and did not bother to ask the doctor what had happened, since his opinion was "irrelevant." She did not ask any questions of Suzette Bilbo. Her only evidence was the report of these events submitted by Dryden, an unreliable witness. Permenter in fact had already decided, before the exit interview, that Williamson was going to be discharged. When Williamson asked a question about the pager, Permenter abruptly ended the interview, saying, "It really doesn't matter. The reason you're here is to be terminated." Prior to the interview, Permenter had already secured permission to speak to the Hospital's attorney.

The General Counsel's prima facie case is established by Williamson's protected activity, Jackson's animus against her for doing so, Permenter's failure to conduct any meaningful investigation of the events, her decision to discharge Williamson without investigation and prior to the exit interview, and her failure to follow the due process policy by discharging Williamson without a written authorization from the administrator.

Respondent's asserted reasons for discharging Williamson are all pretextual, as shown above. The record shows that Williamson engaged in customary conduct when she left after her shift ended. The cases of the two therapists whom the Hospital discharged were not comparable to this case, as Jackson admitted. Respondent has thus not rebutted the General Counsel's prima facie case. I conclude that it discharged Williamson on November 25, 1997, because of her protected, concerted activities, in violation of Section 8(a)(1) of the Act. This conclusion is consistent with the decision of the Texas Workforce Commission granting benefits to Williamson on the ground that she had not engaged in misconduct. The Board has long held that such decisions, although not controlling as to findings of fact and conclusions of law, have some probative value. *Western Publishing Co.*, 263 NLRB 1110 *fn.* 1 (1982).

The complaint also alleges that Respondent discharged Williamson because she filed a charge or gave testimony against the Hospital in Case 16-CA-18871. Although Permenter denied that Williamson's filing of the charge had any effect upon her termination, the depth of Jackson's and Permenter's hostility against Williamson makes this unlikely. I conclude that it was a factor in Respondent's discipline of Williamson, and, accordingly, that the discipline also violated Section 8(a)(4).

²⁹ *Wright Line*, 251 NLRB 1083, 1089 (1980), *enfd.* 662 F.2d 899 (1st Cir. 1981), approved in *NLRB v. Transportation Management Corp.*, 464 U.S. 393 (1983). In *Manno Electric*, 321 NLRB 278, 280 *fn.* 12 (1996), the Board noted that the District of Columbia Circuit had suggested that the General Counsel's burden is one of persuasion, not merely production. "This change in phraseology does not represent a change in the *Wright Line* test," the Board stated (*id.*).

³⁰ Accord: *Hacienda de Salud-Espanola*, 317 NLRB 962 (1995); *American Red Cross Blood Services*, 322 NLRB 590 (1996).

In accordance with my findings above, I make the following.

CONCLUSIONS OF LAW

1. Baptist Hospital, Orange, is an employer engaged in commerce within the meaning of Section 2(6) and (7) of the National Labor Relations Act, and a health care institution within the meaning of Section 2(14).

2. The Charging Party, Elisa Williamson, an individual, engaged in concerted, protected activity in opposition to Respondent's practices and policies, and filed an unfair labor practice charge against Respondent.

3. Respondent gave the Charging Party a low rating as to professionalism because of her concerted, protected activities, and told her that this was the reason for the evaluation, in violation of Section 8(a)(1) of the Act.

4. Respondent discharged the Charging Party on November 25, 1997, because of her concerted protected activities, and because she filed an unfair labor practice charge against Respondent, thus violating Section 8(a)(1), (3), and (4) of the Act.

5. The foregoing unfair labor practices affect commerce within the meaning of Section 2(6) and (7) of the Act.

THE REMEDY

It having been found that Respondent has committed unfair labor practices, I shall recommend that it cease and desist therefrom, and take certain affirmative action designed to effectuate the policies of the Act.

It having been found that Respondent unlawfully discharged Elisa Williamson on November 25, 1997, I shall recommend that Respondent be ordered to offer her reinstatement to her former position, dismissing if necessary any employee hired to fill this position or, if such position does not exist, to a substantially equivalent position. It is further recommended that Williamson be made whole by Respondent for any loss of earnings she may have suffered because of Respondent's unlawful conduct by paying her a sum of money she would have earned from the time of her unlawful discharge to the date of an offer of reinstatement, less net earnings during such period, to be computed in the manner established by the Board in *F. W. Woolworth Co.*, 90 NLRB 289 (1950), with interest as computed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987).³¹

I have found that the raises given to the therapists were based upon their evaluations, that Williamson received a raise of one percent, and that the maximum raise was 4 percent. I have also found that Respondent unlawfully gave Williamson a low evaluation. It is impossible to determine what her raise would have been absent the discriminatory aspect of her evaluation. Accordingly, I shall recommend that she be paid the difference between the raise which she did receive and the maximum of 4-percent which was granted, retroactive to the date of the raises, plus interest as described above.

I shall further recommend an expunction order, including the low evaluation and the posting of appropriate notices.

³¹ Under *New Horizons*, interest is computed at the "short term Federal rate" for the underpayment of taxes as set out in the 1986 amendment to 26 U.S.C. § 6621. Interest accrued before January 1, 1987 (the effective date of the amendment) shall be computed as in *Florida Steel Corp.*, 281 NLRB 651 (1977).

Upon the foregoing findings of fact and conclusions of law, and on the entire record, I recommend the following³²

ORDER

The Respondent, Baptist Hospital, Orange, Orange, Texas, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Giving low evaluations to employees because of their concerted, protected activity, and telling them that the low evaluation was for that reason.

(b) Discouraging employees from engaging in concerted protected activity by discharging employees for engaging in such activity, or by discriminating against them in any other manner pertaining to their wages, hours, tenure of employment, or any other terms and conditions of employment.

(c) In any other like or related manner interfering with, restraining, or coercing its employees in the exercise of their Section 7 rights.

2. Take the following affirmative action necessary to effectuate the purposes of the Act.

(a) Within 14 days from the date of this Order, offer Elisa Williamson reinstatement to her former position or, if that position no longer exists, to a substantially equivalent position, dismissing if necessary any employee hired to fill the position, and make her whole in the manner described in the remedy section of this decision.

(b) Within 14 days from the date of this Order, remove from its records all reference to its low evaluation on professionalism and discharge of Elisa Williamson, and inform her in writing that this has been done, and that the aforesaid actions will not be used as the basis of any future discipline of her.

(c) Preserve and, within 14 days of a request, make available to the Board or its agents, for examination and copying, all payroll records, social security payment record, timecards, and all other records necessary to analyze the amount of backpay due under the terms of this Order.

(d) Within 14 days after service by the Region, post at its Orange, Texas facility, copies of the attached notice marked "Appendix."³³ Copies of the notice, on forms provided by the Regional Director for Region 16, after being signed by Respondent's authorized representatives, shall be posted by Respondent and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since July 31, 1997.

³² If no exceptions are filed as provided by Sec. 102.48 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.

³³ If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

(e) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.