STATE OF MICHIGAN

COURT OF APPEALS

DEPARTMENT OF COMMUNITY HEALTH, Petitioner-Appellee,	UNPUBLISHED February 12, 2009
v	No. 280763 Department of Labor & Economic Growth
BRUCE MILTON RAHE, Respondent-Appellant.	LC No. 2006-000121

Before: Markey, P.J., and Murphy and Borrello, JJ.

PER CURIAM.

Respondent appeals as of right the decision of the Board of Nursing Disciplinary Subcommittee (DSC) to place him on probation for a period of two years. We affirm.

Respondent worked as an LPN (licensed practical nurse) in the emergency room at Lakeland Regional Health Systems (hospital) for a period of ten years. Over the course of his employment, respondent was the subject of investigation by the hospital for complaints about his job performance approximately six to eight times, which was substantially higher than other employees. The hospital required respondent to go through additional educational training with the hospital's staff educator on two occasions. Respondent's employment was eventually terminated based on a determination of continuing violations.

Following respondent's termination, the hospital notified the Bureau of Health Professions (BHP) within the Department of Community Health (DCH) of respondent's change of status. An investigation was conducted by a representative from the BHP, which subsequently resulted in the filing of an administrative complaint against respondent. Following an administrative hearing, the administrative law judge concluded in the proposal for decision that respondent had violated MCL 333.16221(a) in regard to the care he had provided a patient on September 2, 2003. The administrative law judge also concluded that respondent had violated MCL 333.16221(b)(i) in regard to the care he had provided a patient on February 27, 2004. The DSC subsequently issued its final order relative to this matter, accepting and adopting the administrative law judge's findings of fact and conclusions of law and imposing probation for a period of two years. The DSC later denied respondent's request for reconsideration.

Although divided into seven separate arguments by respondent in his appellate brief, he essentially raises two broad issues on appeal. First, respondent challenges the legal and factual conclusions adopted by the DSC. We reject respondent's challenges.

Under the Public Health Code (PHC), MCL 333.1101 *et seq*., "[a] final decision of a disciplinary subcommittee rendered on or after January 1, 1995 may be appealed only to the court of appeals[, and] [a]n appeal filed under this subsection is by right." MCL 333.16237(6). "The PHC is, however, silent regarding the scope of review to be applied in such matters." *Dep't of Community Health v Risch*, 274 Mich App 365, 370; 733 NW2d 403 (2007). The *Risch* panel concluded that, because there was no statutorily enacted scope of review, judicial review of an order rendered by a disciplinary subcommittee "is limited to that set forth in Const 1963, art 6, § 28[.]" *Id.* at 371. Article 6, § 28 provides, in pertinent part:

> All final decisions, findings, rulings and orders of any administrative officer or agency existing under the constitution or by law, which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, as a minimum, the determination whether such final decisions, findings, rulings and orders are authorized by law; and, in cases in which a hearing is required, whether the same are supported by competent, material and substantial evidence on the whole record.

In this context, "substantial evidence" constitutes evidence that a reasonable person would accept as being sufficient to support a conclusion. *Risch, supra* at 372. It requires more than a scintilla of evidence, but it can be substantially less than a preponderance. *Id.* "Moreover, if the administrative findings of fact and conclusions of law are based primarily on credibility determinations, such findings generally will not be disturbed because it is not the function of a reviewing court to assess witness credibility or resolve conflicts in the evidence." *Id.*

MCL 333.16221(a) authorizes discipline to be imposed on a licensed nurse if the DSC finds "[a] violation of general duty, consisting of negligence or failure to exercise due care . . . whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully practice the health profession." The administrative law judge determined in his proposal for decision that the facts related to the September 2003 incident demonstrated that respondent had acted negligently.

On September 2, 2003, patient SM[1] presented to the emergency department complaining of a sickle-cell crisis, light-headedness, and weakness. The chart reflects that a doctor issued several orders that called for an EKG, chest x-ray, lab work, and the administration of drugs. The patient reported her pain scale at 8 out of 10. The chart shows no indication that the lab specimens were obtained or that drugs were administered, nor is there any indication that the patient's pain was reassessed.

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[1] The record refers to the relevant patients only by their initials, presumably to protect their privacy.

Respondent claimed that he failed to obtain the lab samples for this patient because he was unable to start an IV. However, there was no notation in the chart regarding difficulty starting an IV. He also asserted that he transferred the patient to the x-ray department at 5:20 p.m. Respondent stated that his shift normally ended at 5:30 p.m. and that he left the hospital after transferring the patient to the x-ray department. Respondent acknowledged that the patient's chart indicated that no report was received by the incoming nurse.

Lori Hellegna, the manager of the hospital's emergency department, was responsible for investigating nurses alleged to have violated the standard of care. She testified that her investigation into this incident led to the conclusion that respondent's failure to chart the care of the patient and failure to order lab specimens in compliance with the doctor's request constituted a violation of the standard of care.

Laura Conklin, a nursing expert, agreed that failure to document and chart patient care is a violation of the standard of care for an LPN, even if no actual harm comes to the patient. She also testified that failure to obtain lab specimens when ordered is a violation of the standard of care and that when the chart does not indicate that labs have been obtained, there is a presumption that they were not procured. Conklin also stated that it is a violation of the standard of care to fail to report to oncoming staff when leaving at the end of one's shift.

Respondent specifically takes issue with the fact that the administrative law judge rejected his supposition that he might have been busy with other patients when he failed to properly treat patient SM. First of all, respondent concedes that he has no independent recollection of the incident in question. Therefore, his explanation for the dereliction of duty is merely speculation with respect to what he may have been doing. Moreover, Conklin testified that even in cases where a nurse is extremely busy, it does not absolve the nurse from meeting the standard of care.

MCL 333.16221(b)(i) authorizes discipline to be imposed on a licensed nurse if the DSC finds "[i]ncompetence" on the part of the nurse. The administrative law judge determined in his proposal for decision that the facts related to the February 2004 incident demonstrated incompetence on respondent's part.

On February 27, 2004, patient GD, a hypertensive diabetic, presented to the emergency department with complaints of heartburn that had been occurring off and on for a period of a week and a half. Respondent testified that he believed GD to be suffering from heartburn or stomach problems rather than a cardiac problem and that he did not check GD's vital signs because he "didn't think this gentleman was that ill." He further testified that he did not perform an EKG because "all that costs money." Respondent acknowledged that the treating doctor apparently thought the patient was suffering from a cardiac problem, but respondent thought differently. When the patient's care was taken over by another nurse, he was immediately put on a monitor and his vitals were checked.

Hellegna testified that respondent failed to employ the assessment skills an LPN is required to use in regard to this incident. Conklin testified that respondent violated the standard of care related to the February 2004 incident because the chart indicated that he should have assessed and rechecked the patient's vitals more often, given the patient's numbers.

Respondent also claims that his constitutional rights were violated in relation to the deprivation of his nursing license. We disagree.

Respondent's first constitutional claim is grounded on the "fair and just treatment" clause of Const 1963, art 1, §17, which provides:

> No person shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty or property, without due process of law. *The right of all individuals, firms, corporations and voluntary associations to fair and just treatment in the course of legislative and executive investigations and hearings shall not be infringed*. [Emphasis added.]

Respondent claims that the investigations performed by the hospital that eventually led to his termination violated the "fair and just treatment" clause. However, the language of the provision itself limits its applicability to legislative and executive investigations. See *By Lo Oil Co v Dep't of Treasury*, 267 Mich App 19, 40; 703 NW2d 822 (2005) (plain text conveys that clause's protection applies only to executive or legislative investigations and hearings).[2] It is undisputed that the hospital is a private entity. As such, any investigation it performs cannot be considered state action unless the hospital's conduct is fairly attributable to the state, *Moore v Detroit Entertainment, LLC*, 279 Mich App 195, 203; 755 NW2d 686 (2008), which is not the case here.[3] The hospital was not engaged in an executive investigation for purposes of Const 1963, art 1, § 17.

MCL 333.2241 authorizes the DCH to investigate matters to insure compliance with laws enforced by the department. MCL 333.16221 provides that "[t]he department may investigate activities related to the practice of a health profession by a licensee[.]" Neither of these statutes indicate that these provisions are intended to prevent an employer from investigating an employee for violations of its own policies or procedures.

Here, the hospital performed investigations following multiple complaints related to respondent's job performance. Such investigations ultimately led to respondent's termination. Employers routinely look into their employees' job performance, and sometimes these investigations lead to terminations. The decision to terminate respondent's employment affected respondent's employment status but had no direct bearing on the status of his nursing license. Only the BHP has the power to change the status of respondent's nursing license.

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[2] The *By Lo Oil* panel noted that "the historical context in which this clause was adopted suggests that it was intended to protect against the excesses and abuses of Cold War legislative or executive investigations or hearings." *By Lo Oil*, *supra* at 40. Nevertheless, the Court proceeded to examine the conduct that the plaintiff had alleged came within the ambit of the clause "to determine whether it might fit within the plain meaning of the constitutional text." *Id.*

[3] For this same reason, respondent's due process challenge regarding the hospital's actions likewise fails.

Furthermore, we are satisfied that respondent has failed to demonstrate that he was denied fair and just treatment by the investigation performed by the BHP. A review of the record shows that respondent was not treated unfairly or unjustly. Although the BHP representative relied extensively on the information gathered as part of the hospital's investigation, there is no indication that the BHP representative was biased against respondent. And certainly any BHP investigation, by its very nature, will include a thorough review of hospital documentation concerning events that transpired. Moreover, there is no indication that the BHP investigation violated any rules, laws, or other guidelines, let alone evidence of violations having a direct bearing on fair and just treatment.

We are equally unpersuaded by respondent's claims that he was denied due process relative to the investigation and administrative hearing in this matter.

"It is well established that due process rights are not invoked in the context of administrative investigations and investigatory subpoenas, where no legal rights are adjudicated." *In re Petition of Attorney General for Investigative Subpoenas*, 274 Mich App 696, 706; 736 NW2d 594 (2007) (addressing a case in which the DCH was conducting an investigation of a dentist accused of engaging in insurance fraud). After an investigation is initiated, the DCH must take one or more statutorily prescribed actions, "[b]ut except for dismissing a complaint, these actions require further action by an independent hearings examiner and disciplinary subcommittee." *Id.* at 706-707. Here, the investigation performed by BHP's representative was purely investigative in nature and could not lead, on its own, to a deprivation of a protected liberty interest. The sole purpose of the investigation was to gather facts in order to determine whether an administrative complaint would be filed. Any subsequent negative impact on respondent's nursing license could only occur following an administrative hearing, thereby giving respondent an opportunity to be heard.

The panel in *In re Petition of Attorney General, id.* at 707, recited a litany of statutory and regulatory protections afforded to a licensee, stating:

> [A]n individual under investigation is provided with notice and an opportunity to be heard. If a formal complaint is filed, an appropriate disciplinary subcommittee is designated and has jurisdiction over the action. The individual under investigation is afforded notice and the right to a hearing. A compliance conference may be held to resolve the allegations by agreement, and the failure to reach an agreement entitles the investigated party to a hearing. The summary suspension of an individual's license entitles that individual to a hearing, as does the issuance of a cease and desist order[.]
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> In all cases involving a contested case hearing, a hearing referee presides over the dispute. Depositions and written interrogatories may be taken. The parties may present argument and proofs. Upon conclusion of the hearing, the hearing referee submits proposed factual findings and conclusions of law to the assigned disciplinary subcommittee. The assigned disciplinary subcommittee reviews the hearing referee's recommendations and determines whether disciplinary action is appropriate. The subcommittee's final disposition may be appealed as of right to this Court. [Citations omitted.]

A review of the record demonstrates that respondent was afforded all of these protections before and after the hearing.[4] There was no due process violation, no violation of the "fair and just treatment" clause, and all of the state's actions were authorized by law. Reversal is unwarranted.

Affirmed.

/s/ Jane E. Markey
/s/ William B. Murphy
/s/ Stephen L. Borrello

[4] On examination of the record, we find no merit whatsoever concerning respondent's claim that he lacked notice relative to the testimony of Lou Ann Kater.