STATE OF WISCONSIN PERSONNEL COMMISSION

ROMAN KAPLAN,
Complainant,

v.

Chancellor, UNIVERSITY OF WISCONSIN - MADISON,
Respondent.

Case No. 96-0097-PC-ER

FINAL DECISION AND ORDER

A proposed decision and order (PDO) was issued in the above-noted case on August 13, 1999. Due to illnesses of both parties' attorneys, the time for filing written objections was extended to November 15, 1999. Complainant filed objections on November 15, 1999. Respondent filed no objections.

The Commission agrees with the examiner's credibility determinations and adopts the PDO as its final decision, with the amendments noted below:

> On page 36 of the proposed decision, the second to the last sentence in ¶67 is amended to correct an error, as shown below:
>
> ~~TM~~ FR also had low National exam scores (of 14%).

The proposed decision is supplemented by the discussion in this final decision to address the main points raised in the objections filed by complainant. To the extent that additional facts are brought out in this supplemental discussion, the proposed decision is amended to reflect them.

Prior to addressing complainant's objections, the Commission provides the following overview of the record. It was Dr. Vogel who recommended complainant for hire (Finding of Fact (FOF) 6, PDO). She was aware of his age, his national origin/ancestry and his accent when she made the hiring recommendation. These undisputed facts raise a strong inference that her later decision to terminate complainant

was based upon factors other than his age, national origin or ancestry. This inference is further strengthened by documented performance problems that complainant was having at the Appleton Family Practice Clinic (AFP) as detailed in the PDO, including the fact that other faculty physicians concurred in Dr. Vogel's assessment of complainant's problems. Some problems were of an expected nature for a doctor in training. Others simply should not have occurred, such as when he reported lab results incorrectly (FOF 33, PDO) and prescribed a higher dose of medication after learning the prior lower dose was too high (FOF 60, PDO). These examples clearly demonstrate carelessness to an unacceptable degree at the risk of patient safety and support Dr. Vogel's and other AFP faculty's assessment of his performance problems. Complainant also disobeyed patient-safety measures put in place as a requirement of his continuation in the program, as detailed in the PDO. Furthermore, Dr. Vogel allowed EO[1] who shares the same protected characteristics as complainant to graduate from the program. These additional facts raise a strong inference that complainant was terminated for poor performance and not for discriminatory reasons.

I. Credibility

Complainant contends the Commission should not find Dr. Vogel's testimony credible. His main allegation is that after complainant was terminated, she told Dr. Boris Petrikovsky that complainant cheated on his National Exam (see FOFs 9 & 29, PDO) and yet she denied the same at hearing (p. 9-10, written objections).

The testimony supporting complainant's allegation is in the record, not from Dr. Petrikovsky, but from Dr. Grigory S. Rasin and complainant. The critical information in this paragraph, accordingly, is based on their testimony about what Dr. Petrikovsky told them. The details of their testimony are recited here as allegations, not as findings of fact. Dr. Rasin had recommended to Dr. Petrikovsky (in the OB/GYN department in a hospital in New York) that he recommend complainant for a neurology residency

[1] The final decision uses the same coding system as used in the PDO by referring to some residents only by their initials.

in New York. Dr. Petrikovsky met with complainant and later recommended complainant's candidacy for the neurology program to Dr. Helprin, the decision-maker, and complainant thereafter met with Dr. Helprin. Dr. Rasin also recommended complainant's candidacy to Dr. Helprin. Sometime between complainant's meeting with Dr. Petrikovsky and his meeting with Dr. Helprin, Dr. Petrikovsky telephoned Dr. Vogel for a reference. During this conversation, Dr. Vogel told Dr. Petrikovsky that complainant had a poor fund of knowledge. Dr. Petrikovsky questioned her statement due to complainant's high marks on the National Exam. Dr. Vogel responded saying that sometimes students get a copy of the exam and asking him not to divulge the information to complainant because she did not want to be sued. Dr. Petrikovsky telephoned Dr. Rasin shortly after speaking with Dr. Vogel and relayed the above-noted information. Dr. Petrikovsky was upset that Dr. Vogel would suggest complainant cheated on the National Exam and was fearful that if Dr. Vogel said the same thing to Dr. Helprin that complainant would not get the neurology residency. Dr. Rasin testified that he has been a long-time friend of Dr. Petrikovsky and had no reason to doubt what he said. According to complainant's testimony, Dr. Petrikovsky shared essentially the same information with him. Dr. Helprin later decided not to accept complainant in the program. No hearing witness indicated that Dr. Helprin had explained his reasons for rejecting complainant to them.

Dr. Vogel testified that she could not recall receiving a call from Dr. Petrikovsky and she denied telling anyone that complainant cheated on the National Exam. She did recall speaking with Dr. Helprin. Prior to complainant's interviews in New York, Dr. Vogel had advised complainant not to start off a new relationship without disclosing his problems at the AFP. She cautioned complainant that she would have to tell the truth about this if she were called for a reference but that she would present him in the best light she could.[2] Complainant called Dr. Vogel the day he interviewed with Dr. Helprin saying it was a rough interview and he had not told Dr.

[2] Complainant did not dispute this testimony.

Helprin that he had been terminated from the AFP program.[3] Dr. Helprin called Dr. Vogel for a reference. Dr. Vogel asked what complainant told him. Dr. Helprin said he got a sense from complainant that he had difficulties at AFP but Dr. Helprin had not probed this at the interview. Dr. Vogel disclosed that termination occurred. She emphasized how eager complainant was to learn and how much he had accomplished but that he was always in a catching-up period and was not performing at expected levels even with remediation efforts.

The conflicting testimony noted above is difficult to resolve. On the one hand, Dr. Rasin's appearance at hearing showed that he believed what Dr. Petrikovsky said. On the other hand, Dr. Petrikovsky was not a hearing witness and, residing out of state, was beyond respondent's reach to compel his attendance at hearing. As a result, respondent was deprived of the opportunity to conduct cross-examination to test the veracity of what he allegedly told Dr. Rasin and complainant. Under these circumstances, little weight was given to the testimony of complainant and Dr. Rasin to establish that Dr. Vogel actually made the alleged statement to Dr. Petrikovsky. Even if Dr. Vogel made the alleged statement to Dr. Petrikovsky, it would be insufficient to question the credibility of her testimony regarding documented performance problems complainant experienced. Complainant did not contest that most of the problems occurred although he sometimes disagreed with the seriousness Dr. Vogel and other AFP faculty ascribed to them. Other problems were brought to Dr. Vogel's attention by other faculty giving additional credence to the criticisms made.

It should be noted that the record demonstrates problems with complainant's testimony too. For example, a question arose at hearing relating to a pre-hearing discovery request for position descriptions for posts held by complainant after he was terminated at the AFP, including one position in Fond du Lac, Wisconsin. Complainant provided evasive and conflicting testimony as noted below in relevant part. ("RA" is used as an abbreviation for respondent's attorney, "CA" for complainant's attorney, "C" for complainant and "HE" for hearing examiner.)

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[3] Ibid.

RA: Dr. Kaplan do you have a position description for the job that you did at Fond du Lac?
C: I believe so.
* * *
RA: Does one exist?
C: Yeah, well it exists somewhere. Like what I would have to do with that?

RA: So one exists?
C: I - I'm not sure, excuse me. I'm not sure whether we do have anything written but if you ask me what I do I can describe it to you.

RA: So you don't know whether there's a written one or not?
C: I'd have to ask my - my attorney. Is there or not. It was so - it was piles of papers and I - I [doesn't finish sentence].
* * *
RA: Earlier this fall I requested your position description from Fond du Lac. Did you ask your coordinator at that time if one existed?
C: I don't remember. I do not remember this. I apologize.

CA: I'm going to object to this on the basis of relevance.
* * *
HE: And how do you believe it's relevant Attorney Rutherford?
RA: Well, this is the first I've heard about the specifics of the Fond du Lac stuff. I asked them as part of interrogatories for a position description of it. I was told - well, I wasn't given one and I was told one didn't exist.

HE: For the Fond du Lac?
RA: For the Fond du Lac position which is now -- I'm asking him if one did exist and it sounds to me like he may not have asked for it so I'm trying to figure out if that's the case or it just doesn't exist.
C: Well, I don't think it was kind of particular function of duties, I suppose. It's a part of my contract where ah, I think we - we - we - we present part of contract. My understanding the most of the question was about salary there and we definitely - we present part of contract with the salary at that time.

HE: Okay. But let's get back to the legal objection. Even if it were true—

RA: Actually, I misspoke. The answer was that it wasn't available. I was told it was not available at this time. And I've never been supplemented with it. And now today they have talked about the specifics of Fond du Lac and I want to know if I perhaps could have prepared for that testimony.

HE: But even if that were true, Attorney Rutherford, umh, I don't understand your perception that there's been harm.

RA: Well this is the first I've heard that he's worked with women, that he's worked with children. I've never heard that before until today.

* * *

CA: May I take a look at what you're looking at?

* * *

HE: Request 17: Please provide the position descriptions for any employment you have had since leaving the AFPR. Answer: Primary care physician full time Oshkosh Correctional Institution, including care for a significant number of disabled inmates. No PD for Dr. Kaplan's part time job is available at this time.

* * *

RA: May I ask him to answer the question whether or not he asked for a position description. I hear him saying that he thought one may have been available.

HE: Okay. Well, let me let me back up. Did you say that you thought a position description was available for your part time work at Fond du Lac?

C: No. It was just contract. It was not – it was actually like – it's not such severe position description as my work for state. It was much less formal, that I suppose to perform duties as primary physician and medical director on this premises in the Fond du Lac clinic without description, what kind of population I should see, most of them it was kind of interaction with another physician. So it was – it was not particular description. Most of this contract –

HE: (interrupting) But what are you describing? Are you describing the contract at this time?

C: Yeah. Contract. Yeah. And it was not position description as supplement to this contract which I thought should be part of this situation.

* * *

HE: Did you ever ask Fond du Lac if a position description other than in the form of your contract existed?

C: No.

HE: Why not?
C: I didn't realize it's necessary.
* * *
C: Maybe it was mis- I thought it was most important part about salary. Nobody told me about description of position. And I did not realize this. I apologize.

Also, complainant's memory regarding certain events was found to be unreliable. One example relates to his testimony about the prescription error noted at FOF 49, PDO. He provided testimony on this topic as a rebuttal witness. Before he testified, respondent presented two witnesses on this topic – Nurse Christine Van Delen and Dr. Vogel. According to their testimony, complainant wrote a list of prescriptions for a patient (Exh. R-131, p. 3) and placed it in the nurse's box to call in to the pharmacist. Nurse Van Delen reported to Dr. Vogel that two prescriptions listed by complainant were the same medicine, one listed by trade name and the other by its generic equivalent. On the same day, Dr. Vogel wrote a note on complainant's list as shown below (using same emphasis as appears in the original document (Exh. R131, p. 3)):

Roman – You need to call pt (patient) & clarify meds –
Diazide **is** Trianterene HCTC.
Talk with me!
Lee Vogel

Neither of the duplicative medications was crossed off when Dr. Vogel first saw the list. Dr. Vogel said complainant made changes on the list after speaking with her about his error.

Complainant testified that he discovered and corrected the error himself. In order to accept his explanation, the fact finder would have to disregard the testimony of Ms. Van Delen and Dr. Vogel, as well as respondent's more logical sequence of events. Specifically, complainant's claim that he corrected the error before giving the list to the nurses is contrary to the nurse's action of reporting the error to Dr. Vogel. It

is contrary to Dr. Vogel's undisputed action of writing him the note quoted in the prior paragraph. It also is contrary to the fact that he met with Dr. Vogel about the problem. To illustrate these points, excerpts of complainant's rebuttal testimony are shown below using the same abbreviation system as previously used in this decision:

CA: Will you turn to R-131, please? And this is R-131, page 3. I'm quite sure you recognize this exhibit, don't you?
C: Oh, yeah.
* * *
CA: Briefly, okay so as not to overly rehash this subject which has been entered so much, can you explain to the best of your ability what happened in this case?
C: I saw the patient. The patient asked me to refill medication which has been counted. And I wrote off from the chart or from what the patient said. Most probably from the chart. I wrote in the slip, which is supposed to be transferred to the nurse to call in the pharmacy. I discussed different issues with the patient. I let the patient go. Review this script. Realize that patient was on two similar medications - one generic, one trade. Cross one of each and transfer it to nurse.

HE: You're saying you crossed out the entry for Diazide on this exhibit?
C: Yeah. I did. This was exactly what happened.

RA: Did you say this was before giving it to the nurse? I didn't hear . . .
C: Yeah. Before giving to nurse, this what I done.
RA: The first time?
C: And put a "DC" which means disconnect. I dictated, after that I dictated notes when I mentioned that I admitted the same patient that she was on two diff- on two similar medications.

HE: So you're saying that you discovered the error yourself?
C: Yeah.
HE: No one brought it to your attention?
C: Well, later on, later on. I – and this thing which I do not remember somehow - I didn't see this particular – last time – next time, I think, when I saw this copy it was in October '98 because it somehow it was in my file. I remember one of discussion with Dr. – I do not remember discussion about that. I saw about

accident in the Diazide[4], not about that. And, honestly, I do not remember – I do not remember exact what happened with this exhibit after that. But I remember just logical sequence of events. I saw it. Correct it. Dictated. And that's it.

* * *

HE: Okay, but you said that a nurse told you that Dr. Vogel wanted to see you.

C: Yes. And I saw Dr. Vogel.

HE: What was discussed?

C: Is - do I know that this is my understanding. I- my - what I – because this is real way thing – I do not exactly what was discussed. It was just question: "Roman, do you know that this is the same thing?" I say: "Yes, I know." But I think I forgot to mention about generic and brand name.

HE: Why would she ask you if they were the same drug if you had already crossed it out?

C: I do not know. It was the same thing, which it was several - another thing that I mention - the patient had cardiac problems in the first paragraph of my history and later on I found it was an example that I did not mention coronary artery disease in my H & P.[5] I should explain that I was in situation where - that I did accept everything that was told me and I did try to not annoy anybody. And at that time it was the last three months and I knew that sometimes I'm prone to make to make mistake and I – I didn't try to argue about it. It was not necessary. Just – I tried to tell that if it would be the cause that I cross it out, why Dr. Vogel didn't bring it to me and not to anybody's attention that it is something kind of bad evidence about that. I did not see this copy. I didn't see my file since before '98.[6] First thing I ask - I ask Lisa to provide us copies of that and she gave me copy. I didn't have it. I didn't see this thing. And I really didn't think it would be so big issue, honestly. I just was puzzled that – I immediately realized that – that what I alleged in the kind of almost forgery of the thing. Which I just physically could not do. It's just, it's not like, it's – let's forget about it – ah, I honestly – but physically I could not do it. It made no sense. If I did it in that time and it was the case and I was under such scrutiny and it's not mentioned anywhere.

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[4] This word was difficult to decipher from the hearing tapes. Phonetically, the word appeared to be "Remoxide" but was changed here to comport with the context of the discussion about Diazide.

[5] This is a reference to the 8/2/95 incident described in ¶36, PDO.

[6] This is a reference to his Personnel file, as discussed later in this decision.

* * *

HE: So in order for me to believe your version of events, I would have to be suspect of the nurse as well for bringing it to Dr. Vogel's attention, is that not correct?

C: Question is how this whole thing generated.

HE: Right. Otherwise why would the nurse bring it to Dr. Vogel's attention if you had already corrected it?

C: Well it was several occasions that everything has been brought to Dr. Vogel's attention. Even Chris Van Delen said she didn't remember details. And I think this whole thing generation - generated because just nurse being busy. Dictate all the list without mention and after pharmacy called, this thing was brought that I put two medications there. I know that I did not – I didn't change anything afterward. I give this thing to nurse as that's it. I did not see this original since that next time I saw it when it had been produced me by ah – attorney in ah – October 1998. It was not accident when it was discussed that this is problem with cross out after Dr. Vogel said – it was just – I thought that – my feelings were that mistake which I made was that I let the patient go –

HE: (interrupting) Yes, I've heard you say that.

C: I – I - I and I do not see how – how this – how all this thing happen. I was so - under such scrutiny that this episode if it was alleged like forgery, definitely would be brought in much bigger ah –

HE: I still don't understand what you're talking about "forgery."

C: No, not forgery, but cross out – what they are – if I crossed this thing after Dr. Vogel - after Dr. Vogel - after Dr. Vogel saw it and she mention it and she saw that I cross out, it could create – it would create problem with credibility and so on. She would let me know.

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CA: He's not using "forgery" in the sense that –

HE: No, no. But I –

CA: -in the sense that to make a change.

HE: Yeah. I think I understand that now.

The above excerpt demonstrates that complainant's explanation of the entire event is too strained and convoluted to be worthy of belief. The excerpt also demonstrates that, at times, complainant did not complete his sentences or would jump to another topic making it difficult to understand exactly what his answer to a question

was. Testimony of this nature added credence to Dr. Vogel's documented confusion over complainant's explanation for performance problems (FOF 23, PDO, in particular the first full paragraph on p. 12, PDO), as well as similar confusion experienced by Dr. Reinardy (FOFs 34 & 42, PDO).

II. Remaining Major Objections Raised by Complainant

Complainant raised many objections to the PDO. Only the main objections not discussed above or in the PDO are included here.

Complainant criticized the PDO (p. 8 of written objections) for reciting the content of some of respondent's exhibits verbatim. In hindsight, the PDO could have made it clearer that the recited information represented the examiner's (and now the Commission's) findings of complainant's performance problems (with exceptions identified in footnotes), of when complainant was told about them and of what remedial action was taken by the AFP.

Complainant notes (page 2 of written objections) that some of the AFP nurses criticized his Russian accent; whereas it was the opinion of one of his fellow student, RW, that such criticism was unwarranted because RW had no trouble understanding complainant or any FMG who spoke with an accent. RW conceded that the nurses' complaints seemed sincere but questioned whether the nurses had the desire to listen to complainant to the same extent RW did. Complainant also cited to RW's testimony of one patient who said he did not want to see any of those "damn Russian doctors," a comment she did not share with Dr. Vogel. The preponderance of evidence, however, indicates that concerns about complainant's ability to speak English were sincere and warranted. The AFP provided a tutor volunteer who worked with complainant on his English for more than a year, ending in Easter 1995. The tutor was provided due to some patients, the elderly in particular, saying they had difficulty understanding complainant. In November 1995, complainant found another volunteer through the Literacy Society. After complainant worked at OCI for a year, he enrolled in an English as a Second Language (ESL) class at a technical school because he wanted to

be able to speak at a "professional level" and realized he "had a ways to go." The fact that more than a year after leaving the AFP, he felt the need to enter the ESL class for his stated reasons made his claim that he was criticized unjustly for his English-speaking abilities at the AFP improbable.

Complainant contends (p. 3 of written objections) that the parties stipulated at hearing that during Dr. Vogel's tenure as director at the AFP, all FMGs graduated from a medical school outside the U.S. and all were not of U.S. national origin. Complainant then argues that this stipulated fact "makes it clear" that Dr. Vogel's objection was to FMGs with foreign accents. The Commission does not understand how the cited stipulation results in the conclusion suggested by complainant. In fact, the stipulation appears to support the contrary conclusion because those graduating from a medical school outside the U.S. and who were not of U.S. national origin would be expected to have a foreign accent. The stipulation was made when Dr. Reinardy testified but nowhere in the record was it made clear that the stipulated fact meant that Dr. Vogel objected to FMGs with foreign accents.

Complainant's argument regarding exclusion of FMGs for the interview process (pp. 3-4 of written objections) is misleading and incomplete. He notes it is uncontested that no FMG with a foreign accent participated in the recruitment process during October and November 1994. This is a misleading statement because one of the FMGs with a foreign accent was scheduled out of town (EO). It also is misleading because the interview process was comprised of more than the cited two months and there is no reason offered or supported in the record for segmenting the analysis on a month-by-month basis as suggested by complainant. Complainant's arguments are incomplete because he ignores the fact that two non-FMGs had the same level of involvement in the process as complainant.

Complainant also contends (p. 4 of written objections) that he testified at hearing that he "directly heard" Mike Watson say "loudly in public that I don't want any FMGs to interview the resident candidates." The pertinent hearing testimony was reviewed. Complainant testified he heard Mike Watson who was responsible for

scheduling residents for luncheon interviews ask loudly: "Who is available for this lunch interview?" Complainant testified that he heard someone say that "Pricer"[7] and complainant were available and Mr. Watson replied: "No, definitely I do not want to have FMG in on this interview." Complainant makes the connection that this testimony supports a conclusion that Mr. Watson was carrying out Dr. Vogel's policy to exclude FMGs from the interview process. The referenced "connection" was not established at hearing. Dr. Vogel denied giving Mr. Watson instructions to exclude FMGs (unless they were not doing well academically). Complainant cited to Mr. Watson's deposition as containing information supporting his argument. The reference to Mr. Watson's deposition is inappropriate, as it is not part of the hearing record, a fact which the parties were reminded of by letter from the hearing examiner dated February 24, 1999.

Complainant (p. 9 of written objections) criticizes the PDO for failing to include a discussion about a pelvic exam conducted in June 1993, when Dr. Vogel was a faculty member but not the AFP Director. This event occurred within one month of Dr. Vogel recommending complainant for hire. Evidence about the event was accepted in the record not as evidence of discrimination but as evidence of Dr. Vogel's poor judgement. Some witnesses said Dr. Vogel's conduct was proper while others disagreed. Neither complainant, nor any AFP faculty raised concerns at the time. Under these circumstances, the Commission cannot conclude that the event constituted evidence that Dr. Vogel exercised poor judgement or that she had a proclivity to do so.

Complainant also raised an issue about accessing his personnel file (P-file) (p. 9 written objections). This allegation was not offered as evidence of discrimination (due to discovery issues) but as evidence that complainant would not have been so confused about what Dr. Vogel thought he was doing wrong if only he had attained quicker access to his P-file when he requested to see it. Ultimately, complainant was given access to his P-file and was allowed to make copies of any document he wanted. The

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[7] It is unclear whether complainant was referring to Dr. Price, a female of U.S. origin on staff at the AFP, or to PJ who was also a FMG resident. The word spoken by complainant sounded like "Pricer" and this is how the examiner recorded it in notes taken at the hearing. If this was intended to be a reference to "PJ," the word should have ended in a "t."

P-file contained the evaluations of complainant's performance, which are noted in the proposed decision. Complainant contended that the file contained more documents, which were undisclosed until depositions taken three years later. Dr. Vogel, however, explained that the P-file contained the summaries of complainant's performance, which were shared with him (as noted in the PDO). The extra documents provided at the deposition were not kept in the P-file but were gathered in the process of preparing a defense in this litigation. The nature of the extra documents, for example, were patient medical records underlying the incidents cited in the evaluations.

Complainant contends that the hearing examiner erred in exclusion of certain evidence prior to and during the hearing (p. 12 of the written objections). Such rulings were based on complainant's failure to be forthright with his answers to discovery. The Commission discussed with the examiner her rulings and reviewed the examiner's letter rulings. The Commission found them to be fair and correct. The rulings at hearing were extensions of the same discovery failures and were appropriate.

ORDER

This case is dismissed.

Dated: February 9, 2000.

STATE PERSONNEL COMMISSION

LAURIE R. McCALLUM, Chairperson

DONALD R. MURPHY, Commissioner

JUDY M. ROGERS, Commissioner

JMR:960097Cdec2

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NOTICE
OF RIGHT OF PARTIES TO PETITION FOR REHEARING AND JUDICIAL REVIEW

OF AN ADVERSE DECISION BY THE PERSONNEL COMMISSION

Petition for Rehearing. Any person aggrieved by a final order (except an order arising from an arbitration conducted pursuant to §230.44(4)(bm), Wis. Stats.) may, within 20 days after service of the order, file a written petition with the Commission for rehearing. Unless the Commission's order was served personally, service occurred on the date of mailing as set forth in the attached affidavit of mailing. The petition for rehearing must specify the grounds for the relief sought and supporting authorities. Copies shall be served on all parties of record. See §227.49, Wis. Stats., for procedural details regarding petitions for rehearing.

Petition for Judicial Review. Any person aggrieved by a decision is entitled to judicial review thereof. The petition for judicial review must be filed in the appropriate circuit court as provided in §227.53(1)(a)3, Wis. Stats., and a copy of the petition must be served on the Commission pursuant to §227.53(1)(a)1, Wis. Stats. The petition must identify the Wisconsin Personnel Commission as respondent. The petition for judicial review must be served and filed within 30 days after the service of the commission's decision except that if a rehearing is requested, any party desiring judicial review must serve and file a petition for review within 30 days after the service of the Commission's order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. Unless the Commission's decision was served personally, service of the decision occurred on the date of mailing as set forth in the attached affidavit of mailing. Not later than 30 days after the petition has been filed in circuit court, the petitioner must also serve a copy of the petition on all parties who appeared in the proceeding before the Commission (who are identified immediately above as "parties") or upon the party's attorney of record. See §227.53, Wis. Stats., for procedural details regarding petitions for judicial review.

It is the responsibility of the petitioning party to arrange for the preparation of the necessary legal documents because neither the commission nor its staff may assist in such preparation.

Pursuant to 1993 Wis. Act 16, effective August 12, 1993, there are certain additional procedures which apply if the Commission's decision is rendered in an appeal of a classification-related decision made by the Secretary of the Department of Employment Relations (DER) or delegated by DER to another agency. The additional procedures for such decisions are as follows:

1. If the Commission's decision was issued after a contested case hearing, the Commission has 90 days after receipt of notice that a petition for judicial review has been filed in which to issue written findings of fact and conclusions of law. (§3020, 1993 Wis. Act 16, creating §227.47(2), Wis. Stats.)

2. The record of the hearing or arbitration before the Commission is transcribed at the expense of the party petitioning for judicial review. (§3012, 1993 Wis. Act 16, amending §227.44(8), Wis. Stats.)

STATE OF WISCONSIN PERSONNEL COMMISSION

ROMAN KAPLAN,
Complainant,

v.

Chancellor, UNIVERSITY OF WISCONSIN-MADISON,
Respondent.

Case No. 96-0097-PC-ER

PROPOSED DECISION AND ORDER

A hearing was held in the above-noted case on November 5-6, and 9-11, 1998, which continued on January 19-21, 1999. The parties' request to file post-hearing briefs was granted. The Commission received the final brief on June 24, 1999.

The parties agreed to the following statement of issue for hearing (see conference report dated February 23, 1998):

> Whether complainant was discriminated against on the basis of age or national origin or ancestry when he was terminated by respondent in 1995-96.

The following findings of fact are based on the hearing record, and any findings of fact in the discussion portion of this decision are adopted as such.

FINDINGS OF FACT

1. Complainant was born in Russia on October 24, 1948. He worked there as a nurse beginning at age 18. He later attended the Kiev Medical Institute graduating as a physician in 1973. He underwent further training in urology in 1979. He continued practicing as a physician (urologist) until 1989, when he left the Soviet Union.

2. Complainant arrived in Madison, Wisconsin in May 1990, as a refugee. Just a few weeks after he arrived in Madison, he was hired as a nursing assistant. In August 1990, Meritor Hospital hired him in a part-time position as a "tube clerk," with

responsibility for data entry in regard to lab specimens. At this time he also was preparing for the Equivalent Foreign Medical Degree test which he needed to pass before he could enter any medical school residency program in the United States. The test was comprised of two parts, basic medicine and clinical discipline. He successfully completed the test by December 1992.

3. Residency programs have a finite number of resident slots to fill. Slots initially are filled through the National Residency Match Program. Graduates from medical schools in the United States (and equivalent schools such as those in Canada) rank their residency preferences (where they want to work). Similarly, residency programs rank preferences for medical school graduates. The two lists are then "matched" via computer with the resulting assignment of medical school graduates to specific residency programs. The match process (including interviews) begins in October each year and ends in January. Sometimes slots remain unfilled through the match process. The unfilled slots may be filled with graduates from foreign medical schools (in countries whose medical schools are not considered as equivalent to schools in the U.S.). The foreign medical school graduates are referred to as "FMGs."

4. The status as an FMG is not based on an individual's national origin per se. For example, an individual born in the U. S. who graduates from a medical school in Russia (medical schools in Russia are not considered to be equivalent to schools in the U.S.) could be considered for an FMG slot. Also, individuals who graduate from a foreign medical school (such as Russia) could be considered for a residency program through the match process if the individual had previously attained the required certification and work experience.

5. In March 1993, complainant was invited to St. Luke's hospital (in Milwaukee, Wisconsin) for a one-month "observership" with Dr. Turkel. The idea was to give the hospital an opportunity to observe complainant's capacity as a possible residency candidate. All the hospital's residency slots, however, were filled through the match process leaving no slot for complainant to fill on a FMG basis. In mid-March

1993, Dr. Turkel contacted the Appleton Family Practice (AFP) Clinic and recommended that AFP consider complainant for a FMG residency slot.

6. AFP had six resident slots and only 2 had been filled through the match process. The following AFP physicians interviewed complainant for a vacant FMG slot: Dr. Garrett (AFP Director), Dr. John Allheiser (born in the U.S. and about 44 years old at this time) and Dr. Lee Vogel (born in the U.S. and about 37 years old at this time). Dr. Vogel wrote the summary of complainant's interview and recommended that he be hired.

7. Director Garret (age and national origin are not in the record) hired complainant in a FMG slot even though complainant did not meet AFP's usual requirement of having completed 12 months in a residency program in the U.S. prior to being accepted at AFP. Dr. Michael Reinardy (born in the U.S. and about 53 years old at this time), an AFP faculty member, served as complainant's advisor. Complainant liked Dr. Reinardy as his advisor because (among other things) he was readily accessible to answer questions.

8. Two other individuals were hired in FMG slots at the same time as complainant – "PJ"[1] who was from Thailand and "SP"[2] who was from the Philippines. All the FMGs started their first year residency program on June 1, 1993, a month before the match residents began their first year -- a practice which complainant thought was helpful to him.

9. Sometime during complainant's first year as an AFP resident, he took the national in-training exam for family practice (hereafter referred to as the "National Exam"). He received a composite score of 24%, meaning he scored in the lowest quartile.

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[1] The parties agreed to a system whereby some residents would not be referred to in this decision by their full name. "PJ" also is discussed in ¶66 of the Findings of Fact.
[2] This is the same resident discussed in ¶68 of the Findings of Fact.

10. Sometime during complainant's first year as an AFP resident, he participated in the process of interviewing new residency candidates.

11. The first year residency program includes a 12-month rotation as follows: a) four months teaching service with opportunities to admit patients, take turns being up all night and attend 2-3 hours of lectures a week; b) two months rotation on obstetrics; c) two months rotation on pediatrics; d) one month rotation on orthopedics; e) a neurology rotation; f) orientation to family practice and g) 3 weeks of vacation. Superimposed on the foregoing is the first-year resident's responsibility to see patients in a clinical setting but with one-to-one supervision by AFP doctors. During the second year of residency, there is less hospital rotations and more emphasis on gaining experience in the community and clinical settings. During the third year residents are expected to see patients on a half-day basis four or five days a week.

12. In or around June 1994, the AFP passed complainant to the second year of his residency program.

13. Dr. Vogel became the Acting AFP Director in June or July 1994, replacing Dr. Garrett. She became the permanent Director in March 1995.

14. Dr. Vogel began functioning as complainant's advisor in or around July 1994. She wanted to be complainant's advisor because she had heard that problems existed with his performance during his first year. Complainant would have preferred to continue with Dr. Reinardy as his advisor, but complainant did not tell anyone about this preference. Complainant had difficulty getting appointments to see Dr. Vogel because she was busy with her new duties as director. He knew he could have sought guidance from any of the other AFP physicians and yet he chose to try to solve problems alone, a course of action which he acknowledged at hearing as a mistake on his part.

15. Complainant took the National Exam sometime during his second year and received a composite score of 31% (Exh. C-4, p. 2) which was an improvement over the results of the exam he took in his first year (see ¶9 above).

16. All first year residents receive training (FPC1) in the procedures followed at the AFP in regard to required forms and the system for processing forms. On September 15, 1994, Nurse Christine Van Delen (born in the U.S. and about 35 years old at this time) conducted a review of the FPC1 class with complainant due to his failure to follow the required procedures. She summarized the review session as shown below in relevant part (Exh. R-102):

> FPC1 review was done September 15th. We discussed at length the proper use of the "system" (flags, black bins, communication with the nurses i.e. orders, etc.).
>
> The nursing staff at the front desk are feeling a great deal of frustration regarding a poor learning curve with this resident. He continues to be very difficult to work with because he continually misuses the above-mentioned systems that were put in place to create some semblance of order . . .
>
> He continues to misuse the system by letting patients leave the exam room before the nurse has a chance to finish with them. He doesn't use the bin system, but rather places the chart in front of a nurse and demands the patient be taken care of. There was an episode where a nurse was on the phone with an ill patient and the resident rudely came up and waved an order sheet in front of the nurse as she was talking on the phone. The nurse waived him off so he left the order in a bin. When the nurse got off the phone she was going to call in the order, but the writing was so illegible that she couldn't read it, so the resident was paged. When he called back, he stated "I don't remember what I wrote." This was approximately 10 minutes after the order had been written.
>
> I don't think this resident realizes how time consuming and frustrating his lack of organization and refusals to utilize the system is. When he is approached by the nurses with problems he has created, his response is "Ya Ya."

17. Dr. Vogel met with complainant on October 10, 1994, to discuss his performance problems, as shown below (Exh. R-105).

Multiple issues were discussed with Roman, including specific examples of each identified areas of concern. The seriousness of the problem was stressed, although probation was not indicated at this time, though it could be a consequence in the future. He did not have much insight into the kinds of problems and concerns discussed, but as usual, demonstrated an eagerness and commitment to working on these things, with next anticipated evaluation to occur as scheduled for mid academic year.

1. Working within the clinic "system" is problematic. Needs to use flagging, ordering system like everyone else. Phone call management includes timely return of calls and documentation on the message forms as to action taken, with forms placed in dictation room baskets for permanent placement in the chart by Medical Records. Discussed appropriate use of nurses, as tends to expect them to communicate abnormal lab information over the phone to patients (see below). Has expectations that nurses will stop what they are doing to address his needs in clinic, instead of using system (i.e., lab ordering bins, flags, etc.) Gets impatient waiting for them. Frequently speaks to them when they are on the phone or in the midst of other conversations. Discussed/reviewed appropriate approaches to communication and working with nurses. All of this is especially problematic in light of September 15 detailed review of these systems and concerns with Roman by the nursing staff in a separate remediation session especially for him.
2. Management of abnormal lab and communications with patients was discussed, as Roman has a habit of requesting/expecting nursing staff to relay abnormal test results to patients over the phone. Discussed that this is best done by the physician because of different levels of knowledge re: the meaning of the test results . . .
3. Appropriate use of the medical chart has been problematic in several ways, including:
    a. filling prescriptions over the phone without reference to accurate information in the chart and without recording the information in the chart.
    b. Not completing the Ob form required for pre-natal charting (2 different patients with incomplete and important history, physical and lab information near term).
    c. Filling of prescriptions apparently without reference to or consideration of important information in the chart (eg., re-ordering several cardiac meds for an entire year supply, when he had not

seen the patient and the patient had not been seen in the clinic for over a year and there was no contact with the patient) . . . [Also see **Exh. R-104**.]

d. Frequently not putting his charts into the advisor's basket for review and hence bypassing faculty auditing and input into charting.

4. Appearance of attitude problems, as others see him as impatient and rude to staff and with patients as well. Nurses and clinic manager have handled patient complaints and requests to not see him. Nurses have witnessed behavior that they think patients would interpret as cold, hurried and uncaring. He is impatient with nurses and program faculty staffers, frequently interrupting, leaving before getting an opportunity to staff with faculty, even when faculty indicates ability to staff in a minute or so after completing staffing with another resident.
5. Concerns regarding his fund of clinical knowledge and/or how he uses his knowledge to assess patients. Shared concerns re: our perception that he frequently doesn't seem to understand how sick an individual might be, or how serious a situation might be. Examples include a child with pyelonephritis (kidney infection) staffed with Dr. Price, without an indication of how toxic the child was [also see **Exh. R-104**], a multiparous pregnant patient presenting in labor with a hemoglobin of 7 which was discovered and not acted on early in pregnancy (Roman did not know this was a problem). Shared concerns that at this point there is evidence that his fund of knowledge is not what he thinks it is. He should avoid independent management as much as possible, using faculty frequently.
6. Concerns that Roman is contributing to a problem of inadequate experience by an attitude that puts off other people and may prevent community faculty from working with him. For example, I reviewed his admissions to 4N teaching service compared with other residents and they are less. Conversations with some community faculty indicate that they are preferentially not admitting to him.
7. Discussed his current pre-occupation with procedural experience to the detriment of learning other more basic medical information that he currently needs to focus on. It appears that he places procedural experience as more valuable than other clinical experiences. While he is trying to get into the GI lab to observe sigmoidoscopies, he is probably missing out on 4N teaching opportunities. Needs to stop trying to bypass the clinic procedural system, which refers proce-

dures such as flex sigs and skin lesion excisions, etc to our third year resident procedure clinic.[3]

8. More communication with faculty (specifically me as his advisor) regarding planning rotations . . .
9. Several patient complaints were discussed, some apparently arising from communication problems, especially on the phone, but there is this sense that they feel they are not being heard.

Correction discussed:

1. Compliance/cooperation with "systems" established in clinic for quality care and smooth operation.
2. Attention to chart completion.
3. During FPC rotation, will review clinic systems. Will arrange for him to spend a couple of days working "as the nurse" to get an appreciation for the tasks involved and why the system is the way it is.
4. Will be videotaping his encounters with patients and periodically provide feedback. These will be reviewed with Roman by faculty, including behavioral science faculty.
5. Needs to increase his staffing with faculty during clinic.
6. Will continue to evaluate performance on rotations. Need better feedback from rotation preceptors, as currently there is a lag of information.
7. Faculty will periodically review and assess our comfort with his progress.
8. Will ask Dr. Broderdorf (up-coming ER rotation) to watch him closely to assist in assessing his fund of knowledge and guiding his performance.
9. Rotation planning: Pediatrics elective at Madison. Agree to a GI rotation, with emphasis on all aspects of GI medicine especially assessment and formulation of plan in managing GI concerns, not solely a focus on GI procedures.

18. Complainant was excluded from parts of the interview process for residency candidates when Dr. Vogel was the AFP Director. She excluded complainant because of his performance problems. Dr. Vogel wanted to put forth her "best and brightest" residents so those with academic difficulties and those unhappy with their experience at AFP were not invited to participate in the full interview agenda. Dr. Vo-

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[3] Respondent's reason for criticizing complainant on this topic was unpersuasive.

gel did change the interviewing process to ensure that all residents had an opportunity to meet the candidates. Specifically, she changed the portion of the interview process where candidates take a tour of the AFP building and the hospital. Previously, candidates would shake hands with the residents on duty. Dr. Vogel changed this so there was time built into the schedule for candidates to meet the residents. Complainant acknowledged that he had an opportunity to speak to candidates while they toured the hospital.

19. Second-year residents have formal evaluations twice a year. Questionnaires are sent to nursing staff and to staff in the billing office asking how good the resident is in filling out required forms. A separate questionnaire is sent to AFP physicians asking for an evaluation in the areas of professional development, clinical performance and interpersonal skills.

20. The first formal evaluation of complainant in his second year of the residency program was conducted in or around December 1994 (Exh. R-106). The staff physicians' evaluation of complainant is shown in the chart below. The choices available for each category were exceeds standards (3), meets standards (2), partially meets standards (1) and does not meet standards (0). The name of the evaluating physician also is noted below.

Criteria	Allhiser	Garrett	Price	Reinardy	Vogel
Professional Development					
• Displays basic medical knowledge appropriate to level of training.	• 1-2	• 1	• 1	• 1-2	• 1
• Works effectively with other health care professionals.	• 1	• 1	• 1	• 1	• 1
• Was well-prepared and well-read on clinical problems encountered.	• 1-2	• 1	• 2	• 2	• 1
• Displays good clinical judgement, including awareness of personal limits.	• 1-2	• 1	• 1	• 1	• 1

Clinical Performance					
• Displays good clinical judgement in choosing diagnostic and therapeutic options.	• 1-2	• 2	• 1	• 1-2	• 1
• Demonstrates the requisite manual dexterity in clinical procedures.	• 2	• 2	• 2	• 2	• 2
• Accepts responsibility for patient care.	• 2	• 2	• 1.5	• 2	• 2
Interpersonal Skills					
• Attendance is prompt and regular.	• 2	• 2	• 2	• 2	• 2
• Communicates effectively with patients and clinical staff.	• 1-2	• 1	• 1	• 1-2	• 1
• Demonstrates an eagerness to learn	• 2	• 2	• 2	• 3	• 2
• Is sensitive to the patient's needs.	• 1-2	• 2	• 1	• 2	• 2

21. The physicians evaluating complainant (as noted in the prior paragraph) also wrote comments on the evaluation form. The comments are shown in the chart below.

Allhiser	Garrett	Price	Reinardy	Vogel
Has repetitively demonstrated a self serving, me first attitude, eg. recently with flex sig discussion – intimated that he would in house refer patients if he, not 3rd year, did them.	Roman has improved in his staffing behavior, but still has a way to go. I think he has the capacity to perform at a (third-year) level, but he has a way to go yet. Regarding communication skills, noted language and idiom problem.	• Regarding basic medical knowledge, has deficits in peds and OB. • Regarding working effectively with healthcare professionals, tends to forget clinic operations even when reminded. • Regarding clinical judgement, doesn't understand limits in skills with "oscopies" for FP's. • Regarding communication with patients and clinical staff, needs to work better with nurses in not expecting them to do everything.	Tries very hard to give good patient care. Is aware of areas of clinical weakness and tries to fill the void.	I have grave concerns re: Roman's performance. He episodically improves but does not seem able to sustain this and regresses to old patterns and attitudes which are frequently expedient and self-serving. Also have concerns re: Big gaps in fund of knowledges.

22. Dr. Vogel discussed the evaluation (described in the prior two paragraphs) with complainant on January 10, 1995. His strengths were identified, as were the areas in which he needed to improve. Goals were identified for the following six months. Dr. Vogel wrote a summary of the meeting (see Exh. R-107), the final paragraph of which is shown below:

> Discussed at length concerns re: fact that his progress at present raises concerns for whether he will be promotable at the end of the year if persists on same trajectory as is currently on, although some improvement has been noted. Many of the areas of concern are in follow-thru and accountability and should be correctable immediately given the time and effort thus far in reviewing systems. Expect a trend toward fewer patient complaints, preferably none. Review in three months by evaluation by program faculty and nursing staff and review of rotation performance. Understands not currently on probation but may require this at any time, if persistent or increased concerns.

23. On March 1, 1995, Dr. David Lange saw a patient who had been treated about three weeks before by complainant. Dr. Lange was concerned about the treatment complainant provided and reported his concerns to Dr. Vogel (R-108, p. 9). A nurse overheard Dr. Lange talking to complainant about the patient and the nurse also reported concerns to Dr. Vogel. Dr. Vogel discussed the problem with complainant. She wrote a summary of the meeting (Exh. R-108, pp. 1-2) as noted below (but did not share a copy of the summary with complainant):

> Nurses: 3/6/95, raised concern to Dr. Vogel, based on hearing a conversation between Dr. Lange and Dr. Kaplan which indicated a concern with Dr. Kaplan's management of a patient on Coumadin anticoagulation for stroke prevention in the setting of atrial fibrillation.
>
> Dr. Lange: In discussion with me 3/6/95 (Vogel), and later in writing, Dr. Lange indicated he had received abnormal PT (abbreviation for a medical test) result in night clinic 3/1/95: JS - PT = 42.3 / INR 10.7. When spoke with patient, patient indicated Dr. Kaplan had told him to increase his Coumadin from 5 mg daily to 15 mg, because his PT had

not been increasing. Had been on 15 mg daily dose for 3 weeks. Dr. Lange said his conversation with Dr. Kaplan about the incident led him to be concerned that Roman did not clearly understand that such a dosage increase (i.e., from 5 mg to 15 mg) could be so dangerous. Dr. Lange said he was not aware of all the specifics, but was aware that Dr. Kaplan had been trying to reach the patient after he (Dr. Lange) spoke with Roman about the incident, as he overheard Roman ask for the chart and heard him try to call the patient. Dr. Lange reported that on 3/6/95, he was asked by Dr. Kaplan what to do if he couldn't reach a patient by phone, and Dr. Lange instructed him to send a registered letter.

Dr. Kaplan: When questioned re: the incident, Dr. Kaplan seemed very much at a loss to recall the details of the conversations with Dr. Lange and was hesitant with replies re: his communication with, and instructions to the patient. In fact, I'm concerned that his replies were at times contradictory and inconsistent with chart information. Dr. Kaplan reported repeatedly trying to contact the patient about a PT that was too low, and finally left a message to increase his coumadin on the answering machine. When asked about how much of an increase, he said he couldn't remember. When asked if he made note of it in the chart as is expected, he said yes he was certain so. When shown there was no charting except, "Called, left message for James," he said he didn't understand why/couldn't explain why the information was not there. When asked what a reasonable change in dose would have been, given the last PT of 14.7 on 5 mg daily (2/10/95), he couldn't come up with an answer. When informed that the patient understood him to say he should take 3 tablets daily (15 mg), Dr. Kaplan denied this, at that point saying he was certain he had told him to increase it one third as much not 3 times as much, but he could not offer a specific dosage as to how much one third more would be. When asked if he gave the patient a specific dosage as opposed to telling him to take a third as much more, and when questioned how a patient would make those changes without specific prescription changes, Dr. Kaplan could no longer recall any information about the conversation with the patient and his charting re: the event.

Dr. Kaplan acknowledged concern for the seriousness of the error, and an interest in learning. We discussed approaches to coumadin adjustment. Also discussed the concerns related to effective communication with patients and follow-up, including the need to attempt to reach patients after work hours or sending letters. Certainly if information is left

on an answering machine, follow-up to ensure adequate understanding is necessary.

Concerns:

1. Fund of knowledge re: anticoagulation management. This would not be so problematic if Dr. Kaplan would seek advice, but there are legitimate concerns that he doesn't know what he doesn't know.
2. Knowledge about effective ways of contacting patients seem very inadequate for this level of training.
3. Sense of responsibility to patient is inadequate, as demonstrated by lack of initiative in ensuring patient had received the message, and as demonstrated by lack of follow-through to ensure follow-up PT was done after dosage change.
4. Poor documentation of communication with patient and medication dosage changes, which is contrary to expectations outlined in orientations and repeatedly expressed to residents. Also clearly not in step with the performance of colleagues even at a lesser level of training.
5. Concerns re: honesty about his charting and communication with the patient during questioning with Dr. Vogel.

Dr. Vogel updated her notes concerning this incident on June 7, 1995 and again on August 9, 1995, as shown below.

Results: Of note, patient was seen in late March, with history of bumping his shin earlier in March, with development of a 7+ X 7+ cm hematoma. Patient had subsequent management by other resident physicians. Last PT measurement was sub-therapeutic 6/7/95, signed by Dr. Kaplan with no evidence of communication with the patient re: dosage adjustment or follow-up PT.

On follow-up review 8/9/95, Dr. Price was asked to follow up with the patient and arrange transfer of care to another resident to ensure improved care.

Concerns:

6. Repetitive nature of the problem is concerning, in that the 6/7/95 PT was noted by Dr. Kaplan, and there is no evidence of change of dose, communication with the patient and no f/u since, now 2 months later.

24. Coumedin is a tricky drug to manage and you would expect that a resident might make a dosage error. Dr. Vogel legitimately was concerned, however, that complainant failed to seek advice from APR faculty before instructing the patient to change the dose. She also had legitimate concerns about this incident because: a) complainant failed to provide the required patient follow up in March, b) he could not remember the details when discussing the problem with her which suggested that he was not candid with her and c) he failed to take steps after the patient's visit in June. The concerns Dr. Vogel had were not typically seen in a second-year resident.

25. Dr. Reinardy and Dr. Robin Price brought to Dr. Vogel's attention an incident, which occurred with complainant on April 7, 1995. Dr. Price felt that first and second year residents knew they were to contact faculty for emergency-room admissions so faculty could do an assessment to determine if admission was necessary. Complainant was busy with two deliveries on OB and was contacted regarding an emergency room admission. He delayed over two hours in contacting an AFP physician about the emergency-room admission, which resulted in a delay of medical treatment for the patient admitted. Dr. Price (born in the U.S. and about 38 years old at this time) summarized the problem for Dr. Vogel (Exh. R-109) as shown below:

> Dr. Kaplan was covering messages/admits for "TM"[4] for April. On 4/7 (patient's name deleted) was admitted to (emergency room) at (hospital) at 1010. Dr. Kaplan called me at 1550 stating (patient) had been admitted by ER doctor. He said ER doctor called at 1330 saying she had abdominal pain and required admission. Dr. Kaplan was busy w/2 deliveries on OB. He didn't hear anything further and called ER doctor later. Then called me. I instructed him that he should have called faculty (myself or Mike Reinardy) when he first heard about (the ER patient). Then if he was busy, we could have seen her in the ER. He did not seem to understand that this was standard policy. Dr. Reinardy did talk to him further regarding the admission. He did apologize to me on Monday, 4/10. I checked to see if he understood that faculty is to be contacted on all potential admissions. He did seem to understand this.

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[4] This is the same resident discussed in ¶63 of the Findings of Fact.

Dr. Vogel spoke with complainant regarding the incident.

26. Complainant received feedback during his formal meetings with Dr. Vogel. His perception of the performance problems discussed during these meetings was skewed. He felt the problems were not that bad and, accordingly, was surprised when he would receive the written summary of the meeting because he looked so bad "on paper."

Complainant Placed on Probation

27. A meeting was held on April 20, 1995, with complainant, Dr. Vogel and Dr. Hurst. Complainant was informed that he was being placed on probation from May 1, 1995 to August 1, 1995, and that he would not be allowed to advance to the third year residency program as he otherwise would have in July 1995. Dr. Vogel required complainant to "staff all clinic patients," meaning he was required to consult with AFP faculty after he saw a patient (and before the patient left) to discuss his evaluation of the patient's medical problem and his recommended treatment plan. Dr. Hurst wrote a summary of the meeting (Exh. R-112), excerpts from which are shown below.

I. IDENTIFIED PROBLEMS
A. Clinical Performance
1. Fund of Knowledge
a. Pharmacokinetics and treatments
b. Difficulty differentiating serious and non-serious illness
2. Accountability/responsibility to patients
a. Coumadin incident
b. Patient waiting in hospital
c. TSH results – patient uninformed
d. Repeated failures to appear due to automobile problems[5]
e. Windsurfing[6]

[5] This criticism appears to have been unwarranted.
[6] This is a reference to a time when complainant had a pregnant patient who was ready to deliver. Complainant gave his beeper to his wife and went wind surfing. As a result, complainant was late in getting to the patient.

3. Patient complaints
   a. Painful ear irrigation
   b. Migraine patient
   c. H&P patient left sitting in room 90 minutes
4. Time management/organization
   a. Regularly falls behind in clinic
   b. Rounding at AMC from St. E's pediatrics service
   c. Phone calls and message mis-management (often leaves materials carelessly scattered)
4. Inattention to, and non-compliance with, systems for ensuring quality patient care
   a. Inept with referral system/process
   b. Inattentive to clinic schedule
   c. Unreliable phone call/message disposition
   d. Periodic excessive expectations of nursing staff
   e. Irregular follow-through with referrals to specialists . . .

II. SUMMARY CONCLUSIONS
   a. Probable Unreadiness for Promotion to R3 (third year of residency program)
      1. Justification
         a. Inadequate fund of knowledge
         b. History of inadequate integration and synthesis of feedback, as evidenced by insufficient behavior change
         c. Inadequate assumption of responsibility and accountability to sufficiently assure safe patient outcome appropriate to the independence expected of R3 residents

III. ACTION PLAN
   A. Probationary Period
      1. Extending from May 1, 1995 to August 1, 1995 . . .
      3. Defer promotion to 3rd year status, pending satisfactory completion of probationary period and faculty promotion recommendation
      4. Close faculty scrutiny and supervision of resident's performance throughout probationary period, with emphasis on indicated remedial efforts, specifically including:
         a. Resident is required to staff all clinic patients
         b. Staffing encounters will be video-taped, when possible
         c. Resident's patient encounters will be video-taped, when possible.

d. Clinic patients will be seen at a rate not to exceed 2/hour in an effort to assist resident via above-noted teaching modalities, and to address his time-management issues
e. Faculty-resident feedback sessions will be held regularly.

5. Mid-point evaluation will be performed between July 1 and July 15 . . .

28. Sometime after complainant was placed on probation, Dr. Vogel saw him at the hospital and asked why he was there when it was his scheduled day off. Complainant said he was there to visit a patient. Dr. Vogel responded that he still did not understand the rules. Complainant felt Dr. Vogel should have viewed his working on a day off as a positive, not as a negative. It should have been clear to complainant that Dr. Vogel was concerned that he still did not accept that he was not to see patients without staffing.

29. Sometime after complainant was placed on probation, he repeated the National Exam. This time he received a composite score of 72%, meaning he was in the top 28% (Exh. C-4, p. 1).

30. A meeting was held with complainant, Dr. Vogel and Dr. Hurst on June 9, 1995, to assess complainant's performance. Dr. Hurst wrote a summary of the meeting (Exh. R116, pp. 2-3). Concerns noted previously were listed again, as were patient complaints since the meeting on June 5, 1995. The following remedial measures were added to those already in place: review of clinic procedures information, oral examinations on patient care, written examination on pharmacotherapeutics, close supervision for patient care in the hospital and nursing home settings. Also created, as a remedial effort, was a specialized rotation where complainant could work in the AFP clinic with Dr. Hurst. Also scheduled to occur in June was a review of complainant's treatment videotapes (initiated after the April evaluation) with Drs. Vogel, Price and Hurst and others.

31. During the three weeks after the June 9th meeting, Dr. Vogel met with complainant on three separate afternoon sessions (each lasting at least 3 hours) to pro-

vide the oral examinations on patient care. Dr. Vogel would pose a patient scenario and ask complainant what questions he would ask the patient, how would he summarize the major problem, what his treatment plan would be, etc. This remedial approach was unsuccessful. Dr. Vogel felt she was not getting a good idea of complainant's fund of medical knowledge because complainant was so nervous during the sessions. Also, complainant felt it was not a fair evaluation method. The process was discontinued with the understanding that complainant's fund of knowledge would be evaluated by the doctors who staffed his patients.

32. Complainant took a rotation in Madison in May 1995. In June, the three doctors in Madison provided feedback to Mike Watson at AFP. Mr. Watson shared the information with Dr. Vogel in memos dated June 14 and 21, 1995 (Exhs. C-14 and R-114). One of the three physicians (Exh. C-14) thought complainant did a "real nice job" and that his "skills in medicine were comparable to other family practice residents." The other two physicians (Exh. R-114) were critical of complainant's performance. Mr. Watson's description of the criticisms is shown below:

> On Monday, June 19 I spoke with Dr. Judd in Madison concerning his evaluation of Roman Kaplan's performance in May. He said he worked with Roman for 4 or 5-1/2 days and thought he could give a pretty fair evaluation.
>
> > "His history and physical taking was adequate but Roman has difficulty going from the exam to making a diagnosis. And from there he has difficulty communicating his diagnosis back to the patient. He never dictated any notes which was unusual. He wrote everything out which I had to then go over. He worked hard but he is at the level of an intern. I would be concerned to have him function as a 3rd year. My advice would be to have a physician go with him when he is seeing a patient and then give him feedback afterwards."
>
> On Tuesday, June 20 I spoke with Dr. Green in Madison concerning his evaluation of Roman Kaplan's performance in May. He said he couldn't

remember how many half days he worked with Roman, but it was enough to give an evaluation.

> "Roman is energetic, enthusiastic and obviously a bright individual. His verbal skills are adequate. One specific concern I have is his dictation. In the 12 years I've been here I've never had such bad dictation. I spent considerable time going over them. Some words were unintelligible and he had numerous grammatical errors. One other thing that was odd was that neither I nor anyone else in this office knew he was coming. He just showed up one day. I am a pretty easygoing guy so that was not a problem for me but that is very unusual to have someone show up like that. I understand that the Chief Pediatric Resident, David Mellinger was quite peeved because Roman was going to clinics he was not supposed to go to but you will have to talk to David to find out what that was all about. I have been working with residents for 10 years and Roman is not functioning as well as the others I have worked with."

33. On June 7, 1995, complainant reported to a patient that lab results for chlamydia (a sexually transmitted disease) were negative when, in fact, the lab report clearly indicated that the test was positive. (Exh. R-115) A nurse discovered complainant's error when following up to ensure that the required state report on communicable disease was completed. The explanation complainant gave Dr. Vogel was that he told the patient the results were negative because he already had started the patient on the appropriate medication. Dr. Vogel appropriately was concerned that the patient might not understand the need to continue taking the prescribed medication when told incorrectly that the test result was negative. Another legitimate concern was that complainant incorrectly noted in the patient's chart that the test result was negative.

34. On June 15, 1995, complainant admitted a patient to the hospital but failed to do many things relating to the admission. Dr. Reinardy discovered the problem and confronted complainant. Dr. Reinardy reported to Dr. Vogel that complainant's explanation "made no sense to me" (Exh. R-117, p. 2). Dr. Vogel spoke to complainant about the incident and made the following note (Exh. R-117, p. 1):

On 6/23/95 Dr. Reinardy discovered that Dr. Kaplan had done an admission H & P (history and physical) on an AFHC patient admitted to the psychiatric unit 6/15/95. He had not informed the faculty of the admission, nor did he ever see the patient again and did not inform her primary family physician, a resident in our clinic, of her admission to the hospital. He did not follow up on her labs, sign off the case, or bill for the visit. She was in the hospital 8 days before the situation was discovered and discussed with Dr. Kaplan . . . Dr. Kaplan stated to Dr. Reinardy, as well as later to me, that he did not know he had to inform the faculty of an admission under such circumstances (i.e. psychiatric H & Ps).

Concerns:

1. Apparent lack of awareness about residency policy re: need for faculty notification and supervision on all hospital admissions. This is concerning and frankly hard to believe or excuse given the fact that Dr. Kaplan has admitted numerous patients to the hospital and it is customary practice, as well as explicitly discussed in orientation sessions and repeatedly reinforced throughout the training program that residents do not have privileges to independently practice in the hospital setting. It is especially problematic that this occurred, as Dr. Kaplan had previously had a problem with not notifying faculty of an admission of a patient to the medical floor which raised concerns for delay in timely management, as Dr. Kaplan had also not evaluated the patient for a several hours period. During discussions re: his performance at that time, it was reiterated that he must inform faculty of every admission at the time of his first notification of the admission. Though the admission of a patient to the psychiatry service may have been a new experience, it has been discussed time and again with Dr. Kaplan, that he should, at the very least, ask questions when he is unfamiliar with expectations.
2. Lack of acceptance of personal responsibility in the care of this patient as evidenced by lack of follow-through on labs, performing at least one subsequent visit, signing off on the case, informing the primary physician.
3. Non-compliance with residency program billing system.

35. Sometime prior to August 1995, complainant approached Dr. Avi Dar-lev, a friend who has a private practice in Appleton. He told Dr. Dar-lev that he was

having problems at the AFP and asked for help. Dr. Dar-lev worked with complainant 2 evenings per month and when it was Dr. Dar-lev's weekend to be on call. This lasted several months. Dr. Dar-lev did not detect any problems with complainant's application of clinical knowledge. Dr. Dar-lev later participated in a conference about complainant (see ¶44) and supported the decision to extend his probationary period. Dr. Dar-lev testified that he had no reason to doubt Dr. Vogel's assessment of complainant's performance at the APR.

36. On August 2, 1995, Dr. John Allhiser wrote Dr. Vogel a memo regarding two history and physicals done by complainant during one week on the same patient (Exh. R-120). He felt complainant's write-ups were inadequate for a second year resident to the extent that patient safety was an issue. The basic problem was that complainant failed to include vital information about the patient's health in the impression section of the reports and it is the impression section that is relied upon by emergency medical personnel. All the pertinent information was in the reports but not included in the impression section.

Complainant Passed to a Modified 3rd Year

37. Third year residents have beepers and make decisions independently as to whether a need exists to go to a nursing home to evaluate a patient, etc. Dr. Vogel was uncertain whether complainant had progressed sufficiently to be advanced to the third year of the residency program. Beginning on August 2, 1995, he was allowed to start a modified third year level of responsibility. The modification was that he would not be allowed to make decisions independently. Instead, a safety net for patients was created by the requirement for complainant to continue to staff all patients.

38. A patient died the first night complainant was allowed to start a modified third year level of responsibility. Complainant was at the clinic with Dr. Price to staff his patients. She left at about 9:00 p.m. and gave complainant instructions to contact her to staff patients with the caveat that he could "batch" minor problems. A nurse at a nursing home called the clinic and spoke with complainant. He mistakenly understood

the nurse to say that the home had a severely retarded patient who had aspirated and died. He reported the call to Dr. Price saying the patient already was dead. Dr. Price, accordingly, told complainant he could finish up at the clinic and then go to the nursing home to fill out a death certificate. The nursing-home nurse made a second call to complainant saying the patient was better. Complainant realized the prior miscommunication at this point but failed to contact Dr. Price for guidance. The nursing home spoke to complainant a third time "in the middle of the night" saying the patient was cynadic at which time complainant ordered medication to prevent pneumonia. He still failed to contact Dr. Price about the nursing home patient even though he agreed that a patient who was cynadic was a "major" problem about which he had been instructed to call Dr. Price. Complainant later learned that the nursing home patient died.

39. The following morning (8/3/95) Dr. Allhiser was at the nursing home and called Dr. Vogel to inform her that the patient had died. Dr. Allhiser was concerned because the nurses at the nursing home were distressed and felt complainant should have come to the nursing home the prior evening. Dr. Vogel reviewed the nursing notes from the home and spoke with the nurses. Dr. Vogel spoke briefly with complainant about the incident with a more extensive meeting the following day (8/4/95) which was attended by Dr. Vogel, Dr. Price and complainant. He started out saying he believed from the first phone call from the nursing home that the patient was "either dead or dying." Both Doctors Price and Vogel specifically recall this comment and their reply to the effect that there is a great difference between a patient being dead or dying.

40. Dr. Vogel also was informed on August 3, 1995, that there had been two additional patient complaints about the care complainant provided on August 2, 1995. She also discovered that complainant had not reported (had not "batched") minor problems to Dr. Price.

41. Dr. Vogel spoke with complainant on August 7, 1995, and told him to staff all patients until further notice. Despite this instruction, he made two patient ap-

pointments on August 7, 1995, for times when he knew no faculty would be available for staffing. (Exh. R-123, p. 1) These matters were brought to Dr. Vogel's attention by nursing staff. The patients' appointments were changed to a date and time when faculty was available.

42. Dr. Reinardy was dissatisfied with complainant's performance on August 7th, when he staffed for complainant's patients. He communicated his dissatisfaction to Dr. Vogel by memo of the same date (Exh. R-124):

> The sessions when he (complainant) staffed this (morning) had rather loose and disconnected presentations that were hard to follow. On a couple, I had to go see the patient myself in order to understand what he was talking about.
>
> My greater concerns related to his staffing this afternoon, when he knew he was being video-taped. His first patient was a football physical that he didn't even staff until after he'd seen his 2nd patient. In this instance, the only joints he did more than a PROM, were his MTP joints on both halluces. He made no attempt to check knees for ligamentous integrity, nor ankles, nor any other joints. By letting the patient go before staffing, he wasn't able to go back and recheck either.
>
> He also made no attempt to come and staff even though I was standing in the doorway with Shawn. I had to go to the dictation room to ask him if he was going to staff.

Complainant Pulled from Modified 3rd Year

43. After hearing that complainant did not staff a patient with Dr. Reinardy, Dr. Vogel reasonably questioned whether complainant took her directives seriously. She was concerned that patients would not be safe if she could not rely on him to follow her instructions. One of her concerns was that complainant might be avoiding staffing so the faculty would not discover mistakes he made. She prepared a written memo to complainant, dated August 7, 1995 (Exh. R-122), the text of which is shown below in relevant part (emphasis shown is as in the original document):

> I wanted to make you aware of some interim changes in scheduling and your call responsibilities as we sort out how to approach some of the difficulties we've seen you experiencing. To re-iterate our discussion today, we are making some changes while we try to define the best course of action to take in light of our concerns about your fund of knowledge . . .
>
> In the meantime, as we discussed:
> 1. You must staff EVERY patient encounter with a faculty. Because we realize this takes time, we will adjust your clinic schedule accordingly. Hence, you will be seeing fewer patients than currently, but will have increased teaching time.
>
>   I want to stress the need for complying with this directive. You received a similar directive in writing this (morning), and discussion with Dr. Reinardy indicated you did not staff every patient encounter in the afternoon until requested. Your perception was that it was "just a sports physical." We have critical concerns about your approach to even matters which you think are simple. Careful faculty supervision is the only way we are going to be able to assess your fund of knowledge and judgement, and assist you in improving your clinical skills.
>
> 2. You have been pulled from 3rd year call responsibilities.
>
> 3. Probation is continued, and you remain at a second year resident status until further notice . . .

44. Dr. Vogel wanted input from others regarding complainant. She organized a meeting with faculty (Drs. Allhiser, Price and Hurst), two AFP residents (Carels and "SP"[7]), two physicians who wished to attend as advocates for complainant (Drs. Whiteside and Dar-lev) and an outside physician (Dr. Buffo). Complainant was notified that the meeting would take place and who would attend. He was informed that the meeting could not be held right away due to the schedules of the participants. (Exh. R-125) The meeting later was scheduled for September 5, 1995. Dr. Vogel shared information about complainant's performance with the participants for their review prior

to the meeting (Exh. R-126) and at this point in time two additional outsiders were added from the UW-Madison's Department of Family Medicine (Dr. Beasely and Janet Aronson). Dr. Vogel also prepared discussion materials, which were handed out at the meeting (Exh. R-127). The meeting was held as scheduled. The participants reached a consensus that AFP already had "bent backward" in attempting to help complainant and that there was a very severe problem with complainant's performance. The consensus was that complainant should be terminated unless the incident with the nursing-home resident was a "life-altering experience" that would open him up to working with faculty to improve his performance.

45. By memo dated September 6, 1995, (Exh. R-128), Dr. Vogel asked the AFP physicians to complete an "advisory ballot" concerning complainant. The options listed were: a) terminate now, b) continue second-year of residency on a short-term basis (1, 3 or 6 months) with no tolerance for follow-through problems, c) continue third-year of residency on a short-term basis with no tolerance for follow-through problems, d) repeat the second year of residency in its entirety before providing an opportunity to advance to the third year, or e) other (with room for comments). The faculty physician results of this polling (Exh. R-128) are shown below. (This exhibit did not include a ballot completed by Dr. Price.)

Name	Option Chosen	Comment
Allhiser	Terminate now	Adequate to abundant clarifications – warnings. Not getting it means either untenable independence or untenable communication. If this is the central problem, as I believe it is, it will be tough to give him a good recommendation. We've already invested more – far more than any resident deserves in relationship to what the others deserve.

[7] "SP" is the same resident discussed in ¶68 of the Findings of Fact.

Hurst	Repeat entire 2nd year	The issues are incredibly complicated for me, but I repeatedly come back to whether Roman must pay the ultimate price; ie., termination for the wages of Bob Garrett's sins of omission.[8] I think not. I recommend some modification of R-2 year for him with the use of elective time & FPCII time to be directed toward exposing him to the independence associated with R-3 (third-year residents). In other words, using parts of R-2 as functional quasi-R3 clinic months may be helpful- ala "training wheels" for the neophyte bicyclist. Along the way, we must be more clear on behavioral violations & advise him of the price he may pay for their violation; e.g. one violation of the staff-every-encounter-rule results in immediate suspension/termination, etc. Somehow, we must teach him to give up his rigidity, to lower his defenses & to open his receptive channels. If he cannot/will not do these things, then I think he is a lost cause.
Reinardy	Repeat entire 2nd year	If this is not satisfactory, my next choice would be to terminate now. (This is a very close 2d choice as the fairest to both Roman and the program.)

46. A meeting was held on September 7, 1995, with complainant, Dr. Vogel and Dr. Hurst. Dr. Vogel thought she heard from complainant that he believed he had a better understanding of what was behind his "mistake." He explained that he was

[8] The phrase "Bob Garrett's sins of omission" is a reference to when Dr. Garrett was the AFP Director (prior to Dr. Vogel taking over the post). Dr. Garrett accepted complainant as a resident waiving the usual AFP requirement that the candidate have one year's prior experience in a residency program

angry about the probationary period and the way he approached his opportunity to do better was to show he could meet expectations by doing things himself rather than, for example, asking faculty for guidance. At this time complainant's wife had been calling Dr. Vogel asking that complainant be given another chance. Dr. Vogel also was aware that complainant's daughter wanted to go to medical school and looked to her dad as a role model. Dr. Vogel decided to allow complainant to continue in the residency program by repeating the entire second year, with the caveat that a review would occur at the six-month mark with an opportunity to go to the third year after six months. Dr. Hurst's summary of this meeting (Exh. R-147) included the following conditions:

> Dr. Kaplan indicated that, "That is very clear." In response to Dr. Vogel's advising him that faculty will have zero tolerance for further defiance of directives. Previous examples include: staffing each patient encounter and staffing all patient telephone calls. The importance of this vis-à-vis faculty confidence and trust was described, and the willingness of Dr. Vogel to immediately terminate him for any future infractions were clearly articulated. He agreed to comply.

47. The normal period for each year of the residency program is twelve months. When complainant's second year was extended for another 6-12 months (as noted in the prior paragraph), he already had been in the second year for 15 months. At some point, the certification board would need to be approached to authorize this arrangement because the board imposes limits on the time an individual may spend in a residency program.

48. Complainant made two dosage errors on October 4, 1995. The first error (Exhs. R-130) involved complainant prescribing 50 milligrams "BID," whereas the pharmacist who caught the error indicated the patient was to be on 20 milligrams BID and that the medication did not come in a 50 milligram pill. The second error (Exh. R-131, p. 1) was discovered by a nurse and involved complainant prescribing a dosage of 0.5 milligrams, whereas the correct dosage was 0.05 milligrams.

49. Complainant made a dosage error on October 27, 1995 (Exh. R-131, p. 3). Complainant wrote down seven prescribed medicines for a patient and gave them to a nurse to call into the pharmacy. Christine Van Delen called the list into the pharmacist. The pharmacist told her that Diazide and Trianterene (kidney medication) were the same medicine. Ms. Van Delen brought this error to Dr. Vogel's attention. Complainant repeated the same mistake for the same patient on November 3, 1995 (Exh. R-131, p. 5). The patient then selected a new physician.

50. Dr. Allheiser wrote Dr. Vogel a memo regarding complainant's treatment of a patient on November 24, 1995, as noted below:

> Roman did a pre op cataract H & P (history and physical) 11/24 which he presented to me - 83 year old male with (diabetes) Roman had no concept that any insulin adjustment would need to be arranged - or how to do it - on the day of the surgery.

Dr. Vogel spoke with complainant about this patient. Complainant said he knew the patient's insulin needed adjustment and how to do it. Dr. Vogel asked why he had not shared his knowledge when Dr. Allheiser asked him about the patient. Complainant responded that the anesthesiologist already had corrected the dose so complainant did not think it was a big deal. Dr. Vogel reasonably was suspicious of this explanation because it made no sense for complainant to be less than forthright with Dr. Allheiser at the time of the incident. Dr. Vogel reasonably suspected that complainant was trying to hide his lack of knowledge. Complainant also failed to follow procedures on where to put his notes of his examination of the patient (Exh. R-133, pp. 2-3) which caused problems for the nurses trying to locate the notes.

51. Dr. Vogel reviewed complainant's charting between September and December 1995. She would spend about one hour every day reviewing the charts of other residents and about two-three hours daily reviewing complainant's charting using a pre-printed form (Exh. R-134). Dr. Vogel would put her comments on the form but at times there was so much to note that she just wrote "see me" rather than

writing it all down. The process was so time consuming that she asked another faculty person, Cindy Weisflock, to help. Ms. Weisflock at times also used the short-cut of asking complainant to "see me." Ms. Weisflock reported to Dr. Vogel that complainant was not getting back to her.

52. Dr. Vogel documented the incidents described in this decision. She did not document all of the problems brought to her attention about the complainant.

53. Complainant's performance was evaluated for the period beginning in September 1995 and ending in November 1995 (Exh. R-154). Four AFP physicians completed evaluations as did three nurses. The results of the physician evaluations are summarized in the table below. The rating options were "exceeds standards," "meets standards," "partially meets standards," and "does not meet standards."

Category	Results
Professional Development	
• Displays basic medical knowledge appropriate to level of training	• 4 said partially meets standards
• Works effectively with other healthcare professionals	• 1 – meets standards 3 – partially meets
• Was well-prepared and well-read on clinical problems encountered	• 2 – meets standards 2 – partially meets
• Displays good clinical judgement, including awareness of own limits.	• 3 – partially meets
Clinical Performance	
• Displays good clinical judgement in choosing diagnostic & therapeutic options	• 3 – partially meets standards
• Demonstrates the requisite manual dexterity in	• 3 – meets standards

clinical procedures • Accepts responsibility for patient care	 • 2 – meets standards 2 – partially meets
Interpersonal Skills • Attendance is prompt and regular	• 3 – meets standards 1 – partially meets
• Communicates effectively with patients and clinical staff	• 4 – partially meets
• Demonstrates an eagerness to learn	• 3 – exceeds standards 1 – partially meets
• Is sensitive to the patient's needs	• 2 – meets standards 2 – partially meets

54. Dr. Vogel reviewed the evaluations described in the prior paragraph and concluded that complainant had not improved sufficiently to graduate within a 4-year time frame. She discussed the evaluations at a faculty meeting asking what the results meant and whether they "were getting anywhere." Faculty were all concerned (including Dr. Reinardy) that complainant had too many performance problems to continue in the program. Dr. Vogel concluded after the meeting that termination likely would occur. She scheduled a meeting with complainant (and Dr. Hurst) for December 6, 1995.

Complainant Terminated

55. One of the items discussed at the December 6th meeting, was that Dr. Faudree had reported to AFP that complainant did not have Dr. Faudree staff all of complainant's patients. At first complainant did not acknowledge that he failed to staff some patients. Later he acknowledged such failure but said he only provided minor treatment and so he let the patient go without staffing with Dr. Faudree. This was a willful violation of the "zero tolerance" agreement described in ¶46 above. Dr. Faudree had informed Dr. Hurst that complainant performed at the level of a nurse practi-

tioner, meaning complainant could function in an environment working side-by-side with a physician.

56. Complainant was terminated from the residency program at the December 6th meeting. For the first time complainant said he felt he was being treated unfairly. He was given an opportunity to explain his side of incidents but failed to provide a satisfactory explanation of the events. Dr. Hurst prepared a written summary of the meeting (Exh. R-136), excerpts of which are shown below.

> (T)he types of patient care situations that continued to be problematic had been discussed in past evaluation sessions, and were significant enough to cause concern for patient safety. In summary, I addressed a number of concerns that the residency faculty continued to have regarding the deficiencies that we had identified in your performance, the apparent intractable nature of some of the problems, and the limited resources that this program has available for addressing such difficulties. Consequently, I informed you of the faculty's determination that your post-graduate medical education needs could be better met in another setting. In effect, I advised you of the faculty's intent to terminate your involvement with this program at the end of December.
>
> The major features of concern included:
> 1. Continued language difficulties
>   a. Patients still not understanding advice and directives, especially older patients
>   b. Although improved, nurses noted continued lack of understanding of, and compliance with, clinic procedures, and of greater concern, your tendency to say you understand what they are saying and then your behavior indicating that you either didn't understand, were forgetting after repetitive explanations, or were ignoring their communication with you
> 2. Continued problems with working with clinic procedures and systems, in spite of remedial reviews; examples include but are not limited to:
>   a. Front office staff routinely not receiving completed encounter forms so that they have information necessary to schedule patients back (when, how much time, what for, with who)
>   b. Not dictating hospital H & P when chart indicated patient needed it for ECT treatment

3. Fund of knowledge and clinical judgement still far below level of second year peers, with related faculty concerns including:
   a. Presentations on complicated patients still lacked cohesiveness of thought and synthesis of diagnosis and approach
   b. Tendency to jump to diagnostic conclusions with incomplete data base
   c. Close-minded when presenting cases; faculty feel the need to work very hard in suggesting other diagnostic possibilities and approaches
   d. Repeated problems with independent judgement and documentation in the course of non-staffed patient care (prescription-writing, medication changes, documentation of decision-making)
4. Lack of compulsiveness and attention to important details in patient care which has led to unacceptable risk to patients and the need for enhanced faculty supervisory vigilance
5. Concerns re: lack of self-awareness of limitations in your fund of knowledge . . .

Performance concerns were emphasized, despite the fact that your performance in supervised preceptor settings has been adequate, including your most recent family practice rotation with Dr. Faudree in September, 1995 . . . In spite of closer supervision of your performance in continuity clinic, and perhaps because of the greater knowledge of your abilities gained by increased observation, it was apparent that this program had limited resources to address the continued deficiencies in your performance.

Your response to this evaluation was one of "shock," as you believed you had been provided only with feedback that indicated improvement and that your performance on your preceptorship with Dr. Faudree (per your independent conversation with him) was as good as to cause you to conclude that you "would be a third year resident again in January." You expressed concern that the decision was unfair and rooted in a clash of personalities and perspectives; mine versus yours . . .

57. Dr. Allhiser spoke with Dr. Vogel after complainant was terminated. He felt complainant's performance during the probationary period showed he could not be relied upon to follow the directives in place (such as the directive for complainant to staff his patients). This was of special concern to Dr. Allhiser because those directives

were for the purpose of patient safety and if complainant would not follow them then the AFP would be responsible for any malpractice claim. Dr. Allhiser felt complainant's application of medical knowledge was "far below normal." Dr. Allhiser perceived that complainant's sense of self-worth was dependent upon his making decisions independently which, in Allhiser's view, made complainant dangerous.

58. After the December 6th meeting, Dr. Vogel explored the potential that staff were giving complainant mixed messages about whether he was doing well. She discovered, however, that the faculty did not feel they gave complainant the impression that he no longer had to worry about his performance.

59. Dr. Vogel arranged for complainant to meet with the faculty so he could verify for himself that Dr. Vogel was not the only person who felt termination was necessary. This meeting occurred on or about December 8, 1995.

60. Complainant made another dosage error on the day he was terminated (December 6, 1995) and such error was not discovered until after he was terminated. Specifically, he had seen a patient on November 8, 1995, whose lab results were dangerously high and complainant, correctly, lowered the coumadin dose from 4 to 2 milligrams. The patient came in for a recheck on December 6, 1995 (2 weeks late) at which time the lab results were too low. Complainant raised the dose to 6 milligrams which was an error because a 4 milligram dose already was determined to be too much medicine when complainant examined the patient on November 8th. Dr. Carels discovered this error on December 29, 1995, when the patient came in for an examination. When the error was reported to Dr. Vogel, she recalls thinking: "Thank God complainant was terminated -- no matter how hard it was to make the decision." (See Exh. C-23.)

61. After his termination, complainant requested that he be allowed to finish his surgery rotation. Dr. Vogel granted this request with the caveat that complainant could no longer work in the clinic. She did this so complainant could "save face" with the group.

Other Residents[9]

62. "EO" was born in Russia. He started at the AFP in a FMG slot one year prior to complainant's entry into the program. EO was over age 40 when he was at AFP. He transferred to the AFP from a prior residency program where he had a lot of language problems. The AFP worked with him on language skills (as the AFP also had done for complainant). A lot of patients complained about EO and staff attempted to sort out the problems. He had a sound level of medical knowledge and applied it competently. However, he dealt with patients in an abrupt, directive way rather than explaining things. Dr. Vogel addressed EO's problems with Dr. Reinardy (EO's advisor) and was assured by Dr. Reinardy that the problems had been discussed with EO. There came a point when there were so many patients quitting EO's care that the AFP could not keep him fully occupied for training. The problems continued without clear improvement up to a month prior to his scheduled graduation. Dr. Vogel checked and discovered that Dr. Reinardy had not documented any problems with EO's performance. Dr. Vogel told EO he would need to show significant improvement before being allowed to graduate. The AFP tape-recorded and assessed his sessions with patients (as the AFP also had done for complainant). EO explained that he did not ask many questions of patients because he was taught in medical school in Russia that it was unethical and sometimes illegal. Once the root of the problem was identified, EO "blossomed" as a physician and was allowed to graduate.

63. "TM" was a resident at the same time as complainant. She graduated from a medical school in the U.S. and her national origin is the U.S. She experienced mental health problems, which included fatigue and depression, as well as some unprofessional conduct (such as swearing inappropriately while she was in the nurses' station). There was a period when TM was so fatigued that she would fall asleep after

[9] The parties agreed to a system whereby some residents would not be referred to in this decision by their full name.

seeing patients which was the time she was supposed to be dictating her charting. Her written notes were in the patient's file but the typed notes, at one time, were three weeks behind. Specifically, she had 35 charts from July 17-30, 1995 that were not completed (Exh. C-13, pp. 27-28). The policy is that residents are to complete the dictation within 24 hours of the patient visit. A patient safety issue could arise if dictation timeliness standards are not met. Dr. Vogel instituted a medical leave for TM to undergo a mental-health assessment. Later, Dr. Vogel instituted a second medical leave for TM's symptoms of depression and fatigue. Each leave lasted two weeks. Expectations were detailed for TM upon her return to work. She was required to extend her training by two months, one month to make up the leave time and a second month to ensure everything was on track. She continued to have inappropriate outbursts of anger and some charting problems (see Exh. C-13, p. 25). TM's medical judgement and fund of knowledge were good at all times. She worked well with patients.

64. "DC" was an AFP resident at the same time as complainant. Tardiness and attendance problems arose over a two-week period when DC was on a community rotation, which involved spending time with public health nurses, riding in police cars, service at the homeless shelter, etc. He corrected the problem and made up the lost time. DC's clinical judgement and his fund of knowledge were never questioned. He frequently scheduled patients without first ensuring that nursing staff would be available. He also missed two planned portions of a rotation in or around September 1995. Dr. Vogel wrote a corrective memo to DC, dated 9/7/95 (Exh. C-15, p. 25). His deficiencies did not create patient safety problems.

65. "GC" was born in the U.S. and graduated from a medical school in the U.S. He was an AFP resident at the same time as complainant. His scores on the National Exam were very low - 2-3% composite score. To ensure that he did not have a problem that the AFP missed, faculty was asked how GC was performing in the AFP clinical setting. The AFP faculty was unaware of any performance problems that im-

pacted on GC's patient care or on the safety of the patients he treated. Dr. Price was his advisor and felt he had a good fund of medical knowledge with awareness of his limitations and weaknesses.

66. "PJ" was a resident at AFP. He also filled a FMG slot when Dr. Garrett was the director. PJ resigned from the AFP residency program in 1995. Questions arose during his first year at AFP about his fund of knowledge. He was unable to pass a required examination after his first year despite the month Dr. Vogel gave him off work to study for the exam. When PJ heard that he did not pass the test he asked Dr. Vogel, "What do we do now?" She said she was unsure. She noted it was a required test that he should have passed and concerns had been raised regarding his fund of knowledge. He replied that he understood and that if he had to leave the program he would resign. Dr. Vogel said she wanted to talk to Drs. Allheiser and Hurst before making a decision. She did consult with them. She later advised PJ that it would look better for him if he resigned rather than if AFP terminated him. He chose to resign. He was not forced to quit because of his national origin.

67. "FR" was an AFP resident at the same time as complainant. FR was born in the U.S. and graduated from a medical school in the U.S. "RW"[10] had trouble reaching FR by pager on 3 separate occasions in one month when he failed to wear his pager. The problem did not reoccur. On 3/6/97 a question arose about potential drug misuse. On 5/31/95 FR inappropriately prescribed medication and appeared not to know which patients he was supposed to cover for TM. On 5/31/95, FR was unknowledgeable and uncooperative in the procedures required to refer his patient to a smoke cessation class. TM also had low National exam scores (of 14%). FR, however, evidenced a good fund of knowledge in the clinical setting and did not present continued patient safety concerns.

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[10] This is the same resident as referred to in the Opinion section of this decision.

68. SP, a FMG resident who graduated, also had problems with fund of knowledge during her first year but she improved and corrected her mistakes.

Dr. Reinardy

69. Dr. Reinardy left the AFP effective 6/30/97, after receiving notice that his contract would not be renewed. When Dr. Garrett was program director there was a peer review of Dr. Reinardy, which was so bad that Dr. Reinardy had tears in his eyes and said, "I had no idea." Dr. Garrett did not deal with Dr. Reinardy's performance issues and renewed Dr. Reinardy's contract. After Dr. Vogel replaced Dr. Garrett, she worked with Dr. Reinardy to define the problems and develop a remediation plan. With his advisees, Dr. Reinardy did not always give the resident a clear picture of their performance, probably out of kindness but it did not serve the resident well. When it was clear that Dr. Reinardy's performance was not improving, Dr. Vogel went to him and suggested that they try to find a match (another job) because Dr. Vogel wanted to be able to help him find a different job while she could say good things about him. He did not do this and so a termination letter was issued.

Complainant's Current Job

70. On April 15, 1996, the Department of Corrections (DOC) hired complainant as the primary physician for 1,900 adult male prisoners at the Oshkosh Correctional Institution (OCI). Complainant essentially functions at the institution as his own boss. He has no on-site supervisor. Supervision is provided by George M. Daley, DOC's Medical Director, who visits OCI once a month. During his visits to OCI, Dr. Daley reviewed about 5 of complainant's charts to assess the quality of patient care. They saw patients together if complainant wanted a second opinion. Dr. Daley also reviewed the paperwork submitted by complainant when complainant requested a referral for an inmate to see an outside doctor. Dr. Daley also reviewed "a number of complaints" filed by inmates about complainant, which he investigated and found to be without merit. Dr. Daley has never seen any reason to worry about patient safety in regard to the medical care provided by complainant to the inmates. There have been no

complainants from the OCI nurses about complainant treating them poorly. No one has complained about complainant's ability to speak English. Dr. Daley feels complainant has a great deal of medical knowledge, has shown expertise as a physician, and has practiced in a capable and competent manner. Dr. Daley acknowledged that there is a "significant difference" between providing medical care in an adult-male prison and in a family practice clinic.

71. The inmates at OCI present a variety of medical problems. A significant part of the patients are disabled because OCI is one of the few institutions that are wheelchair accessible. There is a significant amount of chronic disease. For example, more than 100 inmates are diabetics with half of those being insulin dependent. There are 6 inmates who require kidney dialysis. About 20 inmates are HIV positive half of which are active with AIDS. The AIDS cases are extremely complex to manage medically and also require complainant to provide emotional support and guidance. Other inmate conditions include asthma, bleeding ulcers, severe orthopedic problems, dermatological problems and heart problems. Complainant does minor medical procedures at the institution such as biopsies and stitches.

72. Complainant, after leaving the AFP, also worked part time at the pain clinic in Fond du Lac where he mainly treated muscular problems. About half of his patients were female. His patients also included "a few kids."

CONCLUSIONS OF LAW

1. This case is before the Commission pursuant to §230.45(1)(b), Stats.

2. It is complainant's burden to establish that respondent terminated his employment because of his age and/or national origin.

3. The complainant failed to meet his burden.

OPINION

Under the Wisconsin Fair Employment Act (FEA), the initial burden of proof is on the complainant to show a prima facie case of discrimination. If complainant meets

this burden, the employer then has the burden of articulating a non-discriminatory reason for the actions taken which the complainant, in turn, may attempt to show was a pretext for discrimination. *McDonnell-Douglas v. Green*, 411 U.S. 792, 93 S. Ct. 1817, 5 FEP Cases 965 (1973), *Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248, 101 S. Ct. 1089, 25 FEP Cases 113 (1981).

A prima facie case of discrimination in relation to a termination is shown if the complainant establishes that: 1) he is protected under the FEA, 2) he was qualified for the job and 3) respondent terminated his employment and 4) circumstances exist which give rise to an inference of discrimination. It is presumed in this decision that complainant established a prima facie case of age and national origin/ancestry discrimination because Dr. Vogel, the decision maker, was of a different national origin/ancestry than complainant and she was under age 40 when she terminated complainant's employment.

The burden then shifts to respondent to articulate a non-discriminatory reason for discharging the complainant. Respondent met this burden stating that complainant was discharged for poor performance.

The burden of persuasion shifts back to the complainant to attempt to establish that respondent's stated reason for the discharge is pretext. The complainant raised several arguments of pretext. All were considered and rejected. The main arguments raised are addressed in the following paragraphs.

Complainant first asserts that if Dr. Vogel truly felt he presented a safety risk to the patients he treated then after his discharge the AFP would have reviewed the charts for patients seen by complainant to ensure everything was okay. No such review occurred and, as a result, an error made by complainant on December 6, 1995 was not discovered for 23 days (see ¶60 of the Findings of Fact). This argument is unpersuasive. While it may have been prudent for AFP to review patient charts as suggested by the complainant, the failure to do so does not change the fact that the record clearly established that complainant's performance did create a safety risk to patients.

Complainant's second argument of pretext relates to what he perceives as preferential treatment given to "TM." (See ¶ 63 of the Findings of Fact.) There were, however, significant differences between TM's and complainant's deficiencies. TM's fund of medical knowledge was never an issue as it was with complainant. Also unlike complainant, she never willfully disobeyed supervisory directives.

Complainant's third argument of pretext is based on his improved scores on the National exam (see ¶¶ 9, 15 & 29 of the Findings of Fact) which he asserts belie respondent's contention that his fund of knowledge was lacking. The scores he achieved do reflect that his medical knowledge was good. The record, however, clearly established that he was unable to apply his knowledge to an acceptable degree within the AFP setting.

Complainant's fourth argument of pretext is based on his perception that he did well during his first year at AFP. He may have done well during his first year. It also could be that Dr. Reinardy (who was having problems with his own performance – see ¶69 of the Findings of Fact) failed to give complainant a clear picture of his performance. In any event, the record is clear that complainant did not do well thereafter to the point that termination was justified based upon unsatisfactory performance.

Complainant's fifth argument of pretext is based on the fact that his current employer is pleased with his work in an institutional setting, which presents complex patient care cases. (See ¶¶70-71 of the Findings of Fact.) This argument is unpersuasive due to the varying degree of oversight at the AFP as compared to the institutional setting. A significant problem complainant had at the AFP was failing to function well under close supervision including, for example, the failure to follow standard procedures and, later, the failure to follow instructions put in place to ensure the safety of his patients. (For example, see ¶¶ 16, 25, 28, 34, 40, 42 & 55 of the Findings of Fact.) The degree of supervision over complainant at the institution is slight and, accordingly, it is not surprising that he has not been criticized at the institution for the types of behaviors he engaged in at the AFP which were related to a higher degree of supervision.

In short, complainant functions well when he essentially works as his own boss. Even complainant's friend, Dr. Barash, acknowledged at hearing that a person might be a good clinician in a certain setting but not in another.

Complainant advanced arguments which he felt demonstrated that the AFP dealt with him in a discriminatory manner. He first argued that Dr. Vogel intentionally misled AFP staff about his performance at the meeting held on September 5, 1995 (see ¶44 of the Findings of Fact). This argument is based on Dr. Reinardy's testimony that Dr. Vogel stated at the meeting that either the chief resident or a group of third year residents did not trust complainant's judgement and were uncomfortable having him responsible for their patients when he was on call. Later, at a graduation party, Dr. Reinardy informally asked "SP"[11], Dr. Sandy Gatsby, "DC"[12] and Dr. Gail Carels (a chief resident) if they were uncomfortable having complainant see their patients and they said they were not. Dr. Reinardy's testimony was suspect due to his own problems at the AFP (see ¶69 of the Findings of Fact) and due to the criticisms he had voiced about complainant (see ¶¶20, 25, 34 and 42 of the Findings of Fact). Dr. Reinardy's credibility at hearing also was questioned due to his statement that he did not know why his own contract at the AFP was not renewed – an assertion which was incredible. Furthermore, the residents Dr. Reinardy spoke to were not the same individuals who told Dr. Vogel they did not trust complainant's judgement. The individuals who spoke to Dr. Vogel were "GC"[13], Tracy Gallagher and Heidi Malling (all second year residents at the time). If Dr. Vogel stated at the meeting that it was third year residents who did not trust complainant's judgement, the preponderance of evidence in the record shows this was an inadvertent error. Dr. Vogel liked complainant. She recommended that he be hired into the AFP program. She admired him and, in fact, did not believe she would have been able to go to a different country where she had to learn

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[11] This is the same individual discussed in ¶68 of the Findings of Fact.
[12] This is the same individual discussed in ¶64 of the Findings of Fact.
[13] This is the same individual discussed in ¶65 of the Findings of Fact.

a new language and achieve as much as complainant has. She spent considerable time and effort to ensure complainant was given a fair chance to improve his performance at AFP.

RW[14] was a resident at the same time as complainant. She was voted as a chief resident on July 1, 1994. She met at least every two weeks with Dr. Vogel and Gail Carales, also a chief resident. RW testified that on about 6 occasions she heard Dr. Vogel say that Dr. Vogel would rather have an open resident slot than fill it with a FMG. Dr. Vogel denied making the alleged comments. Dr. Vogel recalled saying that community physicians were concerned about the quality of the residents over the last two years to the point where some were losing confidence in admitting patients for care by residents. Dr. Vogel also recalled expressing concerns about the performance of complainant and "PJ."[15] Dr. Vogel further recalled when a resident slot was open, she said she would rather leave the position vacant than fill it with someone who was not prepared. It is most likely that RW misunderstood the comments made by Dr. Vogel. The comments that RW alleges as having been made by Dr. Vogel, simply stated, are against the great weight of the evidence, which support the conclusion that Dr. Vogel was not biased against complainant or against FMGs as a group. It also should be noted that RW is a friend of complainant's who was shown to have an unreliable picture of Dr. Vogel in regard to another resident, as discussed in the following paragraph.

Complainant also noted that there was a perception that the AFP was trying to get rid of FMGs. This argument is based on the fact that "SP"[16] went to Dr. Reinardy sometime after "PJ"[17] resigned and "EO"[18] graduated. SP was in tears and told Dr. Reinardy there was a perception among the residents that complainant would be the next to go and, as an FMG, she feared she would follow. SP also approached Dr. Vo-

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[14] RW is used instead of the resident's true name.
[15] This is the same individual discussed in ¶66 of the Findings of Fact.
[16] This is the same individual discussed in ¶68 of the Findings of Fact.
[17] This is the same individual discussed in ¶66 of the Findings of Fact.
[18] This is the same individual discussed in ¶62 of the Findings of Fact.

gel to express her concern. This was the first time Dr. Vogel realized that the other residents had misperceptions about AFP's treatment of some residents. She realized that her decision to keep the performance problems of other residents confidential might have contributed to the misperception. RW contributed to the misperception as well. She spread untrue rumors that PJ had been terminated. Dr. Vogel met with the residents and explained what occurred, at which time RW apologized to Dr. Vogel.

ORDER

This case is dismissed.

Dated: _____, 1999. STATE PERSONNEL COMMISSION

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LAURIE R. McCALLUM, Chairperson

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DONALD R. MURPHY, Commissioner

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JUDY M. ROGERS, Commissioner

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