

Case No. 12-2300
UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

CLAIRE MORIN MD
Plaintiff-Appellant

v.

UNIVERSITY OF MASSACHUSETTS
UNIVERSITY OF MASSACHUSETTS
MEDICAL SCHOOL, BOARD OF
TRUSTEES FOR THE UNIVERSITY
OF MASSACHUSETTS,
Defendants- Appellees

ON APPEAL FROM THE
UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Honorable Joseph L. Tauro
Case No. 09-12022-JLT

Appellants Reply to Appellee

Claire Morin MD
Pro Se Litigant

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 States. Acad Med. 2010: 85 (2): 236-245, p. 237¶2

Abbreviations

ACGME	Accreditation Council for Graduate Medical Education	ER60	Examples in support of Rule 60 in the Addendum of the Brief
Adm Apdx	Addendum Appendix	FMIS	Family Medicine In- service rotation
Br CCU Ct Dktn	Brief Critical care unit Court Docket notes	IM MR60	Integrative Medicine Memorandum in support of Rule 60 motion Apdx (1)
Dkt 137 Or Sept	September 2011 hearing & redaction Apdx (7) (6)	PGY RBr	Post Graduate Year UMass reply to Brief
Dec	December 2010 hearing & redaction Apdx (5) (4)	USMLE	United States Medical Licensing Exam

Ms. Banigo: African born remarked unprecedented overt racism
 Dr. Boudreau: Chairman of Obstetrics at Tuft University (expert)
 Dr. DeMarco: Director of Graduate Medical Education
 Dr. Gleich: Director of Residency Program
 Dr. James: US born only other black resident at FHC
 Dr. Lasser: Chairman of Program
 Dr. Lillard: White peer interested in IM
 Mr. Martin: African born sued for hostile bias "poor evals,

denied opportunities, malicious gossip" Adm p.64
Dr. Morin: Upholds proffered facts as true and consistent.
open to correct her inchoate understanding of
of legal evidence respectfully asks this Court to
make reasonable inferences
Dr. Sun: Foreign born. Sued for hostile bias actions
Dr. Wertheimer: Vice-Chair of program & Secretary of Mass. Board

ORAL ARGUMENT

Contrary to UMass RBr p.10¶1, disability discrimination and
speech were briefed as pretext for race and national bias ER60
at 2 & 12; Dkts 47 p.5;¹ Adm p.50¶3; 97-6 p. 34(24); 97-11; 85-3
p.7¶3; 93 p.4¶2; 97-3 p.72 (278). Presenting them together Br
p.10 is efficient, not different RBr p.12 n.2. While UMass
blamed the Plaintiff for not testing these pretexts Dkt 121-1
p.33¶3; ER60 p.13; it deemed an oral argument Dkt 120 p.1 to
show the 'incriminating inconsistency and poor communication'
RBr p. 27¶2 were discriminatory animus St. Mary's Honor Ctr. v.
Hicks, 509 U.S. 502, 507 (1993)) irrelevant. Contingent on
outcomes the Plaintiff reserves rights to seek an oral argument.

One hundred years after "the Flexner Report on medical
education for racial and ethnic minority physicians in the
United States," researchers conclude:

"The big picture is still the subtleties and the
sophistication that characterize the maintenance of the
status quo." John Franklin, 2009

¹ The MCAD dismissed disability discrimination charges after
summary judgment. The Federal claim does not include the
disability charges discovered in August 2011 & filed in October
2011. Only severe disability precludes practice. So Dr. Morin
noticed appeal of this decision.

INTRODUCTION "INT"

This case of discriminatory tort² shows that the court masked bias to grant summary judgment. It suppressed evidence and applied legal precepts in ways that have merited default judgment and relief for plaintiffs.

The University argues that unsafe, inconsistent performance warranted judgment RBr p.17 last¶. Dr. Morin does not appreciate legal precepts RBr p.11¶3 and therefore thinks court rulings are wrong. ³ Id.

The abuse of discretion includes

- (i) Orders: suppressing discovery, amending the complaint;
- (ii) Summary judgment: overruling expert reviews, inadmissible evidence;
- (iii) Claims: dismissing alleged speech and mental disability without evaluation, retaliation and hostility

PRELIMINARY ISSUES "PI"

The discriminatory tort relates to EEOC charges from 2009 & 2006

² Initial & denied charges include defamation, Dkts 12 p.2; individual defendants & other charges Dkts 50; 50-1.

³ Dr. Morin objected to the R&R entirely. Dkt 120 p.2. UMass presumes she thinks all decisions "throughout the...case were wrong" RBr p.11¶3. When basing judgment on inadmissible evidence warrants a complete review for court abuse after August 2011 MR60 p.4 last¶.

April 2009 "Since May 1, 2006...to date Respondent...continues to retaliate...denying...recognition of...credits I successfully completed...at...minimum completion of one year...and maximum... 2 years...continuing to provide negative references...in my pursuit of continuing in the medical field...and...employment opportunities. I have been told...by...employers...licensing boards...Respondent is saying such...derogatory things...it...is preventing...hire...Respondent...continued to subject me to... employment discrimination in violation of Title VII." Dkts 43 at A; 124-2 p.4; 121-1 pp.61, 59, 60; 110-10 p.12 283(17); Adm pp.39¶5,64.

October 2006 "On May 1, 2006, I was terminated due to unsafe critical care...in retaliation for protesting discriminatory treatment ...Respondent set me up to fail...I was subjected to hostile... environment, kept at academic remediation...and wrongfully accused of...unsafe critical care. ...I asked Respondent to cite examples...they would not provide... evidence to support...alleged poor performance." Dkts 43 at A; 31-1 p.9; Adm p.50¶7

Performance

UMass withheld patient charts⁴ Dkts 91 p.9¶1; 113; 90 pp.2-3; from experts to oppose judgment or support Dkt 85-3 p.1(2). CCU experts invariably passed Dr. Morin.⁵ None of the affiants are competent to certify CCU skills, RBr pp.16¶1,34-35; Dkts 12p.4¶1; 21p.5¶3. So inadmissible evidence is an issue Br p.10.

As "El Conquistador would not have sent Ms. Feliciano even generic commendations if it were truly dissatisfied with her job" Br p.16 n16. FHC would not have appreciated

Dr. Morin's PGY3 call during PGY2, Dkt 124-2 p.82. Or permitted calls without intern back-up or in-house supervision Dkt 121-1

⁴or any legislatively mandated, objective evidence of unsafe care. See MR60 p.4¶1; Br at 32 n. 38; Fed. R. Evid 56

⁵ Dkts 121-1 pp.2-5, 38-49; 124-2 p.81; Adm p. 50¶7.

p. 74. UMass accepted Dr. Morin as a PGY2 resident Dkt 12 p.2¶2
after observing her clinical skills and attesting to the

American Board of Family Practice "The resident's previous graduate training has been carefully evaluated and...judged...comparable to...training the resident would have received at this program." Dkt 121-1 p.75.

"Standardized tests predict graduate students' success"⁶ Dkt 31-1 p.1¶4; Adm p.57¶7. They override evidence from 1991 RBr p.35¶1 and permit licensing and unsupervised practice. Dr. Morin's (86) percent score excludes affirmative action Dkt 43 at 18.⁷

2010 Supreme Court Ruling on Stray Remarks

Reid v. Google, Inc., 50 Cal. 4th 512, *37 (Cal. Nov. 5, 2010) ("Although stray remarks may not have strong probative value...in isolation, they may corroborate...discrimination...or gain significance...with other...evidence... Thus a trial court must review and base...summary judgment determination on the totality of...evidence in the record, including any... discriminatory remarks.") cf. RBr at 13¶2; Dkts 112 at 19¶2; 97 pp.9¶3, 10.

See Shager v. Upjohn, Co., 913 F.2d 398, 402 (7th Cir. 1990) ("[D]isambiguating ambiguous utterances is for trial, not...summary judgment. On...summary judgment...ambiguities in a...testimony must be resolved against the moving party.") Dkts 97 p.9¶3; 108 p.5¶1; 120 p.20¶1; 112 p.18¶1; ER60 pp.6-7.

"When a defendant argues...there is "ambiguity," "uncertainty in meaning or intention" Black's Law Dictionary (2d pocket ed. 2001). The defendant is...arguing...there is more than one possible motivation for the adverse employment action...as motivation is a question of fact. See e.g. Hunt v. Cromartie 536 U.S. 541, 549 (1999) ("The district court...was only

⁶ Kuncel and Hezlett Science 23 February 2007: Vol 315 (5815) 1080-1081

⁷ UMass "does not feel that it can just "pass someone along" and "hope" that eventually someone will become a good doctor." cf. RBr p.50¶2; Adm p.50¶3-4.

partially correct in stating...material facts...were uncontroverted. The legislature's motivation is itself a factual question.") The defendant is therefore admitting...a dispute as to...material fact...which...should preclude granting summary judgment."

The same actor inference

This "convenient shorthand" for plaintiffs without evidence of bias "may not hold...if an employee were the first" black resident⁸ Br p.34 ¶2.

Unsurprisingly, this Circuit has not weighed it RBr p.36. The court dismissed it sans ado Dktn 10/19/2010. So rehashing it as 'insurmountable' Id., by withholding evidence⁸ abuses discretion. Dr. Gleich was not at FHC and doctors who backed the dismissal did not interview Dr. Morin Dkt 25 p.4¶2. They hired Dr. Rosetti to replace her RBr p.24 n.6.

I ORDERS

1. Suppressing Discovery

UMass: "The district court did not abuse its discretion. Dr. Morin...made no showing" RBr p.22¶1 ...had a full...fair opportunity to demonstrate...that...reasons for...rejection were...a cover-up for a...discriminatory decision" RBr p.29¶3... The University...complied with...discovery obligations...at every step and the district court...agreed." RBr p.52¶3-44

Conversely, Dr. Morin represented "in the spirit of Rule 56(f)"⁹ and Rule 60 that she cannot "present facts essential to justify opposition," Br pp. 15¶1, 35-37; Dkts 108 p.1¶2; 93. UMass denies failing "to produce...documents" Br p.37¶2;

⁸ UMass withheld comparative records Br p.33 to determine this

⁹ 56(f) denies judgment if "a party cannot present facts essential to justify opposition." "A party...need not file an affidavit pursuant to Rule 56(f)...to invoke...protection of that rule." Allen v. U.S. EEOC office, No 09-14640, 2010 WL 653329 *2 (11th Cir. Feb 24, 2010) (quote omitted) "written representation...in the spirit of Rule 56(f)"... suffices Little John v. Shell Oil Co., 483 F. 2d 1140, 1146 (5th Cir. 1973)

Dkt 108 p.3¶3; accusing Dr. Morin of making "false" claims
See e.g., Br p.33¶2; Dkts 91 p.4¶2; 93 p.6¶1.

Conversely, UMass and the court opposed "a large number of motions"
for discovery¹⁰ RBr p.15¶2; Dkts 97 p.2¶2; including evidence for
experts ER60 p.15¶5; Dkts 91 p.9¶3; 89; 85 p.4; 113. The court

Planned "When fact discovery is done...then the
plaintiff...discloses...expert reports...identify the topic you're
thinking about Sept at 20(5-21).

Dr. Morin requested "[e]vidence & incident reports...in
the...letter of dismissal" Dkts 37p.4; 91p.7¶2. UMass objected
"I'm not here to cast aspersions, Judge. She served a request
for...documents...going to be HIPPA fights because they are
patient records¹¹...we can't produce those." Dec at 10 from
(25).

Ct: "the problem they're going to have is...they're not going
to turn over...a personnel record" cf. Dec at 11(22-25) & 9(10-
18); Dkt 91 pp.10¶3,12¶1.

Conversely, the court: compelled defendants to produce personnel
records for non-black plaintiffs ER60 pp.8-9; extended discovery
for UMass till April 19, 2010, Dkts 03/29/2012; 124 p.4¶1 and;

¹⁰ Dkts 75, 76, 77, 85, 87, 88, 89, 90, 93 at 1, 113; 113-2;
comparative & patient records & deposing witnesses were denied
RBr pp. 22¶1, 52, 53¶1; Br at 33. Court abuse in Rule 60 (MR60
pp.12,11,10; ER60 pp. 8, 14-17); Dkts 124 at 2; 124-1; 93; 90 at
3¶1; 129; 03/28/2012; Br 29-35; 'cheating' Dkt 137 pp.3,4
showed.

¹¹ Dr. Morin suggested removing identifiers; UMass shifted said
it did not keep patient charts Dkt 91 at 9¶3. That she "did not
designate a single expert in the case, despite the magistrate
reminder" RBr at 15 n.5; cf. Dkts 123 at 3¶2; 124 at 4¶1, Dkt 97
p.7 n.6; should be rejected. UMass withheld discovery that
experts needed Dkts 113; 91 p.10 n.3; 121-1 p.37; Apdx (8)(9);
n.18 infra; UMass experts invariably passed or commended Dr.
Morin's notes Dkts 112p.16n.6; 121-1 pp. 2-5, 38-49.

refused to compel subpoenaed reports that prevent licensing.¹² Dr. Morin was eligible Dkts 93-2; 121-1 pp.61,71,72; 124-2 p.4,

Adm p.37¶3 "The Board may preliminarily deny a license application... because of acts which, were they engaged in by a licensee, would violate M.G.L.c. 112, § 5 or 243 CMR 1.03(5)¹³ the Board will notify the applicant...of...facts...for the denial" 243 CMR 2.04(9) (emph. added) Dkt 101-8 p.2

Attorneys' false explanations conceal facts despite FOIA. ER60 pp.16-17, n.9; MR60 p.10¶3; Dkts 91 p.4¶2,n.2,8¶¶1,4; 93 pp.5-6; 76; 77; 75 esp. p.5¶2; 52p.4; 52-1; Br p.33¶2. 243 CMR 1.03(5) includes drug abuse, mental disability insanity, crime¹⁴cheating gross incompetence cf. Dkt 91 p.3¶3.

A "grave prejudice...has occurred" G.L.c 278§ 33. "Any employee of any agency who willfully maintains a system of records without meeting the notice requirements shall be guilty of a misdemeanor and fined." Title 5 USC § 552 a(i)

Employers regret Dr. Morin cannot work in the US without legal

action (p.9) UMass intimated, "Have you considered __and I'm not trying to be contentious__going back to Africa to practice medicine? cf. Dkts 97-3 p.72 at 281 (20-22); 121-1 pp.59-60; 50-1 p.19¶1; 93 p.9¶3.

The court overruled experts: "If you win this case, right, you don't win your license...don't see how...you could... order ...the board to change its view" Sept pp.32(19)-33(10) Id.; cf. Dkts 124-2 pp. 86, 81; 137 p.4; 93 p.3-4; ER60 p.16¶2.

How did the court "calibrate[] the decisional scales?" This is the case (p.9) Dkts 110-10 p.12 at 283(17); 50p.4¶2.

¹² Dkt 63¶2. UMass denied preventing licensing Dkt 97-1 p.2 & did not notice the Plaintiff.

¹³ n.14 infra

¹⁴ "[R]eviews are indeed the subject of the litigation...she alleges ...negative reviews were racially motivated." Dktn 10/19/2010; Adm pp. 50¶3,4; 64,65

"Court evidence cannot be legitimately relied on for a full and fair trial" Br p27¶3 ln 3

Transcripts convey that Dr. Morin does not want a license Id. &

Ref	Statements Dkts 97-3 p.57; & 101-10 pp. 8-9	Comment
218(20)	<i>Dr. Morin:</i> "My goal is not to be a doctor to practice in the United States of America."	Inaccurate cf. 101-10 p.8 at 218 (20)
219(11)	<i>UMass:</i> "And are you testifying that it is your intention at some point to move back to Zambia?"	
219(14)	<i>Dr. Morin:</i> "I did not say that, and you're taking my <u>words out of context</u>	Cf 101-10 p.9 at 219(14)
219 (15)	<i>UMass:</i> "I'm trying to understand...where is it you plan to practice?"	
219(19)	<i>Dr. Morin:</i> "My point...is...people have to be treated fairly for who they are, for their capabilities, not because of their race...national origin or... because people don't like them."	

The court changed evidence Br p.29-32 to pass judgment cf. U.S. v Roberts, 978 F.2d 17, 21 (1st Cir. 1988); U.S. v. Hastings, 847 F.2d 920, 924 (1st Cir.), cert. denied, 488 U.S. 925 (1988); MR60 p.2; Dkt 97 p.7 n.6. What deters future abuse? UMass

"wrongfully denie[d board reviews, comparative & patient records]...to establish" the [bias & tort] in dispute, the court must draw the **strongest** allowable inference in favor of the aggrieved party." Turnage, Br p.36-37; Fed. R. Civ. P. 56(f); Dkt 93 p.6. "No sanction less than...default judgment...can adequately ...redress...willful obstruction of ...discovery ...nor ...deter[] future acts of willful disregard for...rules of discovery." Overhead Door Corp Br p.37.

It is "the prevailing rule in all circuits" that "parties must be afforded adequate time for...discovery before being required to respond to...summary judgment." See Metropolitan Life Ins. Co v. BanCorp Services LLC, 527 F. 3d 1330 1336-37 and n.3 (Fed Cir. 2008). Br p.35

So granting "summary judgment before any aspect of discovery...completed" South Florida Tea Party, Inc., et al v Tea Party et al. 9:10-cv-80062-KAM Dkt 32 p.1¶2 Br p.35-37

masked alleged discriminatory tort and inferred abuse. The court tolerated and acted on false assertions e.g., Br p.33. Now UMass

a) casts doubt on evidence it altered & accuses Dr. Morin of creating a chart of bias against minorities¹⁵

UMass: "brief is replete with inflammatory and wholly unsupported allegations...("UMass altered academic records"); ("the court changed evidence of high probative value: fabricated evidence");citing own...testimony...("all the black doctors remediated")...self-created charts (e.g., "six of the seven doctors UMass fired...were foreign born")¹⁵...

(Dr. Candib...told Dr. James that blacks have to work twice as hard as whites)...Dr. Rung remark...Dr. Ackerman "testimony" (in reality, his 2003 letter referring her to the University ...("deprived training in Integrative Medicine that Dr. Lillard a white peer received.") None of these assertions are supported by anything in the record" RBr at 31 n10 cf. Dkt 97 p.7n.6.

They are.¹⁶ See e.g., Br p.29-34; cf. Dkts at Br p.16 n15. The academic records change. UMass's December 27, 2006 letter to the EEOC proves that six of the seven doctors fired (incl. Dr. Morin) were foreign born¹⁵ Dkt 50-1 p.18¶47. Upon information and belief the seventh was a black male surgeon. UMass only fired minorities Br p.11¶3.

Dr. Ackermann's testimony to the Board Dkt 101-1; Br p.6. is not his referring letter to UMass in Dkt 43 at 15. Dr. Rung's

¹⁵ EEOC discovery produced this letter & chart that UMass authored & withheld Dkt 90 at 2¶2 line 8; See n.36 infra.

¹⁶ True facts. See Dr. Morin p.7 supra (UMass did not produce discovery for black doctors Dkts 37 p.4¶2; 90 p.7¶1).

statement is in Dkts 97-2 p. 49(3); 124-2 p.7¶4; 31-1 p.3¶1; cf. Adm p.40¶4. See n.20 infra; Dkts 91p.5; 124-1 p.5 and Adm p.50¶3 concerning Dr. Lillard, and about blacks working twice as hard as whites.¹⁷

b) Changing judicial records

Why did UMass misdate proceedings RBr p.14(B)? November 3, 2006 is October 26, 2006, Dkt 12 p.1; August 31, 2009 is August 28, 2009 Id. When the Court misdated proceedings Dkts 93 p.15¶1; ER60 p.11¶3; explanations that Dr. Shields changed Dr. James's review by mistake; and Dr. Candib's email complimented people of color disappeared cf. Dkt 21 p.3¶2. UMass did not refute the assertion

The court also removed Dkts 124 & attachments and did not post nine out of ten exhibits mailed to support Dkt 95. See Dkts 94, 95, 101. So Dr. Morin included Dkts (that do not prejudice official numbering) in the Appendix RBr at 11 n.1 and Rule 60 RBr p.12 n.2. She should not be penalized for improper filing.

The RBr 'contains much the same material as...iterations of' motions to dismiss this case, cf. Dkts 112; 21; 97. The 97 series has over (327) pages Dkt/n 04/18/2012; 120 at 4¶2.

¹⁷UMass did not refute this. It scheduled twice as many FMIS blocks for Dr. Morin (14 v 7). See n. 19, 20, 34 infra

Rather, misleading statements, actions and omissions should be deemed fraud.¹⁸ See ER60 p.13; Br p.38¶2; Cox v. Burke, 706, So. 2d 43, 47 (Fla. 5th DCA 1998). Orders procured by fraud "can be attacked at any time, in any court" Br p.10¶1.

2. Amending the Complaint

a. Statute of Limitations

UMass: "Dr. Morin's claims all relate to the University's May 1, 2006 decision to terminate her..." RBr p.17¶2
 ...all...were...barred by statute of limitation...futile...The court did not abuse its discretion" RBr p.53¶2

It did. The claims were based on discriminatory tort in the context of continued terms, benefits and privileges of contractual relationship discovered *after* May 2006(p.9),

"a pattern of [constitutional] discrimination anchored by acts that occurred within the limitations period" See Cuddyer v. Stop & Shop Supermarket Co., 434 Mass. 521, 750 N.E. 2d 928, 936 (2001); National Railroad Passenger Corp (Amtrak) v. Morgan 122 S.Ct. 2061 (2002) at 2075; Dkts 50 p.2; 75 p.4¶1; 121-1 p.59,60.

All blacks remediated ER60 pp.5-8,10; Adm p.50¶3.

¹⁸ RBr p.14 n.3. In contrast, witnesses of the 4/2012 car crash saw a tractor trailer swerve twice into Dr. Morin's lane & drive off. Her car flipped to face oncoming traffic. (Insurance papers available on request). Dr. Morin was in Pennsylvania with laptop issues. The email noticing the depositions Apdx (8)(9) disappeared from her e-mails when UMass passed Dkt 123. Ms. Wulf from the MD Board reported an email from Dr. Morin vanished as she received it. Ms. Morin's hospital discharge is Dkt 116-1. UMass: compelled depositions knowing Dr. Morin planned to bring an expert Dkt 83, Apdx items (8)(9); & opposed access to pro bono lawyers Dkt 02/24/2012 to add criminal charges during bereavement. Dr. Morin takes time to research & reply & agrees UMass did not assent or oppose extensions to file briefs & waived paper requirement RBr p.14n.3.

"There is no systematic bias here. For some reason, you seem to be unable to rapidly and efficiently process complex information, n.36 infra cf. Dkts 124-2 pp.81, 86; 85-3¶1.

The court disclosed an ex parte relationship with UMass warning it would reject defamation charges as futile Br p.38¶3;

Sept at 15(4-20) and did, "listen to what he [UMass Counsel] has to say because while he's your adversary, he's also a lawyer." Sept at 14(7-9).

The 'futile charges' RBr p.53¶2; Dkts 53pp.1,3; 62 p.3¶3; 50 esp. p.2; 75 esp. p.4¶1; 50-1 masked belief about the 'inferior intellect of minorities;' ¹⁹ conspiracy Dkt 121-1 p.59, 60; and fraud with allusion to spoliation. See e.g.,

"The Court does not consider...statements...to licensing boards...retaliatory... those...acts did not occur within the context of...employment...which...terminated. While they might... be...termed defamatory (if the elements of such a claim could be proven), Dr. Morin has not brought a claim of defamation" Dkts 112 p.21 n.8; 124 p.3¶2; 53p.3¶2.

b. Qualified Immunity

UMass "...is a public institution...an 'arm' of the state entitled to 11th Amendment Immunity." Dkts 62 pp.4¶2,5¶1; cf. Dkt 50 p.21

"The principles of qualified immunity, shield an officer from personal liability when an officer reasonably believes that his or her conduct complies with the law." Pearson v. Callahan 555 U.S. at 19 (2009); Harlow v Fitzgerald, 457 U.S., 800,818 (1982).

Dr. Lasser remarked, "If I were in her shoes, I'd get a lawyer

¹⁹UMass only fired minorities 2003-2006. The program remediated all blacks (2004); engaged the court in creating evidence about remediation Br pp.30-31, 33-34; questioned board scores cf. Adm p.55¶3; withheld comparative records Br p.33 and; could not produce evidence to support the dismissal.

pronto. I think that Gerry [Dr. Gleich] and I need one," cf. Dkt 121-1 pp. 59, 60; RBr p.21¶2.

Officers understood their "conduct violated... constitutional rights...beyond debate." Barton, 632 F.3d at 22; Ashcroft v. al-Kidd, 131 S.Ct. 2074, 2083 (2011); Maldonado v. Fontanes, 568 F.3d 263, 269 (1st Cir. 2009); Dkts 50 pp. 2¶2,3¶4,14¶3.

They were shielded improperly.²⁰ Glik v. Boston et. al. (1st Cir. 2011) stripped police officers' immunity for violating constitutional rights. UMass did not defend court orders in Dkts 124; 124-1 and 77.

II. Summary Judgment

1. Inadmissible Evidence

UMass: "Inadmissible evidence cannot be considered on... summary judgment." SEC v. Ficken, 546 F.3d 45, 53 (1st Cir. 2008) RBr p.19¶2. "Summary judgment is appropriate when there is no genuine issue...and...moving party is entitled to judgment as a matter of law RBr p.18¶3.

"Rose v. Laskey, 110 Fed. Appx. 136, 137 (1st Cir 2004) (plaintiff...unfamiliar with...evidentiary burden at the summary judgment stage provides no basis for appellate relief)...pro se litigant must meet...specificity requirement of...Rule 56...to defeat...summary judgment." Mas Marques v. Digital Equip. Corp., 637 F. 2d 24, 27 (1st Cir. 1980) RBr p.21¶1

"the court...considered...issues...in a light...favorable to her...she could not present a prima facie case...no showing the...legitimate...reason...was pretextual" RBr p. 21¶2 cf. Dkt 121-1 pp.59,60

Ct: "Response...goes...beyond...material facts alleged...not in compliance with L.R. 56.1...the Court...presents the facts...by UMass's decision makers...because the Court does not detect a

²⁰ UMass denied equal IM training opportunity as Dr. Lillard, a white peer. It offered one IM block Dkt 121-1 p. 61 versus forced labor in (14)FMIS blocks. See Adm p.37¶3; Dkts 93 p.7¶2; 97-3 p.17 at 60-61; 91 p.5¶1; 85-3 p.9¶3; 31-1 pp. 3¶3, 10-12. Dr. Lasser supervised Dr. Wertheimer (Secretary of the Board who left UMass after Dr. Morin was licensed).

genuine dispute...(or else is unable to discern one in Dr. Morin's prolix Response)" Dkt 112 p.2 n.1 (emph. added).

The court overruled unanimous expert judgment²¹ for inadmissible evidence from non-experts;²² violating Rule 56 and the Supreme Court (Ewing) Br pp.10,19,26; RBr pp.33¶2 to conclude performance was poor and allow judgment RBr p.13¶1. The review was limited to 'the prolix response' supra cf. Dkt 105; RBr pp.18¶2,21¶2. CCU experts did not observe inconsistency or poor communication supra.²²

"There were multiple incidents...patient safety may have been jeopardized by...*poor communication*...do not trust... you can follow through...*consistently*...in emergency situations." Dismissal letter cf. Dkts 97-2 p.73; 112 p.11¶2; Br pp.31(3),32 n.38(emph. added).

"She had multiple incidents...*poor communication* and errors in ...management...performance...plagued by lack of consistency...concern for patient safety." letter to the licensing board Dkt 121-1 p.71 (emph. added)

Accordingly, the "proffered legitimate, non-discriminatory reason" for firing Dr. Morin is inadmissible, and fails UMass's light burden of producing *competent* evidence cf. RBr p.29¶2. Dkts 120 p.1; 124-2 pp. 81, 86 Br p.40¶1.

The court and UMass abused discretion by censoring the dismissal letter for judgment ER60 p.15; MR60 p.4 and denying

"disability or drug use are" not "part of this case...a red herring...Dr. Morin is trying to sensationalize...to attract attention" cf. Dkts 91 p.3¶3; Dkt 121-1 p.33; 97-7 at 9; 93 p.4(e); 21 pp. 7¶2,9¶1.

²¹CCU & OB reviews (Dkts 124-2 p.81, 86; 121-1 at 2-5 & 38-49); are generalizable over residents from different programs and Boston who worked alongside Dr. Morin.

²² Dkts 12 p. 4¶1; 97-7 pp. 9¶2, 10¶21, 97-6 p. 34(24); 97-11; 31-1 p.2¶4; 25 p.3¶3; 121-1 p.26; See p.9¶3 supra; ER60 p.4 n.3

2. Void Judgments

Discovery abuse Br p.26 and questioned impartiality MR60 p.6¶3

"indicate due process right was unfairly compromised relief under void judgment statute is mandatory." See Carter v. Fenner, 136 F.3d 1000, 1005 (5th Cir. 1998); Orner v. Shalala, 30 F.3d 1307 (Colo. 1994) MR60 pp.9-12; Br pp.35-36

The ex parte order for UMass *not* to address each opposing statement Dkts 108 p.3¶2 violated FRCP 56(c) (2) (C) (i). A movant

"must file in the form required by rule 56(c) (2) B(i) a reply to any additional facts stated by the non-movant" Dkt 120 p.4¶2.

The court's reply Dkt 112 (cf. 120; 124; 124-1) dismissed ACGME policies Dkt 31-1 pp. 5-8 that void the dismissal²³ and judgment as Dr. Morin's subjective ideas Dkt 112 p.17¶2.

The court engaged in proscribed "credibility determinations ...weighing of...evidence and drawing of legitimate inferences from the facts" Adickes v. S. h. Kress & CO., 398 U.S. 144 (1970); arguing independently²⁴ without "look[ing] at... evidence in the light most favorable to the plaintiff" Anderson v. Liberty Lobby, 477 U.S. (1986) at 247-48, 106 S. Ct.at 2509-10" Br p.28¶2;

The Supreme Court in Desert Palace Inc., v Costa 539 U.S. 90

(2003) ruled that "no special evidentiary showing is required" for Title VII. Id. at 99 "the...rule... merely requires a plaintiff to prove his case 'by a preponderance of the evidence,' with 'direct or circumstantial evidence.' Id (quoting Postal Service Bd. of Governors U.S Aikens, 460 U.S. 711, 714 n.3 (1980) RBr p.20¶3

While UMass "ought not to benefit from" preempting a "preponderance of evidence" Br pp.10(1),35¶1; MR60 p.12¶2; RBr

²³ The ACGME, Supreme Court & FRE 56, RBr at 34¶1 proscribe overriding expert judgment. See p.20¶1

²⁴ ER60 pp.10¶4,11; Dkts 124; 124-1; 123 p.4¶1

p.19²⁵ As a matter of law UMass is not entitled to judgment. Since inadmissible evidence cannot be considered or rebut prima facie claims Br p.39; Dktn 10/19/2010; 43; 17; 50-1.

III. Claims

1. Retaliation

UMass: "It is doubtful...protected activity...employee engages in protected activity...when she complains...to...supervisor about possible racial discrimination. Benoit...query to Dr. Candib in February 2004 did not address discrimination...asked Dr. Candib to "clarify"...alleged comment...made to the...speaker not a decision-making supervisor. RBr p. 46n.16

"did not establish...causal connection between...appeal of August 2004...and...2006 dismissal...temporal proximity must be...close." RBr pp. 47-48 "...did not...mention...discrimination...until...dismissed...the first time...six months after the...remark" RBr p.49

"poor performance pre-dates...February 2004...University did not terminate her because of...allegations: it reinstated her...no direct or circumstantial evidence" of retaliation RBr p.47-51.

Conversely, "Dr. Morin (i) complained about discrimination; (ii) bore the brunt of materially adverse actions; and (iii) the two were causally related." See Ahern v. Shinskei, 629 F. 2d 49, 55 (1st Cir. 2010); Dkt 50 p.14¶3; Br p.39.

Dr. Morin proved prima facie pleadings Dkts 10/19/2010; 25 pp.5¶2, 6; 50 pp.16-18; 50-1 p.15¶43; Br pp.17-25, 13; i.e., "negative evaluations were discriminatory"²⁶ Dkts 25 p.3¶3 and adverse

²⁵UMass agrees RBr p.33¶2: in "the context of due process challenges...a court should defer to a school's professional judgment regarding a student's...qualifications." i.e., UMass experts RBr p.15 n.5; Dkts 121-1 pp. 2-5, 38-49

²⁶ limited to FHC influence since 2004 Dkt 97-2 p.32

outcomes (discrimination) followed complaints about negative reviews (protected activity) closely Dkt 25 p.6¶1.

Since Dr. Morin offered that "[p]rotected conduct includes...complaining to...supervisors" quoting Valentin-Almeyda v. Municipality of Aguadilla, 447 F.3d 85, 94 (1st Cir. 2006); Matima v. Celli 228 F.3d 68, 78-79 (2nd Cir. 2000) Dkt 50 p. 15¶3; Br pp. 17-25.

and "[t]he...practice...opposed need not be a Title VII violation so long as [the plaintiff] had a reasonable belief...it was, and...communicated that...to his employer in good faith' Benoit 331 F. 3d at 174-75; Dkts 50 p.15; 43.

and "the anti-retaliation provision covers...actions that would have been materially adverse to...dissuade a reasonable worker from making or supporting a charge of discrimination"²⁷ Burlington N. & Santa Fe Ry. Co. v. White 548 U.S. 53, 64 (2006) at 57; Dkts 50 p.15¶2; 124-1 p.5¶1;

Dr. Morin "offered...evidence to support...complaints about her demotion, substandard evaluations, and failed classes involved discrimination" cf. RBr p.48¶2

See e.g., UMass "engaged in a series of adverse actions including: demotion, hostility, unjust adverse evaluations...due to unlawful discrimination...for engaging in protected activity" Dkt 25 p. 6¶1.

Almost always UMass's argument is not valid. What degree of abuse warrants judgment? Br p.10. UMass excluded inter alia asking Dr. Candib, a decision maker Dkt 97-7 p.7¶14, Br p.19¶4 about selection bias²⁸ RBr p.46 n. 16, from protected conduct. When

²⁷ Adverse actions during residency & tort afterwards dissuaded Drs. James, Rung and Ms. Banigo from supporting this case fully See Dkt 124-1 at full¶1;

²⁸ Dkt 97-7 p.8¶17; 121-1 p.26. Many doctors left in 2002/3 and forced UMass to select Drs. *James, *Morin, Pillai, Radwan, *Williams. Four blacks* was exceptional RBr p.50 n. 17. FHC selected Dr. Rosetti a sixth PGY2 to fail Dr. Morin in Nov. 2003 Dkt 12 p.2¶3. Only five PGY2s were funded, FHC selected Dr.

UMass deferred Dr. Morin's promotion two days later 121-1 p.25; Br p.18¶2. Then overruled experts seeking to license the "conscientious physician" Dkts 124-2 at 86; 121-1 p.27; 124-2 p. 71; RBr pp. 15 n.5, 49¶2; Br p.16¶3; for non-experts beset by relevant Fed R. Evid. 401 cross-culture challenges²⁹ Dkts 97-7 p.10¶21; 124-2 p.68; Adm p.50¶¶3,7,10 & p.67¶2; Br p.40; 105-6 p.14. The court credited UMass's arguments.

"Almost every job...involves...duties...less desirable than others. Common sense suggests...one good way to discourage ... discrimination charges would be to insist that [Dr. Morin] spend more time performing...more arduous duties and less time performing" IM, White, 548 U.S. at 70-71.

"That is presumably why the EEOC has consistently found [r]etaliatory work assignments' to be a classic and 'widely recognized' example of 'forbidden retaliation.' ...Whether a particular reassignment is materially adverse...'should be judged from the perspective of a reasonable person in the plaintiff's position.' Id.

Dr. Lasser would get a lawyer *pronto* Dkt 121-1 p.59; Dr. DeMarco question ever succeeding Dkt 121-1 p.60. Rehire at FHC against Appeal Panel directives Dkt 97-2 pp. 60, 61 was therefore "materially adverse." See Ellerth 524 U.S. at 751, 765 (1998) Br pp. 21-25 & 27; Dkts 90 p.12; 25 p.6¶1; 50 at 14-21;

Morin tentatively to secure funds. Drs. Rosetti and Morin were the only white & only black-African born PGY2. The case highlights selection bias RBr p.27 n.8 & articles are relevant. See e.g., Dkts 75 p.2¶2; 75; 85-3 p.7¶4.

²⁹ HHS Plans to Reduce Racial & Ethnic Health Disparity recognize that negative assumptions about ethnic patients Adm p.50¶10 increases disparity & need more minorities. UMass fires & delays minorities preferentially & changed its stance about 'the email' in view of litigation. See n.19 supra

121-1 at 74, 77; 97-3 p. 37 at 141-144. Adverse enough to belie Dr. Morin and say she "received a transfer" by May 2005 Dkts 12p.4¶1; 97-2 pp.60, 61. A reasonable jury could

concede RBr p.50¶1 that "complaints...were ...answered with...threats of termination efforts to obstruct work, additional, unnecessary and unreasonable job requirement" and reverse judgment Br p.22; Adm p.41¶¶2-3.

Dr. Gillian Nelson's interview Dkt 21 p.4¶4; RBr p.50 n. 17; (after Dr. Morin's license was denied Dkts 101-8; 121-1 pp.59-60 and a trainee left) supports bias, conspiracy and constructive discharge. She had to be black to preempt bias charges.

2. Hostile work environment

UMass: "A hostile work environment exists when "the workplace is permeated with discriminatory intimidation, ridicule, and insult that are sufficiently...pervasive to alter...conditions...of...employment and create an abusive working environment." Prescott, 538F. 3d at 42; Walker, 523 F. Supp. 2d at 102, RBr p.39¶2;

"reliance on a single race-related comment supported entry of summary judgment...for purposes of summary judgment only, the University accepted...testimony regarding Dr. Candib's alleged statement RBr p.40¶2.

"...claimed...email...said...residents of color should do better than other resident...then...complained... she was...held to higher standards" Id. [cf.nn. 15, 17, 20, 24,34]

"Almost without fail...incidents...pointed as hostile consisted of...criticisms of...performance...unfounded, rude, too critical, too loud...or...not to her liking" RBr p.42

"When stray comments and incidents...are viewed...Dr. Morin was not subject to...offensive harassment RBr p.45.

Conversely, Dr. Morin belongs to a protected class; and experienced uninvited harassment, Br pp. 17-25 & 13; Dkts 124-2 pp. 73-79; 50 p. 14-20. That was objectively subjectively and

pervasively offensive. It created an abusive work environment decision makers believed "unreasonably interfered with...ability to work" Prescott v. Higgins, 538 F.3d 32, 42 (1st Cir. 2008); Faragher 524 U.S. at 787-88; RBr p. 39¶1.

Enough to warrant a lawyer Dkt 121-1 p.59, 60 or use for "retaliatory work assignments"³⁰ Dkt 97-2 pp. 60, 61; Adm p.39¶5; Dkt 90 p.12. So judgment was entered improperly." RBr pp. 40¶2, 44¶3.

Biased employers rarely say "I review negatively because I discriminate." They could write she "speaks beautifully, but English is not her first language...[h]er verbal and written communication is often awkward...to the point where comprehension is difficult" Dkts 85-3 p.7; 97-11; Adm p.43¶3,4

Or, inject drug addiction Dkt 121-1 p. 26; 101-8; 85-3 p.14 and attack mental ability through residency Dkts 97-7 p.8¶17; 121-2 pp.18-22; 97-3 p.28 at 103-104; Adm p.50¶3; ER60 p.12-14.

"[N]one of us believe...you have...ability to do...medicine...you are dangerous." n.37 infra cf. Dkt 124-2 pp.81,86

"She should...consider...formal testing to explore the 'disconnect' between what she 'knows' and how she practices. This may represent a learning disability, an anxiety disorder, or both" cf. Dkts 97-6 p.34; 91 p.3¶3

Or, assign patients during time restricted for education Dkts 121-1 pp.77, 34 Id., and spectate abuse Id; Dkt 124-2 p.73-79; 121-1 p.74; 91 p.8¶3. UMass's Moron typo shifted from doubtful Dkt

³⁰ See nn. 34, 20, 19, 17

12p.6¶3 to "an unfortunate mistake...[the coordinator] apologized for." Dkt 121-1 p.34. To who?

UMass failed to take action cf. Ellerth, 524 U.S. at 751 and withheld requested discovery Dkts 91p.5¶4; 93 p.7¶1; 90 pp.5,12; knowing that Dr. Lu and Dr. Khan saw Dr. Morin receiving the Liar text Id., RBr p.43 n. 13; 50-1 p.13¶37;.

Ms. Banigo's Fed. R. Evid 803 remark of unprecedented overt racism³¹ RBr p.45 n. 15; Dkts 85-3 p. 7¶3; 50-1 p.19¶47 corroborates unprecedented hostility towards Dr. Morin Dkt 97-3 at 30 p.112 (7-14); reversal of summary judgment for hostile bias towards Mr. Martin Dkt 50-1 p. 18¶47 Id and; liability of the same Id., towards Dr. Sun (who sought an order for UMass to hire women of color) Id. Dr. Quiros and Dr. Rung recognized race issues Dkts 124-2 p.68 & 71¶3; 97-2 p. 49(3).

As with the chart of bias RBr p.32 n.10, UMass conveyed that Dr. Morin made up the mistreatment Dkt 121-1 p.34. Labor in FMIS, one IM block 121-1 p.61 Id; license ineligibility Dkt 93-2; years of joblessness and family emotional distress with demise Dkts 124-2 pp. 55-60; 13-4; 107-1; 107-4; 107-6; 52; 52-1; 77; 46-1; ER60 p.12 at 280(1-15).

3. Race & National Discrimination

UMass: "...no direct evidence of racial or national discrimination... required to prove...claims...with the McDonnell

³¹ Ms. Banigo filed an administrative report UMass failed to produce or rebut.

Douglas burden-shifting framework RBr p.23¶2. "not performing...at...a level that rules out...job performance" RBr p.24¶1...no evidence...the University...replace her with a similarly qualified resident RBr p.24 n.6... "acknowledges ...supervisors" repeated concerns about performance ...from August 2003" RBr pp.25 n.7 26 ¶1;

"needed to: demonstrate...dismissal was (i)...motivated by discrimination than...the explanation...or (ii) ...explanation was unworthy of credence in circumstances where the suspect denial...together with other facts, suggests a motivation... to prove...discriminatory animus" RBr p. 26¶2-27...claims have nothing to do with...acceptance to the program RBr p.27 n.8 (See n.28 supra).

Conversely, FHC was "behaving irrationally [and] discriminatorily" ER60 p.2-3 1d;³² threatening to fire and not license Dr. Morin Dkt 97-7 p. 10¶21³³ with unfair communication reviews Dkts 97-11; 13-10. The court censored this direct evidence of discrimination and pretext to pass judgment ER60 p.2; 21¶2; Dkt 124-1 p.7. The reviews were "unworthy of credence; circumstances" suggested retaliation Dkts 97-7 p.10¶21 RBr pp. 23¶2, 26¶2-27.

FHC failed Dr. Morin's CCU skills cf. Dkts 21 p.5¶3; 121-2 p.22; 124-2 p.80; 121-1 p.41-43 124-2 p.81. When PGY3 calls Dkt 124-2 p.82 inferred she: met or exceeded PGY2 expectations and; "was performing...at a level that rules out the possibility...[she] was fired for job performance" RBr p.24 when Dr. Rosetti, a

³² See Br at 21-24; Dkt 121-2 p. 18; Dkt 120-2 at 2

³³ The false speech review, created after threats to fire Dr. Morin after rehire RBr at 26 ¶2 was "more likely motivated by retaliation than the reason offered "

similarly qualified doctor Dkt 124-2 p.83, replaced her RBr p. 24 n.6; supra p. 24 n.28. See Benoit, 331 F.3d at 173.

Contrary to UMass RBr pp. 24¶2, 26¶1 experts like Dr. Manno & Dr. Greenberg observed 'a dedicated physician' with 'wonderful communication skills' Dkt 121-1 pp.5, 9; supra p.20 around August 2003. So outstanding performance Dkt 13-12; 43 at 5 did not stop UMass labelling the Plaintiff 'dangerous' or rescinding residency. It assured patients until August 2004 Dkt 97-2 p.13.

³⁴ Experts were surprised and recommended Dr. Morin as smart after the dismissal Dkts 121-1 p.17; 124-2 at 81.

Each concern was raised and controverted to show it was inadmissible evidence RBr p.25 n7. False and shifting explanations e.g., Dkt 85-1 permit a jury to infer unlawful motives. See St. Mary's Honor Ctr. v. Hicks, 509 U.S. 502, 511 (1993); Adm p.35. The court and UMass contradicted Appeal Panel findings Dkt 97-2 p.60 to claim that remediation³⁵ was beneficial Br p.31; ER60 pp.8-9 and Dr. Gundersen met "monthly with Claire" Dkt 121-1 p.57; Br p.34.

UMass changed stance about the email Dkt 21 pp.3¶2,11¶2

³⁴ The 2004 decision Br p.21, scheduled (14) FMIS blocks with FHC doctors who fired Dr. Morin as a student Dkt 121-2 p.22. She passed (8) FMIS rotations Dkts 121-1 pp.80, 81; 43 at 18 before the 1st dismissal. Peers graduate with (7) FMIS blocks. It follows under equal protection & due process the 2006, FMIS dismissal is void & pretextual, RBr p.31 n. 9

³⁵Highly probative for race bias. All blacks remediated.

"It is possible...I did say...I hoped or wanted "residents of color to shine" because I believe they can be wonderful role models." "Blacks have to work twice as hard as whites." Dkts 97-7 p.8¶17; 124-1p.5¶2

The court opined "Dr. Morin seems to interpret Dr. Candib... would only consider minority...to be successful once they... outperformed non-minorities that...is at odds with the statement...which...appears to express only a desire to see minority...succeed," Dkt 112 p.19¶2 cf. "we strove to find ways of helping you...succeed."³⁶ Adm p.50¶4 "We try to help minorities."

What evidence shows 'they' do not succeed Adm p.55¶3?

UMass "asks the court to assume that statements" or incidents by non-decision-makers diminish over time and "are irrelevant to evaluating...discriminatory animus of the decision-maker" RBr pp.38, 45 n.14; Dkts 97 p.10¶1; Dkts 112 p.19¶2.

Making this inference "in the defendant's favor, disregards Liberty Lobby³⁷...seems...based on an untenable assumption about human behavior. Labeling discriminatory remarks...outside...the decision making process as "stray"...not probative...seems to assume...attitudes...in...statements...changed...between when... statements were made and...the adverse employment decision...made." ³⁸ (citation omitted)

Conversely, "a jury [can] conclude that an evaluation at any level, if based on discrimination, influenced the decision making process and...allowed discrimination to infect the ultimate decision." Roebuck v. Drexel University, 852F.2d 715, 727 (3rd Cir. 1988); Santiago-Ramos v. Centennial P.R. Wireless Corp., 217 F.3d 46, 55 (1st Cir. 2000); Br p.23 n29; Dkts 120-2 p.2; 124 p.6 cf. Adm p.51¶4. "Decisions are not made in a vacuum, and discriminatory remarks by a non-decision-maker can and do influence decision-makers."³⁹

³⁶ See the Br Adm, item (4) after Dkt 120-2

³⁷ "[D]rawing...legitimate inferences from facts are jury function, not those of a judge" 477 U.S. (1986) at 255

³⁸ Generally, Lawton, *The Meritocracy Myth and the Illusion of Equal Employment Opportunity*, 85 Minn. L. Rev. 587 (2000); McGinley, *¡Viva La Evolucion! Recognizing Unconscious Motive in Title VII*, 9 Cornell J. L. & Pub. Policy 415 (2000);

³⁹ Ercegovich v. Goodyear Tire & Rubber Co., 154 F.3d 344, 354-55 (6th Cir. 1998) non-decision makers with "a meaningful role" in firing a plaintiff are relevant cf. Dkt 97-7 at 10¶21; Russell v. McKinney Hosp. Venture, 235 F.3d 219, 226 (5th Cir. 2000) Dkt 120-2 at 2; Griffin v. Washington Convention Ctr. 142 F.3d

Racial profiling killed the Plaintiff's career under provisions for criminal conduct with no evidence whatsoever. As a matter of law stray remarks are drawn in the non-movant's favor at summary judgment.

CONCLUSION

Br pp. 10, 40-41 and ER60 p.17 are incorporated here.

Respectfully submitted July 29, 2013.

/s/ Claire Morin MD,

Pro Se Litigant

CERTIFICATE OF COMPLIANCE

I certify, in accord with Fed. R. App. P. 32(a)(7)(C), that the foregoing response exclusive of the sections listed in Rule 32(a)(7)(B)(iii), contains 6262 words as calculated by Microsoft 8 (Word) from Introduction to Conclusion

/s/ Claire Morin

CERTIFICATE OF SERVICE

I, Claire Morin certify that this document was served today on the University's Counsel Ms. Denise Barton Esq. 333 South Street Fourth Floor Shrewsbury MA 01545 through the CM/ECF electronic filing system of the United States Court of Appeals for the First Circuit.

/s/ Claire Morin

ADDENDUM

1. Baldwin, Daugherty & Rowley : Racial and ethnic.....63
discrimination during residency: results of a national survey

1308, 1312 (D.C. Cir. 1998) bias from a subordinate "is relevant where...decision maker is not insulated from" his/her influence cf. Dkts 121-2 at 5 & communication in Dkts 97-11; 97-2 at 73¶1; 121-1 p.71; 97-1 at 2.

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4. Desbiens & Vidaillet: Discrimination against.....	55
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selection process BMC Med Educ, 2010:10:5	
5. Hood: Confronting racial and ethnic.....	66
disparities in health care Acad. Med. 2001:76 (6) 584-5	
6. Nasir: Evidence of discrimination against.....	60
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residency programs Fam Med. 1994 Nov-Dec; 26(10):625-9	
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Medical Graduates JAMA 1991; 266 (7): 956-8	

UMass asks the 1st Circuit to contradict Supreme Court judgments in Burdine; Cleveland Bd. Of Educ. V. Loudermill; Ellerth; Ewing; Faragher; Hunt v. Cromartie; Liberty Lobby; Pearson v. Callahan; Prescott and Reid v. Google Inc., (to name a few) as well as ACGME policies for its doctors, as the district court did. When: (i) no objective evidence bars Dr. Morin from employment; (ii) UMass did not evaluate the alleged incriminating disability (inconsistency and poor communication) and; (iii) conceals evidence that could prove it racially profiled Dr. Morin.

UMass censored reviews searched and 'forgot' an email that linked race to poor performance. When it explains why UMass only fired minorities and made all black doctors remediate. UMass discriminates against minorities. They cope in various ways. Drs. James and Morin transformed adverse circumstances into opportunities to excel Dkt 124-2 p.84; Adm pp.52¶5, 53. Dr.

Alhabaal advised playing down skills to placate supervisors. Dr. James would cry with frustration, buy coffee for Dr. Candib or Dr. Kedian and urge, "Claire perm your hair, look white" cf. Adm p.51¶6. People have died so we can be authentic and live abundantly

"How is it possible...that the proportion of African American physicians to African Americans in the U.S. population is now actually lower than it was in 1910?⁴⁰

"Discrimination occurs as a result of the tension created by the need for diversity and its resistance from individuals who refuse to address this need." Adm p.45¶4.

Experience shows its bark and actions are strong only because of tolerance from very high and low places. What!! You said the 'D' word, want to graduate? Bias is a rite of passage that does not go away. In 2005 the Massachusetts Medical Society (MMS) Committee on Ethnic Diversity and Harvard Dept. of Social Medicine studied "Workplace Discrimination: Experiences of Practicing Physicians and confirmed, Adm p.45¶3-5

"discrimination among physicians in ...Massachusetts...future research should...characterize[] ...specific areas of discrimination for certain subgroups of physicians [Dr. Morin, female, non-white & IMG proposed this case, herself and individual defendants as resources, Dkts 50; 75]. This will bring the MMS closer to putting an end to discrimination in the 21st century."

"[w]e are facing a U.S. population that is becoming more...diverse each day [Dkt 105-6 p.14]...issues of equality, justice and cultural competence will become...more important." "We are at a crossroads for the healthcare

⁴⁰Steinecke & Terrell: Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States. Acad Med. 2010: 85 (2): 236-245, p. 237¶2.

workforce, and addressing...discrimination is both a priority and a necessity for the development of the American healthcare system."

"This study [and case are mutually supportive]...in providing...evidence and...education in the area of discrimination that would support institutional changes to address workplace discrimination."

IMG: "Physicians...from a medical program outside...are more likely to experience all forms of discrimination compared to physicians...trained in this country" Adm p.39¶5.

"Over 60% of respondents (regardless of their own personal characteristics) believed discrimination against IMGs was very or somewhat significant" Adm p.39¶4; 44% of USMGs respondents also believed this Adm p.40¶4 cf. Adm p.57¶2; Dr. Rung.

"Fifty two percent of those reporting an incident of discrimination were "not satisfied" with the organization's response...almost 19% said the situation worsened Adm p.41¶2; Dkt 91 p.8¶3; Br p.21¶2

"The language barrier, both nonverbal as well as verbal communications, poses a significant threat to the patient-physician relationship Adm p.43¶3." and UMass stereotyped Dr. Morin unfairly Dkts 97-11; 97-1 p.2; 13-10

Other responses: "I was not fairly considered for promotion...was rated lower than I deserved" Adm p.43¶5; Br p.18¶2; Dkt 121-1 p.18, correlate.

Non-white: "Discrimination...of race is most often experienced in the form of career obstacles and disrespectful or punitive actions" Adm p.39¶5; Inter alia Dkts 50; 50-1; 52, 52-1; 77; 101-8 p.2; 121-1 p.59,60; Liar, Moron, cheating on exams query

"[L]iterature has supported the presence of discrimination ...in academic institutions with...denied opportunities in postgraduate training programs for black...residents," Adm p.37¶3.

"Non-whites...were more likely to report that discrimination ...was significant...almost 29% of white respondents also believed...that such discrimination was very or somewhat significant" Adm p.40¶7; Dkt 97-2 p.49(3)

Female: "Women were more likely...to have brought a complaint of discrimination...[and reported] a worsening situation following the complaint" Adm p.41¶3.E

Contrary to the court and UMass RBr p.54; Br pp. 33-38 a reasonable jury could infer discriminatory animus from:

- (1) the subjective criteria overruling experts
- (2) false explanations for remediation, demotion, termination, licensing board, EEOC & court;
- (3) inconsistent, contradicting or shifting explanations for disability, speech, drug tests & Dr. Candib's email;
- (4) deviations from normal...procedures, e.g., failing to change clinics readily. See Wheeler v. BNSF No. 10-3155 p.9¶2.
- (5) the consistency in all the documents Dr. Morin submitted since 2003 and fact that she proved allegations in Dkts 17 and 50 except for evidence UMass withheld.

Open tolerance lowers awareness to this critical issue that could account in part, for the US's humble health indices. That generally trail behind most developed nations. Dr. Morin respectfully asks that the status and influence of physicians in high places that affected district court rulings succumb to this Courts overarching goal of justice. That upholds, inter alia that blacks have a right to evidence and life if they question discrimination.

Workplace Discrimination: Experiences of Practicing Physicians

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Alice A. Tolbert Coombs, MD and Roderick K. King, MD, MPH
Boston, Massachusetts

Background: In response to a growing concern regarding physician discrimination in the workplace, this study was developed to: 1) describe the types of discrimination that exist for the practicing physician and 2) determine which groups of physicians are more likely to experience the various forms of discrimination.

Methods: Surveys were mailed to 1,930 practicing physicians in Massachusetts. Participants were asked if they had encountered discrimination, how significant the discrimination was against a specific group, the frequency of personal discrimination, and the type of discrimination. Factor analysis identified four types of discrimination: career advancement, punitive behaviors, practice barriers and hiring barriers.

Results: A total of 445 responses were received (a 24% response rate). Sixty-three percent of responding physicians had experienced some form of discrimination. Respondents were women (46%), racial/ethnic minorities (42%) and international medical graduates (IMGs) (40%). In addition, 26% of those classified as white were also IMGs. Over 60% of respondents believed discrimination against IMGs was very or somewhat significant.

Almost 27% of males acknowledged that gender bias against females was very or somewhat significant. IMGs were more likely to indicate that discrimination against IMGs was significant in their current organization. Of U.S. medical graduates (USMGs) 44% reported that discrimination against IMGs in their current organization was significant.

Nonwhites were more likely to report that discrimination based on race/ethnicity was significant. Nearly 29% of white respondents also believed that such discrimination was very or somewhat significant.

Conclusions: Physicians practicing in academic, research, and private practice sectors experience discrimination based on gender, ethnic/racial, and IMG status.

Key words: cultural competence ■ healthcare workforce ■ physician discrimination

BACKGROUND

As the country begins to develop a more diversified workforce, discrimination in the workplace has become an ever-increasing challenge. In particular, the physician workforce practicing medicine over the past two decades has changed significantly. From 1992 to 2002, there was a 15% (5,543/15,356 compared to 6,823/15,778) increase in women graduating from medical school. In 1992, 8% (1,233/15,356) of the graduating medical class was considered an underrepresented ethnic/racial minority, and 0.9% (135/15,356) of medical graduates had a birthplace outside the United States.¹ The 2001 U.S. graduating medical school class was represented by 44% (6,823/15,778) women, 10.6% (1,680/15,778) underrepresented ethnic racial minority, 11% (1,680/15,778) underrepresented racial minority, and 9.1% (143/15,778) were medical graduates born outside the United States.¹

There are a number of survey investigations that describe discrimination of medical students and physicians at various levels: graduate and postgraduate educational training.²⁻⁹ Only a few studies, however, examine the significance and impact of discriminatory practices on practicing physicians. In this study, workplace is defined as the organizational or occupational setting where medicine is practiced, researched or instructed by physicians who have completed postgraduate training.

There are several challenges of examining discrimination in the workplace. First, discrimination toward an individual is a subjective experience and is based upon the perception of one or more individuals. Although subjective experiences cannot be minimized, it poses a challenge when trying to quantify using traditional tools of scientific investigation. Second, discrimination may be intermittent or pervasive, subtle or overt—again, making it difficult to quantify or monitor. Given that the purpose of this study was to document the presence of discrimination by practicing physicians in Massachusetts, the focus was on documenting the presence or absence

© 2005. From the Department of Social Medicine, Harvard Medical School (King, instructor), Massachusetts Medical Society Committee on Ethnic Diversity, Massachusetts Medical Society, and the Committee on Ethnic Diversity. Send correspondence and reprint requests for J Natl Med Assoc. 2005; 97:467-477 to: Alice A. Tolbert Coombs, MD, South Shore Hospital, 55 Fogg Road, South Weymouth, MA 02190; phone: (781) 682-5445, (781) 337-4224; e-mail: alice-coombs@comcast.net

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of said discrimination as well as the contributing environmental factors. Regardless, these types of discriminatory practices can create an unequal two-tier promotional system as well as decrease job satisfaction and ultimately affect patient care.¹⁰⁻¹² As described by Rothenberg, “The perception of discrimination or unequal opportunity in one’s workplace seems to exact a toll on workers’ attitudes, behavior and productivity—whether or not their perception would be found to have an objective basis.”¹²

The issue of discrimination against women in medicine has focused on gender bias, sexual harassment and “gender-fair” environments.¹³ Although the majority of the studies were done with medical students and residents, it is clear that sexual harassment does occur and creates a “hostile learning and work environment.”¹⁴ Many medical schools and training institutions are grappling with this issue and the adverse effects it may have on medical education and patient care.

In the case of physicians who comprise the racial/ethnic minority group, the literature has supported the presence of discrimination for several years in academic institutions with faculty promotions as well as denied opportunities in postgraduate training programs for black, Hispanic and Native-American residents.^{2,7,9,15} Data on discrimination for

practicing physicians and their overall occupational impact, however, are still sparse.

Similarly, even fewer studies have alluded to discrimination for international medical graduates (IMGs). With respect to residency selection, Nasir revealed “a pattern of dissimilarity” with the dissemination of postgraduate training information for IMGs applying for training.¹⁶ However, studies regarding the perceived discrimination of IMGs in medical practice and its impact on their careers are even more scarce. The complexities of investigating discrimination issues confronting IMG physicians introduce several limitations to this study. The issues that confront the IMG physician born in the United States (US-IMG) vs. the IMG physician born outside of the United States pose different cultural challenges in the practice of medicine.

In 2000, the Massachusetts Medical Society (MMS) conducted a survey of licensed physicians in Massachusetts to document issues of discrimination that affect physicians in the workplace. While all types of discrimination were addressed in the survey, an emphasis was placed on issues of discrimination that affect women, racial/ethnic minority physicians and IMGs.

To address some of these issues, physicians practicing in Massachusetts were asked about their expe-

Table 1.

Ever Experienced by Female Physicians	Percent
1. My pay and/or benefits were not equivalent to my peers at my level.	39.8%
2. I was not included in administrative decision-making.	29.3%
3. I was treated with disrespect by nursing or other support staff.	28.8%
4. I was held to a higher standard of performance than my peers.	26.2%
5. I was not fairly considered for a promotion or senior management.	21.5%

Table 2.

Ever Experienced by IMGs	Percent
1. I had difficulty getting job interviews.	38.1%
2. I was held to a higher standard of performance than my peers.	31.5%
3. My pay and/or benefits were not equivalent to my peers at my level.	28.0%
4. I was not included in administrative decision-making.	24.4%
5. I was not fairly considered for a promotion or senior management.	23.2%

periences of discrimination. The goal was to assess the types, sources and adverse outcomes of perceived discrimination with respect to career advancement obstacles, punitive/disrespectful actions, hiring obstacles and practice barriers. The Committee on Ethnic Diversity of the MMS developed the study to help assess the extent of the problem and to help design potential solutions to improve the workplace for practicing physicians.

METHODOLOGY

In January 2000, MMS conducted a survey of licensed physicians in Massachusetts to gather information regarding issues of discrimination that affect physicians in the workplace. The MMS Committee on Ethnic Diversity (CED) worked with a research firm to conduct focus groups and develop a survey instrument, which was sent to member and non-member physicians, including IMGs, women and racial/ethnic minorities.

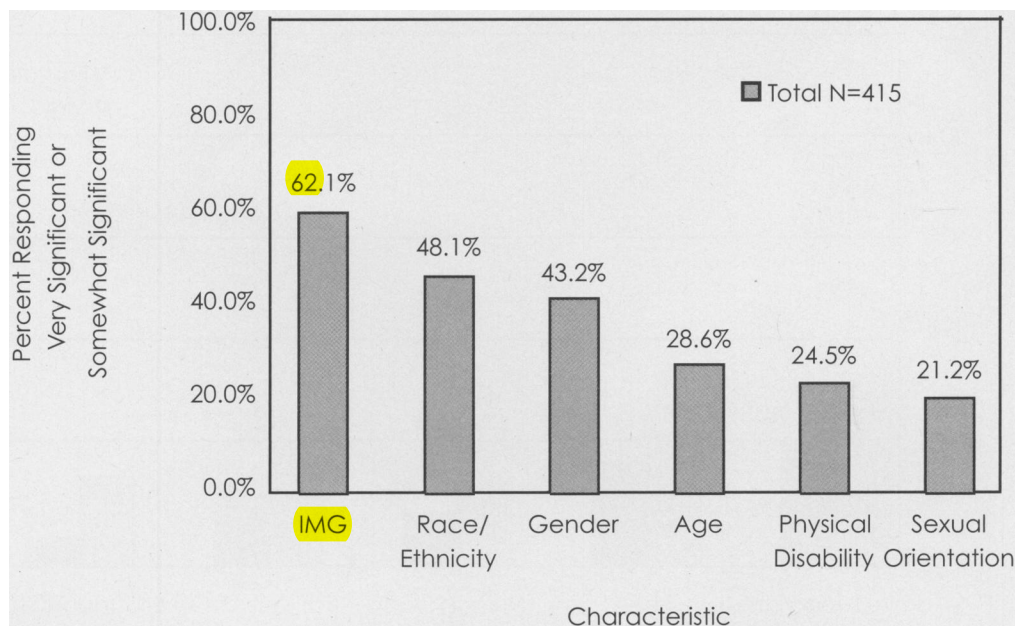
Survey Instrument

Input to the survey design and content was obtained through an expansive literature review of physician discrimination studies. In Phase I, the CED worked with the firm, John Snow Inc., to conduct informal focus groups of MMS physicians for the purpose of framing discriminatory issues and practices that would assist in the development of the survey instrument. A mailing list of 2,011 names with

an oversampling of racial/ethnic minority and IMGs was compiled by MMS. In addition, The New England Medical Society's database was utilized. The sample was not developed from the universe of all practicing physicians but from a more selective list of physicians. Following removal of duplicate names⁵⁶ and names without complete addresses,²⁵ a final list of 1,867 physicians remained. Two mailings were sent to obtain the best sample population, with ethnic/racial, female and IMG oversampling. (The eligible physician population practicing in Massachusetts was approximately 21,000 physicians; the total number of licensed physicians in 2000–2001, including residents, was approximately 27,000.)

The survey was distributed to a sample of physicians (not in training) across various specialties and practice settings in Massachusetts. The discrimination survey was designed to gather information about the significance, frequency and the types of discrimination in the physician's workplace. Physicians were asked if, in the current work setting, discrimination (based on gender, race/ethnicity, IMG status, age, physical ability, sexual orientation) was very significant, somewhat significant, not significant or not applicable. Respondents were asked to describe ways in which they experienced discrimination in the preceding 12 months or any time following completion of training (but longer than 12 months) and to evaluate on which personal characteristic(s) the discrimination was based.

Figure 1. In Your Current Work Setting, How Significant Is Discrimination against Physicians because of the Following Characteristics? ("Not Applicable" Responses Excluded)



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RESULTS

A total of 445 responses were received from an eligible sample of 1,867 physicians (24% response rate). Of 445 respondents, the breakdown was as follows: 53.6% male, 46.4% female, 59.3% (263) U.S. graduates (USMGs) and 40.5% (179) IMGs.

The race or ethnicity categories taken from the Office of Management and Budget Federal Standard¹⁵ were as follows: white, black/African-American (not Hispanic), Hispanic, American Indian/Eskimo/Aleut, Asian/Pacific Islander and other. The distribution of respondents (442 total) answering the question, "What do you consider yourself to be?" was as follows: 57.7% (255) white, 12.9% (57) black/African-American (not Hispanic), 7.0% (31) Hispanic, 0.5% (2) American Indian/Eskimo/Aleut, 19.2% (85) Asian/Pacific Islander, and 2.7% (12) other. In addition, 26% of those classified as white were also IMGs. English was the first language for 28.3%. Of those responding, 39.4% worked with their current organizations for longer than 10 years, while 38.55% practiced for less than five years.

Physicians were well represented from all practice settings: 25.1% (109) private practice; 6% (26) group or staff model HMO; 6.7% (29) community health center; 16.4% (71) solo practice; 30.2% (131) hospital-based practice; and 2.7% academic research and other unspecified practices.

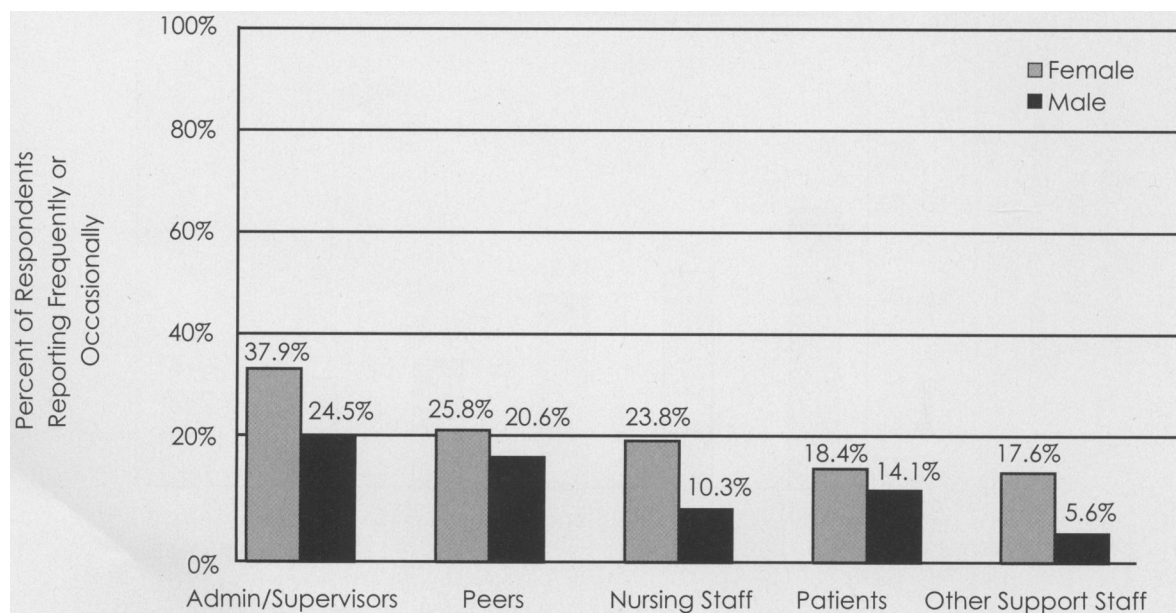
All respondents, regardless of their own personal characteristics, were asked how significant they believed discrimination was in their current organi-

zations against specific groups. Over 60% of respondents believed discrimination against IMGs was very or somewhat significant. Similarly, racial or gender discrimination was noted by a large proportion of survey respondents, 48.1% and 43.2% respectively, at a very or somewhat significant extent in their current work setting.

The methodology uncovered the underlying relationships among the events that physicians have experienced. For example, of the responding physicians, 63% experienced some form of discrimination, and the majority experienced more than one form of discrimination (Figure 1). Results of logistic regression analysis indicated the following:

- Discrimination based on gender clearly takes the form of career advancement obstacles and disrespectful/punitive actions.
- Females are almost five times more likely than male physicians to experience career advancement obstacles and more than three times more likely to experience disrespectful/punitive actions.
- Discrimination on the basis of race is most often experienced in the form of career obstacles and disrespectful or punitive actions, and to a lesser degree in hiring obstacles and practice barriers.
- Physicians who graduate from a medical program outside of the United States are more likely to experience all forms of discrimination compared to physicians who are trained in this country.

Figure 2. How Often Do You Feel Discriminated against by the Following Groups?



Surveyed physicians were also asked to report how often they personally felt discriminated against by various groups. Respondents were most likely to report being discriminated against either frequently or occasionally by administrators/supervisors [30.6% (128)], followed by peers [22.8% (96)], nursing staff [16.4% (68)], patients [16.0% (66)], and other support staff [11.1% (45)]. In addition, 3.4% (15) of surveyed physicians identified discrimination based upon sexual orientation.

Gender Discrimination

A total of 191 (46.4%) of survey respondents were female physicians. As displayed by the next chart, women were significantly more likely than men to report feeling gender discrimination and discriminated against by administrators/supervisors (Figure 2). However, almost 27% of males did acknowledge that gender bias was very or somewhat significant.

Female physicians were significantly more likely than males to have experienced at least one form of discrimination in the past 12 months (51.3% vs. 31.2%). In addition, women were more likely than men to have brought a complaint of discrimination to their organization (15.2% vs. 8.2%). Satisfaction levels with the organizational response did not significantly differ. However, females were more likely to report a worsening situation following the complaint than were males (27.6% vs. 5.6%). In Table 1, all responses except number 4 were statistically higher for female physicians than for males.

International Medical Graduate Discrimination

A total of 168 (40.8%) survey respondents were IMGs. IMGs when compared to USMGs were more likely to indicate that discrimination against IMGs was significant in their current organizations. However, 44% of USMGs reported that discrimination against IMGs in their current organizations was very or somewhat significant.

While IMGs (42.3%) were more likely than USMGs (38.9%) to have experienced at least one type of discrimination in the past 12 months, the difference was not statistically significant. In Table 2, response numbers 1, 3 and 5 were statistically higher for IMGs when compared to USMGs.

Race/Ethnicity Discrimination

A total of 168 (40.9%) survey respondents classified themselves as a racial or ethnic minority. The respondent racial/ethnic categories employed (standard racial and ethnic categories used by the U.S. Bureau of the Census) were as follows: white (non-Hispanic), black/African-American, Hispanic, American Indian/Eskimo/Aleut, Asian/Pacific Islander and other.

Nonwhites when compared to white physicians were more likely to report that discrimination based on race/ethnicity was significant in their current organizations. However, almost 29% of white respondents also believed that such discrimination was very or somewhat significant. Nonwhites were statistically more likely than whites to have experienced at least one type of discrimination in their organization (14.3% vs. 9.9%). There was not a statistical difference in satisfaction with how the complaint was handled by the organizations. However, nonwhites were more likely to find no change in their situation following the complaint (62.5% vs. 37.5%).

In Table 3, all but response number 2 were statistically higher than for whites. Because the percentage of IMGs within the nonwhite respondents was high, it is more relevant to look at the top five responses for nonwhites excluding IMGs.

Occurrence of Discrimination

Physicians were asked to indicate whether they had experienced any of 30 different types of discrimination either in the past 12 months or at any other time since completing residency (Figure 3). Among all survey respondents, 190 (42.7%) had

Table 3.

Ever Experienced by Nonwhites (IMGs Excluded)	Percent
1. I was treated with disrespect by nursing or other support staff.	40.9%
2. My pay and/or benefits were not equivalent to my peers at my level.	36.4%
3. I was held to a higher standard of performance than my peers.	33.3%
4. I was treated as if I was invisible by supervisors.	31.8%
5. I was not included in administrative decision-making.	28.8%

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experienced at least one of the 30 listed types of discrimination in the past 12 months. Significant differences were observed between the proportion of females vs. males and the proportion of nonwhite vs. white respondents who experienced discrimination in the past 12 months. The percentage of IMGs who experienced discrimination in the past 12 months was also higher than for USMGs, although this dif-

ference was not statistically significant.

Fifty survey respondents (11.3%) indicated that they had ever reported an incident of discrimination to someone in their organization. Fifty-two percent of those reporting an incident of discrimination were "not satisfied" with the organization's response (Figure 4). When asked how the situation changed as a result of the report, less than one-third said the situation improved, while almost 19% said the situation worsened (Figure 5).

Women were more likely than men to have brought a complaint of discrimination to their organization (14.6% vs. 8.1%). Women were also more likely to report a worsening situation following the complaint than were males (26.7% vs. 5.3%). Nonwhites were more likely than whites to have brought a complaint of discrimination to their organization (13.9% vs. 9.4%). Nonwhites were also more likely to find no change in their situation following the complaint (65.4% vs. 37.5%).

Table 4. Respondent Practice and Age Characteristics Chart

Respondent Characteristics (N=415)

Age (Years)

29–35	39 (8.9%)
36–45	141 (32.2%)
46–55	141 (32.2%)
56–65	89 (20.3%)
65+	28 (6.4%)

Specialty

General practice	7 (1.6%)
Family practice	16 (3.6%)
General internal medicine	90 (20.4%)
Internal medicine subspecialty	82 (18.6%)
Pediatrics	67 (15.2%)
Obstetrics/gynecology	34 (7.7%)
General surgery	15 (3.4%)
Surgical specialty	28 (6.3%)
Psychiatry	30 (6.8%)
Emergency room	14 (3.1%)
Anesthesiology	24 (5.4%)
Radiology	13 (2.9%)
Other	21 (4.8%)

Main Practice Setting

Private group practice	109 (25.2%)
Group or staff-model HMO	26 (6.0%)
Community health center	29 (6.7%)
Solo practice	71 (16.4%)
Hospital-based practice	131 (30.2%)
Academic/research	55 (12.7%)
Other	13 (3.0%)

* Not all respondents specified in categories so total numbers do not equal to 100%

Table 5. Respondent Gender Distribution Chart

Females by IMG Status

USMGs	145 (71.8%)
IMGs	57 (28.2%)

Females by Race

White	133 (65.5%)
Black/African-American	31 (15.3%)
Hispanic	5 (2.5%)
American Indian/Eskimo/Aleut	2 (1.0%)
Asian/Pacific Islander	27 (13.3%)
Other	5 (2.5%)

Table 6. Respondent Racial/Ethnicity Distribution Chart

White	255 (57.7%)
Black/African-American	57 (12.9%)
Hispanic	31 (7.0%)
American Indian/Eskimo/Aleut	2 (0.5%)
Asian/Pacific Islander	85 (19.2%)
Other (mostly mixed race)	12 (2.7%)

Table 7. Respondent Racial/Ethnicity (Nonwhite) Gender/IMG Status Distribution Chart

Nonwhite by Gender

Male	115 (62.2%)
Female	70 (37.8%)

Nonwhite by IMG Status

USMGs	67 (40.6%)
IMGs	111 (59.4%)

Table 8. Respondent IMG Distribution Chart

IMGs by Gender

Male	119 (67.6%)
Female	57 (32.4%)

IMGs' Race

White	67 (37.6%)
Black/African-American	11 (6.7%)
Hispanic	18 (11.2%)
American Indian/Eskimo/Aleut	1 (0.6%)
Asian/Pacific Islander	70 (39.3%)
Other	8 (4.5%)

The data and comments provided by respondents to the survey provided quantitative and qualitative evidence of perceived discrimination by physicians in the workplace.

Organizational Response to Complaints

Fifty survey respondents (11.3%) indicated that they had ever reported an incident of discrimination to someone in their organization. Among those reporting an incident, only 10% were "very satisfied" with the organization's response. Another 38% were "somewhat satisfied," and 52% were "not satisfied" (Figure 4). When asked how the situation changed as a result of the report, more than 30% said the situation improved, less than 20% said the situation worsened and 50% said there was no significant change.

DISCUSSION

Presence of Discrimination among Physicians in Massachusetts

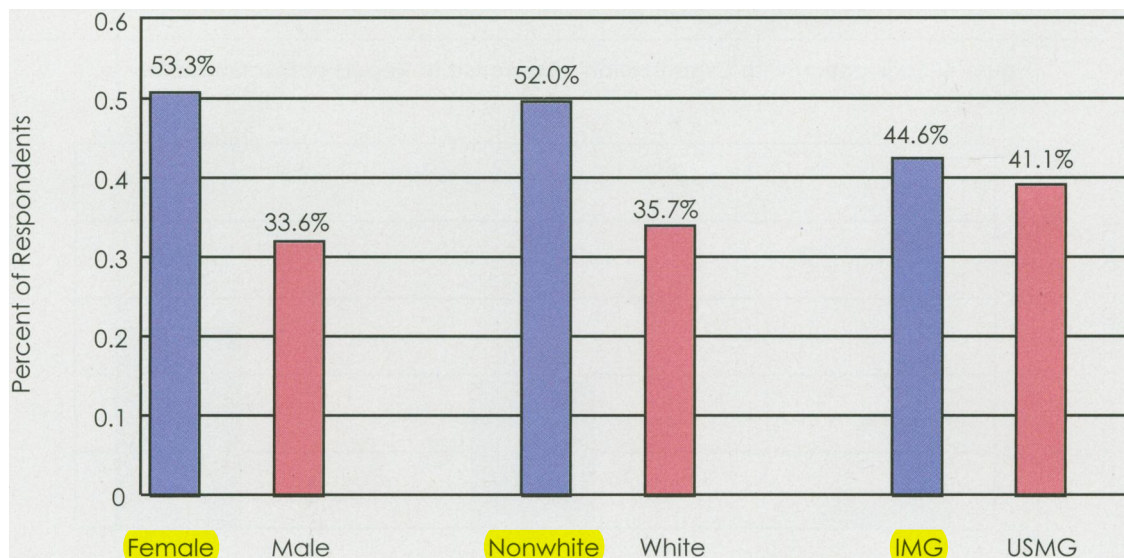
Research exploring discrimination in medicine has focused on confirming the existence of discrimination through survey instruments with little investigation as to the nature of discrimination for specific physician subsets. Lenhart et al. surveyed Massachusetts members of the American Medical Women's Association in which 27% experienced sexual harassment and 24% acknowledged discrimination related to parenthood.¹⁶ While this study noted that women in private practice (compared to aca-

demic) observed less discrimination in the form of sexual harassment (22%), the survey respondents were 89% white. The demographics of the present study lends itself to a more diverse physician population examining gender, racial/ethnic, IMG status and practice setting, and their impact on specific measurable, perceived outcomes (i.e., compensation, hiring, etc.). Identifiable elements of discrimination were categorized: career advancement, punitive behaviors, and practice and hiring barriers. Of these categories, the major focus of discrimination research in this country has been mainly on punitive and disrespectful actions, concentrating mainly on physicians in training.

Gender Discrimination

Canadian female surgeons were surveyed in a study by Ferris et al., which revealed that more than 50% of the female physicians reported discriminatory actions from male staff attending.²⁸ In spite of this, only 17% of respondents indicated that they felt that discrimination hindered their career advancement. This differs from others studies. Areas of discrimination included lack of promotion, failure in decision-making processes, inadequate research time allocation and deficiency in mentoring. Several investigations¹³⁻¹⁵ have disclosed that the determinant of career structure and advancement involve marital status, childbearing history, age when the physician started working and academic vs. private practice. The impact of age, specialties, practice setting and medical environment (fee-for-service vs. managed care) on gender-fair environments cannot be underes-

Figure 3. Experienced Discrimination in Past 12 Months



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timated.^{13,15,28} Limitations of this study included lack of assessment of childbearing status and marital status and the perceived effect on career advancement.

The practice setting proved to be important in terms of career advancement in gender discrimination. Previous surveys have confirmed the perception that female physicians are less likely than their male counterparts to be promoted as professor.^{34,35} Salary information has been scrutinized only to demonstrate that women faculty's income is less than their male counterparts for a comparable academic rank.^{27,34,37} Both the changing climate of medicine and the evolution of an increasingly managed care environment have contributed to women having less hiring barriers in order to meet the manpower needs in medicine.^{10,11}

Table 9. Additional Sample Demographics

White males, U.S. graduates	81
White females, U.S. graduates	106
IMG males	119
IMG females	57
Ethnic minority males	115
Ethnic minority females	70
Ethnic minority IMG females (eight black, two Hispanic, one American Indian, 17 Asian/Pacific Islander, three other)	31
Ethnic minority IMG males (four black, 17 Hispanic, 52 Asian/Pacific Islander, five other)	78
IMG English first language	72
IMG English not first language	106

* There was no variable for American born

IMG Discrimination

IMG physicians were 40.5% of the respondents and, when compared to USMGs, were more likely to acknowledge discrimination in their current work environment. In addition, 43.5% of USMGs reported that discrimination against IMGs in their current organization was very or somewhat significant.

Language was clearly a barrier primarily in hiring and in developing successful practices. English was the second language in 28.3% of the respondents. The language barrier, both nonverbal as well as verbal communications, poses a significant threat to the patient-physician relationship.

In the IMG group, 6.7% acknowledged that they were unable to obtain certification/board eligibility. This figure compares to the general overall board certification of 96.4%.

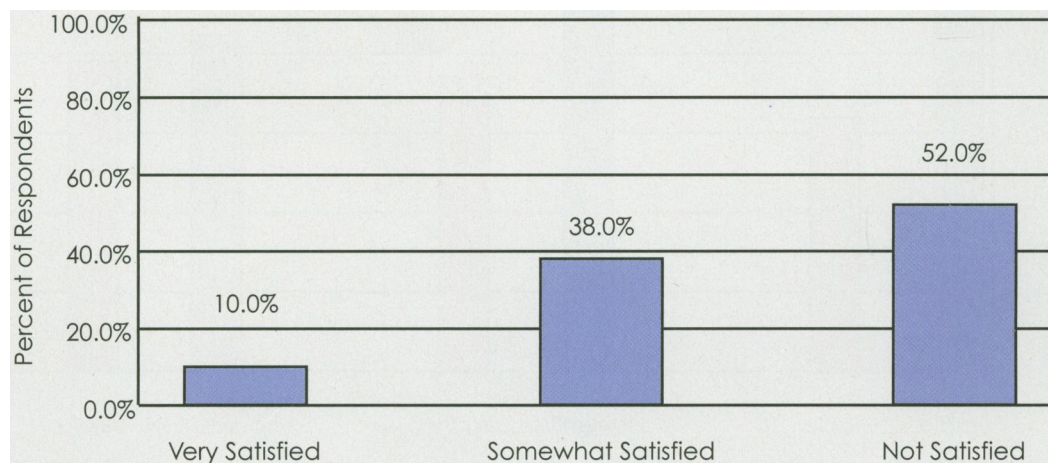
Several IMG responses to the questions were similar to the non-IMG group: "I was not fairly considered for promotion or senior management." "I was rated lower than I deserved." "My pay was not equivalent to my peers." Major differences existed in the area of getting a job interview (38% vs. 4.8% white, non-IMG).

As mentioned earlier, graduation prior to 1980 and length of service with an organization were also important in whether a physician experienced career

Table 10. Factor Analysis

Four Forms of Discrimination Experienced by Physicians	Percent Respondents Ever Experienced
Career Advancement Obstacles	46%
Punitive/Disrespectful Actions	43%
Hiring Obstacles	26%
Practice Barriers	23%

Figure 4. Satisfaction with Organization's Response to Report of Discrimination



obstacles. From the data, obstacles emerged primarily in the first five years, after which a physician may leave an organization. Years in clinical practice appear to be key in all forms of perceived discrimination. Another possible dilemma is the distribution of IMG physicians in certain specialties among various working environments: hospital-based, managed care, group or solo practice, or research. IMG physicians who are temporary visa holders are more likely to pursue primary care specialties,¹⁸ whereas IMG physicians with permanent resident/citizen status will embark upon subspecialty training more often than physicians with temporary visas, but slightly less often than USMGs.¹⁸ Also, IMG physicians who are temporary visa holders “expressed significantly more difficulty finding a satisfactory practice opportunity than USMGs.”¹⁸

A complicating factor in the data was the obvious overlap that occurred with IMG, racial/ethnic and female gender status. In the IMG group, overlap groups (those IMGs who were female and/or ethnic minority) could have affected the results. A contributing number of IMG physicians were born in the United States, which subtracted from potential language and cultural barriers (Table 6).

Racial/Ethnic Discrimination

Fifty-four percent of respondents indicated that they had experienced discrimination in the academic setting in contrast to 28.1% of respondents who were in solo practice. Research by Fang et al. examining racial and ethnic faculty promotion in academic medicine unveiled a 16% gap: 46% of white assistant professors were promoted, whereas only 30% of under-represented minorities were promoted to associate

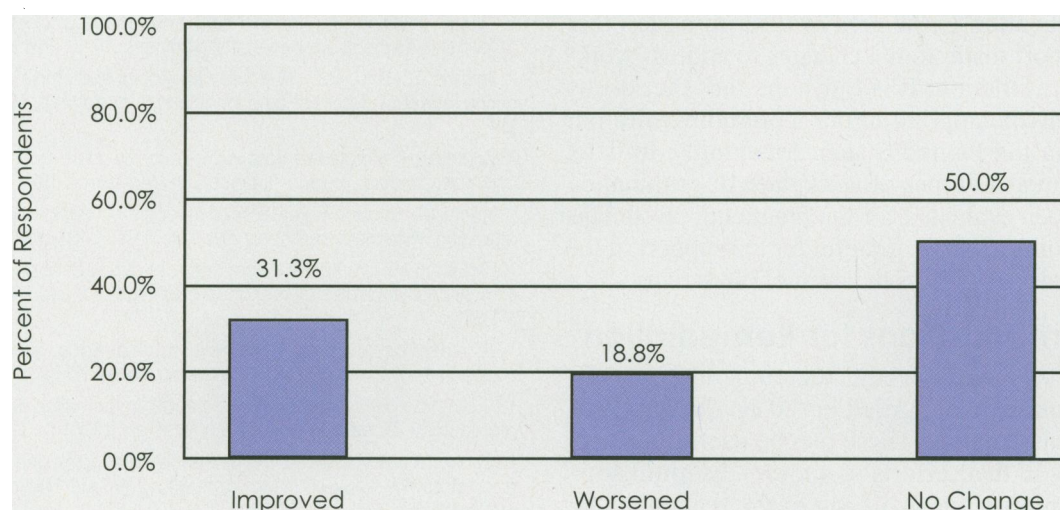
professors, and 37% Asian/Pacific Islander assistant professors were promoted.¹⁵ Of note, these disparities persist regardless of awards from the National Institutes of Health, sex, tenure status or department.

Interestingly enough, there is also overlap in this group, with the IMG representing approximately 59.4% of the ethnic/racial group. On the other hand, in the IMG group, black/African Americans (6.7%), Hispanics (11.2%), American Indian/Eskimo/Aleut (6%) represented less than 20%. The significance of this is to note that the IMG distribution is predominantly white and Asian/Pacific Islander (80%). Hence, the impact of the American-born IMG may influence the data in both the IMG and the race/ethnicity groups.

Limitations of the Study

The survey was distributed to a sample of physicians across various specialties and practice settings in Massachusetts. As mentioned earlier, the sample was not developed from the universe of all practicing physicians in Massachusetts, thereby introducing an element of response bias. It is likely that there was a response bias; that is, those most likely to have experienced discrimination were most likely to respond to the survey. To ensure an adequate representation of specific subgroups, there was intentional oversampling of women, ethnic minorities and IMGs for the purpose of this study. Hence, the prevalence of discrimination among all physicians in Massachusetts due to survey sampling issues could not be determined. The consequences of discrimination on medical communities were difficult to address. This is an area that additional research will address in the future.

Figure 5. How the Situation Changed after Report of Discrimination



WORKPLACE DISCRIMINATION

As previously mentioned, there are several challenges to examining discrimination, particularly when trying to extrapolate results to the general population, since discrimination may have subjective elements.

Organizational Response to Complaints

Organizational response to complaints resulted in improvement for 31.3% of respondents. It is difficult from this study to adequately evaluate organization actions generated by the physicians' complaints. Further research is needed to elucidate the anatomy of complaints and institutional reactions.

CONCLUSION

The present study demonstrated the presence of discrimination among physicians in the Commonwealth of Massachusetts. This is a landmark study, and the MMS should be commended for its bold step to better understand the challenges of its membership. However, future research should be targeted at better characterizing the specific areas of discrimination for certain subgroups of physicians. This will bring the MMS closer to putting an end to discrimination in medicine in the 21st century.

Inarguably, the in-depth investigation of discrimination by practicing physicians is going to be a long, controversial and arduous endeavor. However, we are facing a U.S. population that is becoming more and more diverse each day. Therefore, the issues of equality, justice and cultural competence will become ever more important. **Discrimination** occurs as a result of the **tension** created by the **need for more diversity** and its **resistance** from individuals who refuse to address this need. We are at a crossroads for the healthcare workforce, and addressing issues of discrimination is both a priority and a necessity for the development of the American healthcare system.

This study is significant in providing the evidence and the education in the area of discrimination that would support institutional changes to address workplace discrimination. It is our hope that the results will not only be applied in our Commonwealth but through out the United States. Amazingly, to date, these key areas of types of workplace discrimination have not been evaluated for the practicing physicians (not in training). We are grateful for the support of the MMS in order to address the need of physicians.

Recommendations for Remediation

As part of the survey, recommendations for remediation were compiled based on the feedback from the participants. These can be useful tools for institutions in their efforts to address discrimination issues for physicians. A listing of the recommendations follows below:

- Improve cultural understanding and diversity in general and in medical training programs in particular;
- Raise awareness of discrimination;
- Communicate with decision-makers, such as administrators, senior management and program directors, regarding the need for education and training programs;
- Identify resources to support women, minorities and IMGs who experience discrimination;
- Pursue the collection and publication of information to document problems and solutions;
- Develop strategies to address salary inequities and advancement obstacles for women;
- Encourage the promotion of women and minorities in positions of leadership; and
- Increase representation of women and minorities in the MMS.

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REFERENCES

1. AAMC Data Warehouse: student section as of 01/16/02. www.aamc.org/data/facts/famg92001.htm. Accessed 10/17/03.
2. Baldwin DC, Daugherty SR, Rowley BD. Residents' and medical students' reports of sexual harassment and discrimination. *Acad Med*. 1996;71(suppl):S25-S27.
3. VanIneveld CH, Cook DJ, Kane SC, et al. Discrimination and abuse in internal medicine residency. *J Gen Intern Med*. 1996;11:401-405.
4. Cook DJ, Liutkus JF, Risdon CL, et al. Residents' experience of abuse, discrimination and sexual harassment during residency training. *Can Med Assoc J*. 1996;154:1657-1665.
5. Komaromy M, Bindman AB, Haber RJ, et al. Sexual harassment in medical training. *N Engl J Med*. 1993;328:322-326.
6. Council on Ethical and Judicial Affairs, American Medical Association. Disputes between medical supervisors and trainees. *JAMA*. 1994;272:1861-1865.
7. Baldwin DC, Daugherty SR, Rowley BD. Racial and ethnic discrimination during residency: results of a national survey. *Acad Med*. 1994;69(suppl):S19-S21.
8. Moscarello R, Margittai KJ, Rossi M. Differences in abuse reported by female and male Canadian medical students. *Can Med Assoc J*. 1994;150: 357-363.
9. Bullock SC, Houston E. Perceptions of racism by black medical students attending white medical schools. *J Natl Med Assoc*. 1987;79:601-608.
10. Bindman AB, Grumbach K, Vranizan K, et al. Selection and exclusion of primary care physicians by managed care organizations. *JAMA*. 1998;279: 675-679.
11. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender and partnership in the patient-physician relationship. *JAMA*. 1999;282:583-589.
12. Rothenberg PS. Race, class and gender in the United States: an integrated study, 4th ed. New York: St. Martin's Press, 1997.
13. Lenhart SA, Klein F, Falcao P, et al. Gender bias against and sexual harassment of AMWA members in Massachusetts. *J Am Med Wom Assoc*. 1991; 46:121-125.
14. Bickel J. Gender stereotypes and misconceptions: unresolved issues in

physicians' professional development. *JAMA*. 1997;277:1405.

15. Fang D, Moy E, Colburn L, et al. Racial and Ethnic Disparities in Faculty Promotion in Academic Medicine. *JAMA*. 2000;284:1085-1092.

16. Nasir LS. Evidence of discrimination against international medical graduates applying to family practice residency programs. *Fam Med*. 1994;26:625-629. Special Series: IMG in Family Practice.

17. Salsberg E, Nolan J. The posttraining plans of international medical graduates and U.S. medical graduates in New York State. *JAMA*. 2000;283:1749-1750.

18. Fiscella K, Frankel R. Overcoming cultural barriers: International medical graduates in the United States. *JAMA*. 2000;283:1751.

19. Brotherton SE, Simon FA, Etzel SI. U.S. graduate medical education 2001-2002: changing dynamics. *JAMA*. 2002;288:1073-1078.

20. Dow WH, Harris DM. Exclusion of international medical graduates from federal healthcare programs. *Med Care*. 2002;40:68-72.

21. Cook D, Griffin LE, Cohen M, et al. Discrimination: an abuse experienced by general internists in Canada. *J Gen Intern Med*. 1995;10:565-572.

22. Rydén L, Schenck-Gustafsson K. The careers of female cardiologists. *Eur Heart J*. 1999;20:1219-1221. Editorial.

23. Moscarello R, Margittai KJ, Rossi M. Differences in abuse reported by female and male Canadian medical students. *Can Med Assoc J*. 1994;150:357-363.

24. Rydén L, Schenck-Gustafsson K. The careers of female cardiologists. *Eur Heart J*. 1999;20:1219-1221. Editorial.

25. Frank E, Brogan D, Schiffman M. Prevalence and correlates of harassment among U.S. women physicians. *Arch Intern Med*. 1998;158:352-358.

26. Hostler SL, Gressard RP. Perceptions of gender fairness of the medical education environment. *J Am Med Wom Assoc*. 1993;48:51-54.

27. Modena MG, Lalla M, Molinari R. Determinants of career structure and advancement among Italian cardiologists: an example of segregation and discrimination against women? *Eur Heart J*. 1999;20:1276-1284.

28. Ferris LE, MacKinnon SE, Mizgala CL, et al. Do Canadian female surgeons feel discriminated against as women? *Can Med Assoc J*. 1996;154:21-27.

29. Barr ES, Seale NS, Waggoner WF. The experiences of women pediatric dental residents: a survey. *Pediatric Dent*. 1992;14:100-104.

30. Gulland A. Ethnic minority doctors hit glass ceiling in NHS. *BMJ*. 2001;322:1505.

31. Swart JC, Wendt AC, Slonaker WM. Employment discrimination experiences of registered nurses. *J Nurs Admin*. 1996;26:37-43.

32. Rydén L, Schenck-Gustafsson K. The careers of female cardiologists. *Eur Heart J*. 1999;20:1219-1221. Editorial.

33. Frank E, Brogan D, Schiffman M. Prevalence and correlates of harassment among U.S. women physicians. *Arch Intern Med*. 1998;158:352-358.

34. Hostler SL, Gressard RP. Perceptions of gender fairness of the medical education environment. *J Am Med Wom Assoc*. 1993;48:51-54.

35. Bickel J. Women in medical education: a status report. *N Engl J Med*. 1988;319:1579-1984.

36. Wolf TM, Scuria PL, et al. Perceived Mistreatment of Graduating Dental Students. *J Dent Educ*. 1992;56:313-316.

37. McBride D. Inequality of availability of black physicians. *NY State J Med*. 1985;85:139-142. ■

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University of California San Francisco at
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PERCEPTIONS OF RACISM BY BLACK MEDICAL STUDENTS ATTENDING WHITE MEDICAL SCHOOLS

Samuel C. Bullock, MD, and Earline Houston, MD†
Philadelphia, Pennsylvania

Thirty-one black medical students attending five white medical schools were seen in individual interviews of one to two hours to evaluate their perceptions of racism in their medical school education. The interviews focused on racism experienced in high school, college, and medical school. Over one half of the population experienced racism during their high school and college education, while 30 of 31 subjects reported racist experiences in their medical school education. The students reported a variety of methods of coping with racist experiences and emphasized the importance of fellow minority students, faculty, and the minority office in coping with the stresses of racist experiences. Those offering counseling services to minority students should recognize the reality of racist experiences in medical education.

Although the practice of medicine is accorded one of the highest occupational ranks and statuses in America, the profession has not been able to divest itself of the subtle racism that permeates the infra-

structure of our entire society. An examination of literature on American medicine tells us that **discrimination and prejudice** in this **profession** have been **longstanding**. Since the time of Reconstruction, schools have existed solely to train black doctors. Both during and after Reconstruction, some eight medical schools were established for the training of black physicians. Of this group, two four-year medical schools, Howard University College of Medicine founded in 1867 and Meharry Medical College founded in 1876, remain.¹ During this period, penalties were imposed upon white physicians who showed sympathy for the cause of training blacks for the practice of medicine.

The development of parallel organizations among minority groups is often a response to covert or overt discriminatory policies. So it was with the formation of the National Medical Association (NMA) in 1895. The NMA convened because black physicians were not welcome in the American Medical Association (AMA), especially in the seventeen southern states and the District of Columbia.² It is also significant that 43 years later the "Giles Committee" (named for the then-President of NMA) was formed to appeal to the AMA to erase the abbreviation "Col" (colored) following the names of black physicians in the AMA directory. In 1940 this was accomplished (F. Dorsey-Young, unpublished data, 1974).

Although the gains of the 60s and 70s look dramatic in terms of percentages, nonetheless it is still disheartening to note that, in absolute numbers, the number of blacks in medical schools and actually practicing medicine remains small. As of 1981, black Americans made up approximately 2 percent of all physicians

† Deceased June 1986.

From the Department of Mental Health Sciences, Hahnemann University Medical School, and the Philadelphia State Hospital, Philadelphia, Pennsylvania. Requests for reprints should be addressed to Dr. Samuel C. Bullock, Office of the Dean, School of Medicine, Mail Stop 440, Broad and Vine Streets, Philadelphia, PA 19102-1192.

PERCEPTIONS OF RACISM

in America.¹ Forty-four of the nation's medical schools admitted fewer than 50 black students in first-year medical classes throughout the decade beginning in 1970. It is noteworthy that there has been a **declining proportion of black and minority students in the entering classes of US medical schools** in the decade from 1974 to 1983, even though blacks have made up a larger percentage of the applicants to medical schools and their admission test scores have increased.³ The authors conclude from these data that the commitment of medical schools to affirmative action has slackened.

The authors collected data on black medical students' perception of issues of discrimination and prejudice in their school experience for several reasons: 1. Experiences of prejudice and discrimination are frequent topics of discussion by black medical students. 2. Racial discrimination has been mentioned as one of the stresses in the medical school experience. 3. No study has been done presenting in-depth data on perceptions of discrimination by black medical students in white medical schools. Information was especially sought on how much stress individual students felt discriminatory experiences to be and how the students dealt with these experiences. Another concern was the lack of awareness and appreciation that some of our white medical colleagues showed to what seemed a significant source of negative experience that added considerably to the overall stress of medical education.

The authors hypothesized that there were at least two possible causes of the perception of racism: (1) that the perception of racism is the result of unhealthy paranoid attitudes, or (2) that the perception of racism is a part of a good and necessary reality testing. Further, at some point would racism and discrimination become a stressful focal issue compounding the more general problems of adapting to a white medical school environment.

Lloyd,⁴ Assistant Dean of Howard University School of Medicine, found that the stresses experienced by minority medical students, except for overt or covert racism, are largely no different in kind from those experienced by majority medical students. These stresses are often magnified in complexity and degree for the minority students. Schatzhin and Yergin⁵ reported that 30 years ago (as vividly recalled by the father of one of the authors) professors at a leading medical school regularly warmed up their classes with anecdotes that included racial epithets and stereotyping. The authors speculated that the presence of in-

creased numbers of minorities within the medical profession (with 30 rather than five minority students in a class of 150) would reduce discriminatory attitudes within the profession and would improve the relations of the profession with the public and other health care workers.

Reitzes, Roosevelt University in Chicago, stated that the percentage of medical students who are black increased from 2.7 percent in 1955–1956 to 6.0 percent in 1973–1974.⁶ Interviews with black medical students conducted during the two periods suggested that the increase in the number of black students was accompanied by a considerable reduction in racial discriminatory practices in medical schools. These data imply that in 1973–1974 actual discrimination against blacks in medical schools was low compared with the discrimination experienced by black physicians when they attended medical school 18 years earlier. However, in the 1973–1974 mail survey, 60 percent of the students reported they experienced discrimination in white medical schools while only 49 percent of the physicians reported they had experienced discrimination as students in those medical schools 18 years earlier.

METHODS

Interview Process

Thirty-one students attending five white medical schools were seen by one of the authors in a one- to two-hour interview. Demographic characteristics of the population of the 31 students who participated in the present study are presented in Table 1. In addition to a series of questions about demographic characteristics, students were asked about their perception of racism in high school, college, and medical school (specifically the medical school admission process, the preclinical years, and the clinical years) (Table 2).

The report of our findings in the interview will be described under the following headings: (1) Perceptions of racism during high school and college, (2) perceptions of racism during medical school—the admission process, the preclinical, and the clinical years, (3) responses to racism; (4) variations in the nature of the experience as they relate to student characteristics, and (5) successful coping styles described by those students recognized as doing well academically or recognized as leaders by other students.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF MEDICAL STUDENT POPULATION (n = 31)	
	No. (%)
Sex	
Male	14 (45)
Female	17 (54)
Age	
22–31 years	31 (100)
Region of youth	
Mid-Atlantic	27 (87)
South	4 (12)
Medical school programs	
Medical students	28 (90)
Graduate residents	3 (9)
Medical students	
1st year	6 (19)
2nd year	7 (23)
3rd year	4 (13)
4th year	11 (35)
Postgraduate	3 (10)
Medical school environment (n = 5)	
Non-active minority programs	2 (40)
Active minority programs	3 (60)
High school training	
All black	8 (26)
All black, then integrated	3 (10)
Racially integrated	20 (64)
College training	
White colleges	23 (74)
Black colleges	8 (26)
Family data	
Intact family	24 (77)
Broken family	7 (23)
Parental occupation	
White collar	
Father	15 (48)
Mother	18 (58)
Blue collar	
Father	16 (52)
Mother	3 (10)
Maternal homemakers	8 (26)
Number of children per household	
0–1	4 (13)
2–3	5 (16)
4 or more	22 (70)

Earlier School Racism

Fifteen students reported experiences of racism in high school, nine of which were described as subtle. The experiences ranged from difficulty in obtaining recognition and support from teachers to being ac-

TABLE 2. ADDITIONAL INTERVIEW QUESTIONS ASKED OF 31 BLACK MEDICAL STUDENTS	
Did you expect as much racism as you experienced?	
Did you encounter stereotypic labeling directed at self and/or black patients?	
Was there any designation of diseases as “belonging to blacks?”	
How did you deal with feelings mobilized by racism: by talking about feelings? by acting on feelings? by internalizing feelings?	
Was your study process influenced by your perception of the role you were supposed to carry out, especially if your role was viewed as stereotypical?	

tively discouraged from taking science courses by counselors and from making applications to prestigious colleges. Three students reported conflicts between black and white students up to and including riots. One student, who described his integrated high school experience as nonracist, reported participation in racial conflicts in the community that involved life threat.

Seven students, six of whom had attended black colleges, reported experiencing no racism. Twenty students who had attended integrated colleges experienced racism, which was described by 11 of the subjects as being subtle and which included not receiving adequate premedical counseling and being discouraged from pursuing a medical career by counselors.

Racism was experienced by approximately one half of the population under study in high schools. Those attending white undergraduate colleges were more likely to encounter racism than those having gone to black institutions.

Medical School Racism

The Admission Process. In the admission process approximately one half of the 31 students had experiences that varied from abruptness in the interview with the subjective impression that the student was not wanted, to the loss of the application and transcript and letters, with the statement by one dean that no minority student had applied. One student was told the tale that students from her state were not being accepted by a certain school. Another student

reported being told by an interviewer, "You don't look black to me, a white student would not be able to recognize you as black." The student felt that as she was clearly recognizable as black, she was being told she was too middle class in appearance.

Approximately one half of the students seen felt that some form of racism had been a part of at least one of their admission interviews.

The Preclinical Years. The following experiences in the preclinical years were described. Of 31 students interviewed, all but two of them related one or more examples of discriminatory behavior on the part of their classmates or instructors in the preclinical years. **Certain repetitive themes emerged. Blacks were treated as though they were intellectually less able than white students. Blacks felt they were "invisible."**

Twenty-five of the 31 students volunteered that black students were felt to be intellectually inferior to whites. **Four students described public statements by instructors that "standards would not be lowered to allow minority students to pass," or "Just because we let you in, doesn't mean we'll let you out."** One black student, on attempting to defend in a meeting several white students who had failed, was told, "I don't know why you don't understand. **We try to help minorities** (then noticing a handicapped student also present) and the handicapped, **but we can't let things go for everybody."**

Individual anecdotes include one about a neuroanatomy instructor who consistently mispronounced substantia nigra as "substantia nigger." The student fantasized, but did not make a statement about the "redneck nucleus." The student's impression was that the instructor was **not comfortable with his answering questions** in lab that **others could not answer.** The same student noted, however, that one professor thought to be uncooperative by blacks was very helpful and "more than fair" once approached.

Nine students complained about what one called the "Invisible Man" syndrome.⁷ They made such statements as, "They don't see me," "It is incumbent on you to make your presence known . . . you have a difficult time getting attention," "An extra effort was needed to get an instructor to your lab table, responses were abrupt," "I'd answer questions other students couldn't, there was never any praise." The authors feel this behavior on the part of instructors helps perpetuate the stereotype of black intellectual inferiority by making the learning of the information presented more difficult for the student and by de-

creasing access of the instructors to information that would contradict the stereotype.

The Clinical Years. Students in their clinical years (namely the first "hands-on" experience) reported some degree of apprehension about the fact that clinical **evaluations are mainly subjective.** One student stated, "Things get hairy in your clinical years because if your evaluation is below average you know a good written examination grade is not going to bring your grade up." Nine of 17 students felt their **negative clinical evaluations** had been **clearly subjective.** Students perceived they were in a "no-win" situation and that, regardless of their efforts, the rewards would be minimal. There was agreement that **blacks who excelled were generally not given adequate credit.** Several students expressed surprise over good evaluations when they felt a lack of communication with their instructors.

Five students responded to experiences in which they felt unfairly treated by direct discussion of the problem with the medical staff involved. In two instances the students felt the problem was not resolved and the attempt to discuss the problem was perceived as their being too aggressive, a factor that was included in a poor evaluation. In three instances the students felt the problem situation was resolved satisfactorily.

There was a variety of personal experiences that students felt were a direct response to their race. One female student reported that at the end of a rotation a female attending physician said to her, "Besides looking like you were going to throttle me, you did very well on your rotation." The student was surprised by the statement, as she perceived herself as being low key with attending physicians.

All 18 students who had performed clinical rotations presented at least one example of negative or discriminatory attitudes toward black patients by white staff. The incidents range from the observation that black patients frequently were called by their first names, compared with white patients who were addressed by a title, to a description of general attitudes shown toward black patients. A student reported, **"Certain things are assumed about black patients before they open their mouths . . . that is, the patient won't be able to follow directions for care."** The observation that less effort is made to obtain necessary information and that certain **negative assumptions are made about the patient because of race** was presented by eighteen students.

The diseases in which negative stereotypes of blacks

were frequently presented were alcoholism, cirrhosis of the liver, and venereal disease. Students stated, "Some people on gynecology think venereal disease is a black disease and any black woman with abdominal pain is assumed to have pelvic inflammatory disease." One student reported, "There is never a statement made about middle-class blacks. I guess they don't know any." All students reported some negative attitudes expressed toward black patients, the epitome of which was patients being described as "dirt balls."

The following query was made by a white male patient who asked on the conclusion of his examination by a black female medical student, "What pay do maids get in this hospital?" She responded she was a senior medical student and did not know. The patient pursued this further with the attending intern when he stated, "The maid was just here and did not clean my room." One student stated, "The equation is black woman equals maid and we have to deal with this." In another striking incident, two female students examined a white male patient and drew blood for testing. The patient stated, "It's good you colored girls are becoming doctors," then added, "You know I hate niggers." The student reported she had to restrain herself from using the needle aggressively at this moment.

Racism appears to be a component of the medical training of most of the students in the area medical schools, whether preclinical or clinical. Not only does it involve direct hostility, but the student has to experience the disparagement expressed toward black patients.

Responses to Racism

Twenty-nine of the 31 students described feeling anger at the various aspects of racism they experienced. These students spoke of suppressing anger or being in a state of shock at the environment they found. They spoke repetitively of feeling frustrated about being able to do nothing about it. One said, "To see that people carry these attitudes from the bottom to the top, I'm going to have to deal with them from now until. . . ." Another stated, "I feel a lot of anger. It's hard to be angry and have your hands tied. I don't want to jeopardize my chances so I hold my tongue or talk about it with other black students." Another student stated that racist incidents would catch her by surprise and she would be very angry at herself for not having said anything.

The anger expressed in the statements above was alleviated to a degree by talking with other students. Other responses to racism were: (1) acting directly by speaking out regardless of the consequences, (2) diverting energy to academic mastery and demonstrating mastery, and (3) diverting energy into activities to improve the lot of blacks. Prejudice produced a diversified effect among students. Nineteen students felt prejudice influenced their study process. Ten students reported being motivated to study harder, while nine reported difficulty in studying. Several reported feeling so alienated that they would not participate in class and attempted to learn exclusively from their reading material. Silence often reaffirmed invisibility, because in the absence of active, repetitive behavioral evidence to the contrary, instructors could continue to believe in the stereotype of black intellectual inferiority.

When asked to what extent they found themselves behaving or pushed to behave in a manner consistent with the stereotypes, eight students responded that they didn't feel such pressure and felt rather successful at being themselves. Fourteen students felt they tried to behave in a manner to disprove the stereotypes. One student felt he had become "hypercareful, felt pressure to become like whites, to mingle in . . . to stop frequenting the minority office, to speak like them, act like them, play rugby." He described a feeling of pressure to become what he called a "white-thinking black man."

Anger was the primary affect mobilized as a response to racism. An infrequent response was to deal directly with a discriminatory situation by speaking up, even though this response was perceived to be risky. The more common response was to experience feelings of frustration and helplessness, with increased anxiety about the ability to study and master the material. Two students described temporary somatization reactions.

All the students found the presence of other black students and faculty and formal minority programs supportive. Most of the students felt that the presence of even more black instructors and doctors in general would improve the experience, and that students would benefit from a more positive attitude about their capabilities on the part of the school in particular.

Ideas to improve the quality of the medical school experience ranged from the creation of an atmosphere that is receptive and supportive of the minority stu-

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dent to programs organized to create attitude changes in the relationships of blacks and whites. Most frequently mentioned was the importance of programs that promote cohesiveness and enable minority students to support each other in academic and social areas. An increase in black faculty and resident staff was suggested as a means of having greater staff accessibility, cultural understanding, and support.

There was recognition that attitude change is difficult, but an important step is exposure. One student suggested seminars to discuss black-white cultural differences to bring about better understanding. Another student stated, "Racism affects whites too. They need to be educated to be more sensitive and aware of specific racial issues."

Variations in Response

Ten students did not feel their experience had influenced the type of work or area of practice they chose. Eight students felt their experience had heightened their own awareness of themselves as blacks. They were more determined than before to practice with black patients, as they felt black patients were getting poor care.

The majority of students felt they would definitely advise others who were seriously interested to go to medical school. But several cautioned they would alert prospective students of the difficulties they would face.

Most respondents thought that the future of blacks in medicine is dim because of the declining enrollment of blacks since the Bakke decision, the increase of conservatism in the country, the increasing cost of training, and the decreased federal support for minority programs. The majority of students expected the racism they experienced in medical school based on their previous high school or college experiences but several did not. A number of the latter described themselves as **shocked** and **disappointed** at what they found, with one student stating that she thought medicine was "above the petty stuff."

Successful Coping Styles

There was an almost universal perception of significant amounts of discriminatory behavior in medical school. In spite of this, there were repetitive indications of successful coping styles employed to a greater or lesser degree by all the students, but par-

ticularly by those recognized as doing well academically or recognized as leaders by other students.

Transient episodes of general mistrust and/or avoidance of whites were present to a significant degree in all but one of the students. Those in the last two years of school appeared to have worked through this feeling with the realization that some whites could be trusted, while others could not. One student, however, received significant support, both academic and emotional, from white roommates from the beginning. This student had also benefited greatly from the minority pre-admission summer program. At first he was failing, but took the advice of the counselors and got his study patterns more organized during the summer. He agreed that part of his ease in dealing with whites seemed related to his less idealistic expectations of them. For example, he avoids those who are bigoted and, as a matter of course, associates with those who are trustworthy. He was disappointed, however, with his fellow black students who were less willing to share with the group or less serious about correcting their difficulties than he. He had much higher expectations of black students and cared more about their imperfections. Paradoxically, this resulted in his getting along better with whites, a painful situation he planned to change by softening his overly idealistic expectations of blacks.

A number of students went through a period of active avoidance and deep mistrust of whites. One fourth-year student felt reluctant to approach whites and to trust them. "I felt uncomfortable in the classroom because of how I was treated. I felt I was just there to get by and not excel. I was depressed and at times decided not to go to class. I'd stay home and read notes." She got out of her withdrawal through the support of other black students and the minority office. Now, she says, "There has been an important learning experience. . . . I think I am aware of racism. . . . I think I could adjust to any situation and be able to speak up about it."

While the students recognized the existence of racism and related poignant instances of it in their personal experiences, **they were not exclusively focused on it**. In fact, they seemed, **in** a deliberate way, to have emotionally distanced themselves from it. They found other blacks helpful for talking out feelings and exchanging mutual assistance, especially when facing intense overt racism for the first time in an institution. They also found it valuable to remain open to close

relationships with those white students and instructors whom they found trustworthy in spite of the considerable emotional risk of rejection before ascertaining who those individuals were. The authors know of certain instructors who were thought untrustworthy initially but who have evolved over several years of contact to a very supportive position. It should be noted that student response to these instructors has changed accordingly.

The students repeatedly emphasized the importance of separating feelings about the social situation from the reality of the need to study or to study harder because of it. "It is important to know the work" was a frequent statement. One student said, "The bottom line is absorbing the material and performing well on the tests." Several students also mentioned the importance of the difference between the attitude of trying not to flunk vs the attitude of trying to excel, and emphasized the value of the latter. A willingness to risk a change at the suggestion of a trusted friend or advisor from unsuccessful study patterns to more fruitful ones was an important part of the history of some students.

The students who did well described making themselves heard assertively on clinical rotations, whether they were made to feel welcome or not. One student described a transition from talking so softly that a fellow student could repeat her responses and get credit for it to speaking up and being heard.

SUMMARY

The study indicates a widespread perception of racism (30 of 31 subjects) among the black medical students participating in this study. These students had attended high school and college in the 1970s, and had been participants in the civil rights changes of the decade that had profoundly influenced their education. The majority described experiences that were racist in their high school and college education. In the medical school experience, the majority expected the racism that was encountered, and a minority described themselves as surprised and shocked by the racism experienced. The majority of the latter group had not previously studied in a white institution. The racism experienced can be described as stereotyped attitudes expressing varying degrees of disparagement directed toward black students both in-

dividually and as a group and a significant degree of negative stereotyping of black patients.

As there is abundant prejudice to be found in the world outside of medical school, the authors were not surprised to find significant perceptions of racism by the black medical students interviewed for this study. The perception of racism led to specific behaviors by black medical students. One behavior was a deliberate attempt to refute the stereotype of intellectual inferiority by studying harder. Another behavior present in some students in response to a perception of lack of welcome or outright rebuff by their instructors was to withdraw into passive silence. Such passivity, of course, did nothing to change whatever subjective impression the instructor might have had about the intellectual capabilities of the students. Indeed, it might have allowed for the persistence of negative stereotypes. This is consistent with the experience of the more successful students who described actively speaking out during clinical rotations whether or not they felt the approval of the instructor.

The increased frequency of perceptions of racism the authors found in this study over the 1976 study of Reitzes and Elkhani⁶ could be due to several factors. The sensitivity of students to racism could have increased, or their sense of entitlement to complain about it could have increased. Both factors are likely. It is probable that the use of individual one-to-two-hour interviews elicited more exact data about the students' perception of racism.

The important question of the extent to which the pressures of racist experiences play a deleterious role in the scholastic performance of minority students was addressed indirectly. The study data suggest that the role it plays is variable from student to student, based on both intellectual capacity and dynamic-experiential factors. There are some students for whom the pressure of racism, added to the other pressures of medical school, is decisive in determining poor academic performance. What can be said with assurance is that it does not help.

Experiences of prejudice and discrimination are an additional stress for black medical students. It is possible that the volunteer sample used in this study was selective and that the better adapted students responded to the interview and not students who were having serious difficulties. All of the subjects in this study, except one, were performing satisfactorily in medical school. However, those who were doing well

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academically or who were in positions of leadership recognized racist experiences for what they were. They had developed ways of dealing with these experiences and did not become overly anxious or overly focused on them. The presence of support from fellow black students and faculty was of primary importance in handling racist experiences. It is important for those providing counseling and treatment services for black medical students in white medical schools to recognize that experiences of prejudice and discrimination are reality issues. These issues certainly deserve exploration in the counseling of black students.

Literature Cited

1. Blackwell JE. Mainstreaming Outsiders. Bayside, New York: General Hall, 1981.
2. Cobb W. What hath God wrought. J Natl Med Assoc 1968; 60:518-521.
3. Shea F, Fullilove M. Entry of black and minority students into US medical schools. N Engl J Med 1985; 393:933-938.
4. Lloyd S. Problems of Adjustment in Minority Medical Students, panel. Association of American Medical Colleges Annual Meeting, Psychiatry section, Washington, DC, November 5, 1979.
5. Schatzhin A, Yergin J. Sounding board—The case for minority admissions. N Engl J Med 1977; 297:556.
6. Reitzes D, Elkhaniy H. Black students in medical schools. J Med Educ 1976; 51:1004.
7. Ellison R. Invisible Man. New York: Random House, 1952.

RESEARCH ARTICLE

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Discrimination against international medical graduates in the United States residency program selection process

Norman A Desbiens^{1*}, Humberto J Vidaillet Jr²

Abstract

Background: Available evidence suggests that international medical graduates have improved the availability of U.S. health care while maintaining academic standards. We wondered whether studies had been conducted to address how international graduates were treated in the post-graduate selection process compared to U.S. graduates.

Methods: We conducted a Medline search for research on the selection process.

Results: Two studies provide strong evidence that psychiatry and family practice programs respond to identical requests for applications at least 80% more often for U.S. medical graduates than for international graduates. In a third study, a survey of surgical program directors, over 70% perceived that there was discrimination against international graduates in the selection process.

Conclusions: There is sufficient evidence to support action against discrimination in the selection process. Medical organizations should publish explicit proscriptions of discrimination against international medical graduates (as the American Psychiatric Association has done) and promote them in diversity statements. They should develop uniform and transparent policies for program directors to use to select applicants that minimize the possibility of non-academic discrimination, and the accreditation organization should monitor whether it is occurring. Whether there should be protectionism for U.S. graduates or whether post-graduate medical education should be an unfettered meritocracy needs to be openly discussed by medicine and society.

Background

The United States owes a huge debt of gratitude to its physicians who graduated from non-U.S. medical schools [1]. Despite this, medical educators have sometimes seemed to be embarrassed by the presence of these residents in their programs. For example, in a recent article that praises international medical graduates (IMGs) one leader states that his program chooses that IMGs comprise 10 percent of his residents - a quota system that belies his later assertion that "U.S. academic medicine is ... a classic meritocracy" [2].

The proportion of IMGs practicing in the U.S. is considerable. About one-quarter of practicing U.S. physicians are IMGs, up from 15 percent in 1967 and 6.3 percent in 1959. In 2004, 28 percent of the residency

cohort was represented by IMGs, and more so in some specialties, such as psychiatry and nephrology [3]. The proportion of U.S. physicians who themselves are immigrants or who are the children or grandchildren of immigrants is even greater [4]. This should not be surprising. The U.S. is a nation of immigrants that has always been dependent on those from other countries to make it an economic and intellectual powerhouse.

Recent studies indicate that medical educators, perhaps because of improved information from the U.S. Medical Licensing Exam (USMLE) and the Educational Commission for Foreign Medical Graduates (ECFMG), are becoming better at selecting and educating IMGs. For example, **since 1995 non-U.S. graduates have outperformed U.S. graduates (USMGs) on the In-Training Examination** [5].

Physicians from other countries have enriched U.S. medicine clinically, scientifically and culturally [6].

* Correspondence: nadesbiens@gmail.com

¹12301 Creek Hollow Lane, Soddy Daisy, Tennessee, USA

Relying on other countries to partially educate about a quarter of its physicians has saved the U.S. a huge amount of money. In 2002, instructional costs ranged from about \$48,000 to \$51,000 and educational resources \$80,000 to \$105,000 per student per year [7]. Medical educational organizations have recently argued that the U.S. should increase the number of U.S. students, and many allopathic and osteopathic schools are in the process of so doing. The major rationale that they have used has been to meet the increased demand for medical care that a burgeoning population will bring, not to replace non-U. S. graduates in residency programs [8].

Despite the benefits that IMGs have brought to the U. S., we have perceived discrimination against IMGs during the residency selection process. We wondered whether there was research evidence in the medical literature to support our impression.

Methods

On 5-27-09 we queried Medline using the following search string using MESH headings: “biomedical research” AND “Education, Medical, Graduate” AND “Foreign Medical Graduates”. This search produced one irrelevant article. We then used the following string: (international OR foreign) AND ((graduate OR post-graduate) AND “medical education”). We found 1543 papers from 1961 to the present. We manually reviewed this listing for scientific studies of the recruitment process. We found two papers that used paired data designs to determine whether U.S. graduate medical educational programs responded to requests for applications by U.S. and international medical graduates differently. We then used the “related articles” feature on each of these papers which led us to another paper that surveyed surgical program directors (a cross-sectional study design) about international medical graduates which we used in the discussion section. We searched the reference lists of these papers and found no additional research articles.

We report the author’s statistics for the two studies that requested applications. They used McNemar’s chi-square for correlated proportions or the continuity-corrected McNemar’s chi-square. In addition to the authors’ calculations, we calculated relative response rates. For dichotomous variables from the survey study, we calculated 95% binomial confidence intervals using the binconf function in Harrell’s Hmisc library in S-Plus (Insightful Corporation; Seattle, WA).

Results

We found three relevant studies. Two were directed at the application process and used similar paired data designs, while a third surveyed surgical residency

program directors for their perceptions about IMGs (cross-sectional study design).

One study sent applications to 146 family practice residency programs randomly selected from the 384 programs in the *Directory of Graduate Medical Education Programs, 1991-1992* (38% sampled) [9]. The letters requested information and an application. All letters were identical except that the author of the first set was described as “a foreign medical graduate” while the author of the second was described as “a fourth-year medical student at the University of Nebraska Medical Center”. Pseudonyms were used and surnames were selected that “would not suggest any particular ethnic group”. Only a first initial was used to eliminate the possibility of gender bias. The letters from the IMG were sent first, and those from the USMG followed one week later. Of the 146 requests, 143 were received by programs.

When analyzed at 6 weeks by any response, 102 programs (71%) responded to the fourth-year medical student and 57 (40%) to the foreign graduate (relative response, U.S. medical student to foreign graduate: 1.8). Of the 46 programs responding to both, 9 required the foreign graduate to meet standards that exceeded requirements set by the ECFMG. When analyzed by reception of application forms, 39 programs sent applications to both (27%), 60 to only the U.S. medical student applicant (42%), 10 to only the foreign graduate (7%) and 34 to neither (24%) (relative application response, U.S. medical student to foreign graduate: 2.0; $p < .01$).

The second study sent identical requests (details not provided) for a program application to 193 psychiatry residency training programs, omitting those in Michigan since the persons requesting applications were enrolled in a Michigan program. The letters differed in only two respects: the names of the writers (one “American” and one “Pakistani”) and the medical schools from which they graduated (Wayne State University School of Medicine and King Edward Medical College). Letters were sent one week apart. Five programs reported they were closed, leaving 188 for analysis.

When analyzed by any response, 99 programs (53%) responded to both applicants, 60 only to the USMG (32%), 6 only to the IMG (3%) and 23 to neither requester (12%) ($p < .001$; relative response, USMG to IMG: 1.5). When analyzed by reception of application forms, the USMG received 159 responses with application forms (85% response rate) while the IMG received 87 responses with application forms (46%) ($p < .001$; relative application response, USMG to IMG: 1.8) [10]. The authors also report that in the year prior to their study, psychiatry residency slots remained empty, with only 84 percent of available positions filled.

The third study surveyed all 283 members of the Association of Program Directors of Surgery in 2007 [11]. Of these, they determined that 261 were active at the time of the survey and this was their targeted study population; 125 directors responded (48%) and 112 were analyzed. Most of the program directors were male (95%). They were 52 years of age (range: 37, 71 years) on average and their median tenor as program directors was 7 years; 90% reported being USMGs and 8% IMGs; and 49% were university-based and 47% community-based.

In response to five-point Likert-scale questions, 69 (59, 77) (95% binomial confidence interval) percent of directors strongly agreed, agreed or were neutral to the statement that on standardized exams IMGs perform as well as USMGs and 79 (70, 85) percent strongly agreed, agreed or were neutral to the statement that surgical skill level, as measured by performance in the operating room, is equal or better for IMGs compared to USMGs. For the statement, "In reality, all things being equal, our program would rather offer positions to USMGs than to IMGs", 97 (92, 99) percent agreed or were neutral (strongly agreed [47%], agreed [40%], neutral [10%]). In response to a yes or no question, 18 (11, 26) percent of directors answered that they had felt external pressure not to rank a better qualified IMG over a USMG and 71 percent felt that IMGs are discriminated against.

Discussion

Despite the difficulty of performing research on discrimination, we were able to find two studies conducted with family practice and psychiatry programs that reported similar methods and findings. In addition, a survey of directors of surgical residency program reported that more than 70 percent of directors believed IMGs were discriminated against in the selection process and nearly 20 percent reported that they had been pressured to discriminate against IMGs in favor of USMGs.

The paired-study technique used by two of the studies is a strong design and has a long biometrical application history. A large random sample of programs was used in one study but sampling bias was not an issue in the other, since it used an enumerative design: all programs in the specialty, with a few feasibility exceptions, were studied. The effect sizes in both studies were large and consistent. The differences in responses and responses to requests for applications in each study were large and statistically significantly biased in favor of USMGs over IMGs by a 50 to 100 percent margin.

Nonetheless, it would have been helpful to see similar studies in other larger specialty residency programs such as internal medicine and surgery, though inferences to the latter specialty programs are strengthened by the findings from the surgical program directors' survey. A

listing of the details of the request letters or a sample figure would have been helpful. A higher response to the survey would have strengthened point estimates on the questions, but the findings are disconcerting despite this limitation. For example, if all of the non-responders had answered that they did not feel that there was discrimination against IMGs, 31 (25, 37) percent of directors would have agreed with this statement – still a worrisome figure. Finally, a more extensive search using sources in addition to Medline might have discovered other relevant studies.

Our findings provide scientific evidence to bolster opinions in the medical literature that there is discrimination against IMGs in the selection process. This bias could be operationalized in three ways: categorical refusal to consider non-U.S. applicants, quota systems and hierarchical two-rank systems. In a quota system, a program determines the percentage of IMGs that it will allow. Quotas are facilitated by the present system that allows IMGs (and osteopathic and former USMGs) to be taken into a program outside the National Resident Matching Program (NRMP). A program may choose a certain number of IMGs before the match to meet its quota and then rank only USMGs for the remaining approved spots. A hierarchical two-rank system works by ranking USMGs first, then IMGs, regardless of qualifications.

Part of the bias against IMGs by residency programs in the past may have been evaluative bias. It had been very difficult to ascertain whether IMGs were adequately trained or prepared for U.S. residency programs [12]. However, changes made by the ECFMG have largely eliminated this problem. IMGs now take the same medical knowledge examination as USMGs (the USMLE), must all pass a standardized language exam (TOEFL or the former ECFMG English test), and must travel to the U.S. to prove their history and physical exam abilities (ECFMG CSA [clinical skills assessment]). Standardized examinations such as the USMLE are being increasingly recognized as valid indicators of professional success [13]. Most programs also require selected applicants to come for an interview to vet their communication and interpersonal skills. In fact, in many ways it is now easier to evaluate IMGs than many graduates of U.S. osteopathic schools who often do not take the USMLE.

If evaluative bias is no longer a factor, then why would U.S. programs discriminate against IMGs during the application process? Possibilities include additional educational burden and costs imposed on programs by IMGs, conflict over goals for medical and post-graduate medical education, protectionism for USMGs, concerns about image, administrative simplification, and discrimination based on xenophobia, country of origin, chauvinism, or other factors.

There is no doubt that IMGs impose an extra educational burden on U.S. residency programs, especially in the first year of residency. These graduates have to be acculturated to the U.S. and its health care and laws, the epidemiology of disease in the U.S., patient-physician cooperative decision making, the willingness and ability of the U.S. to spend much more to improve quality and length of life than their home countries, and perhaps evidence-based medicine, AIDS care in the U.S. and cultural competence, among others. These knowledge deficits are not trivial and take real resources in the form of special curriculum and faculty time to resolve. However, experience indicates that they can be expunged [14].

We suspect that post-graduate medical education has been protectionistic because educators conflate academic considerations with social policy. If U.S. residency programs were pure meritocracies, there should be no categorical refusal to consider IMGs and no quotas, and USMGs and IMGs should be intercalated in match lists of all programs. Applicants from all countries, including the U.S., would be ranked solely on individual merit. This approach would allow the best and brightest from throughout the world to compete for U.S. residency positions.

Those who favor protectionism might argue that federal or state legislatures made a social contract with their citizens that if they undertook the rigors, expense and, oftentimes, indebtedness of medical education, they would be guaranteed a residency position in this country. The available evidence suggests that this is the implicit policy followed by the majority of U.S. programs. Whether such an approach leads to the best physicians for a country needs to be studied. U.S. medical organizations need to lead the discussion on these issues and develop explicit policies for selecting IMGs.

Medical schools' perceptions of the *raison d'être* of their post-graduate programs may conflict with those of residency program leadership. If a primary purpose of the residency programs is perceived to be assisting medical school graduates to obtain U.S. residency positions, residency programs might use different selection strategies than if their goal were academic excellence. For example, they might rank U.S. students in the tenth percentile on the USMLE ahead of IMGs in the ninety-ninth percentile or not rank the latter at all. This potential conflict of interest between residency program and sponsoring medical schools needs to be openly discussed.

Medical educators may want to limit the number of IMGs in their programs because of general perceptions among faculty, residents, U.S. applicants and even non-U.S. applicants that programs with IMGs are inferior [15]. They may be concerned about image or that image will affect recruiting of U.S. applicants. To combat these perceptions, U.S. medicine should promote objective

standards for applicants to use in evaluating the quality of residency programs that do not consider the medical school or country of origin of residents. These criteria could include board passage rate, faculty research, resident presentations and research, aggregate USMLE scores, resident success in obtaining fellowships or positions, and resident satisfaction surveys, *inter alia*. Once these sources of bias have been eliminated, there remains the likelihood that discrimination based on xenophobia, racism, chauvinism or other factors is operative.

At this point in a manuscript it is customary for authors to suggest that further studies be undertaken to strengthen and extend existing findings. We doubt that this would be possible for at least the studies that used paired comparison. In the nearly fifty years of articles analyzed by our search, the three studies that we identified were conducted in an eight year period between 1994 and 2002. We could not find any indication that the studies were approved by an institutional review board and they used some degree of deception in order to gather data. Since 2002, very little has changed to encourage residency programs to use just and unbiased methods to deal with all applicants.

Much can be done to prevent or eliminate discrimination against IMGs. Interested stakeholders could convene task forces to deal with the overarching issue of meritocracy and social policy and medical schools' posture towards post-graduate education, and give program directors clear guidelines for selecting applicants. Such transparent policies could assist program directors in dealing with the deluge of IMG applicants, so that categorical refusal to consider these applicants is not used for administrative simplification. Research studies could be undertaken with the assistance of the NRMP to better understand and monitor the occurrence of categorical non-ranking of non-U.S. applicants and two-tiered hierarchical match lists. U.S. medical schools and specialty organizations could explicitly mention IMGs in their diversity statements and actively monitor perceptions of discrimination with confidential questionnaires. (To our knowledge, the American Psychiatric Association is the only medical group that has published an explicit statement opposing discrimination against IMGs, though it does not specifically refer to residency selection [16].) The Liaison Committee on Medical Education could require and monitor these activities. The Accreditation Council for Graduate Medical Education could add similar statements to its common requirements and monitor perceptions in its surveys to residents, and develop a standardized list of objective criteria for applicants to use to evaluate residency programs. Requiring IMGs to enter the NRMP would effectively eliminate quota systems.

Conclusions

It is time for the U.S. to re-examine its residency selection process and develop explicit and just selection policies for all applicants. Farra has expressed it aptly: "We have a duty to help this group that is so important. When you get a chance, ask your IMG colleagues about their stories and struggles to become accepted in this country. Let us welcome more of them into our large House of Medicine so that we can continue to make it better for everyone, especially our patients" [17]. A recent review concludes that, "the reduction of prejudice is not just a social nicety. Prejudice and discrimination are profoundly harmful to individuals and society as a whole." [18]. More openness in and monitoring of the residency selection process would help propagate the message that U.S. medicine abjures discrimination. The available evidence suggests otherwise and supports the contention of a prominent U.S. medical educator that, "there is little doubt that a bias against IMGs has existed within graduate medical training in the U.S." [19].

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Author details

¹12301 Creek Hollow Lane, Soddy Daisy, Tennessee, USA. ²Marshfield Clinic Research Foundation, 1000 N. Oak Avenue, Marshfield Wisconsin, USA.

Authors' contributions

ND did the literature search and wrote the manuscript drafts. HV was involved in many discussions and critical revisions. Both authors read and approved the final manuscript.

Authors' information

ND recently retired from the Chattanooga Unit of the University of Tennessee College of Medicine where he was Chair and Professor of Medicine. HV is Clinical Professor of Medicine at the University of Wisconsin Medical School and Director of the Marshfield Clinic Research Foundation. They represent a combined 60 years of experience as medical educator and have served either as members of residency program selection committees, program director of residency programs or a chair of a department of medicine.

Competing interests

The authors declare that they have no competing interests.

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References

- Gastel B: Impact of International Medical Graduates on U.S. and Global Health Care: summary of the ECFMG 50th anniversary invitational conference. *Acad Med* 2006, **81**:S3-S6.
- Centor R: What I Have Learned from IMGs. *SGIM Forum* 2007, **30**:3-12.
- Akl EA, Mustafa R, Bdair F, Schunemann HJ: The United States Physician Workforce and International Medical Graduates: Trends and Characteristics. *J Gen Intern Med* 2007, **22**:264-268.
- Brown D: At Med Schools, A New Degree of Diversity: Classes Reflect a Foreign Flavor. *Washington Post* 2007.
- Garibaldi RA, Subhiyah R, Moore ME, Waxman H: In-Training Examination in Internal Medicine: an analysis of resident performance over time. *Ann Intern Med* 2002, **137**:505-10.
- Stephan PE, Levin SG: Exceptional contributions to US science by the foreign-born and foreign-educated. *Pop Research and Pol Rev* 2001, **20**:59-79.
- Report 2 of the Council on Medical Education (I-00): Medical school financing, tuition and student debt. http://www.ama-assn.org/ama1/pub/upload/mm/15/cme_report_2_i00.doc.
- Salsberg E, Grover A: Physician workforce shortages: implications and issues for academic health centers and policymakers. *Acad Med* 2006, **81**:782-787.
- Nasir LS: Evidence of discrimination against international medical graduates applying to family practice residency programs. *Fam Med* 1994, **26**:625-9.
- Balon R, Mufti R, Williams M, Riba M: Possible discrimination in recruitment of psychiatry residents?. *Am J Psych* 1997, **154**:1608-1609.
- Moore RA, Rhodenbaugh EJ: The unkindest cut of all: Are international medical school graduates subjected to discrimination by general surgery residency programs?. *Curr Surg* 2002, **59**:228-236.
- Tinsely JA, McAlpine DE: Another explanation for the apparent discrimination against international medical graduates by residency programs. (letter). *Am J Psych* 1999, **156**:496-497.
- Kuncel NR, Hezlett SA: Standardized tests predict graduate students' success. *Science* 2007, **315**:1080-1081.
- Horvath K, Coluccio G, Foy H, Pellegrini C: A program for successful integration of international medical graduates (IMGs) into U.S. surgical residency training. *Curr Surg* 2004, **61**:492-498.
- Riley JD, Hannis M, Rice KG: Are international medical graduates a factor in residency program selection? A survey of fourth-year medical students. *Acad Med* 1996, **71**:381-386.
- The American Psychiatric Association Position Statement: Discrimination Against International Medical Graduates. Document Reference No. 200102 Washington, D.C.: American Psychiatric Association 2001.
- Farr PO: The impact of international medical graduates in US health care. *Mich Med* 2006, **105**:32.
- Christie DJ, Dawes A: Tolerance and solidarity. *J of Peace Psych* 2001, **7**:131-142.
- Waxman H: Workforce reform, international medical graduates, and the in-training examination. 1997, **126**:803-805.

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1. Fam Med. 1994 Nov-Dec;26(10):625-9.

Evidence of discrimination against international medical graduates applying to family practice residency programs.

Nasir LS.

Department of Family Practice, University of Nebraska Medical Center, Omaha.

BACKGROUND AND OBJECTIVES: The purpose of the study was to test the hypothesis that discrimination exists against international medical graduates (IMGs) applying to US family practice residency programs.

METHODS: Two sets of letters were sent to 146 family practice residency programs randomly selected from the Directory of Graduate Medical Education Programs. The letters requested information and an application. All letters were identical except that the author of the first set was described as "a foreign medical graduate." The author of the second set was described as "a fourth-year medical student at the University of Nebraska Medical Center." Replies were monitored for

6 weeks after the second mailing. Response rates to each "candidate" were

measured. In addition, responses were evaluated for the presence of a brochure describing the residency program, an application, cover letter, invitation for interview, eligibility criteria, and other material.

RESULTS: A total of 113 programs (79%) responded. Of these, 102 responded to the fourth-year medical student and 57 responded to the IMG. Of the 46 programs replying to both candidates, only 20 provided identical mailings. Nine of the 46 programs required IMGs to meet standards that exceeded requirements set by the

Educational Commission for Foreign Medical Graduates for residency training in the United States.

CONCLUSIONS: A pattern of dissimilarity exists in the way family practice residency programs respond to requests for application materials, and the differences appear to depend on whether the candidate is a US medical graduate or an IMG. These results raise questions about the fairness of current methods of resident selection. PMID: 7859953 [PubMed - indexed for MEDLINE]

ARTICLE | August 21, 1991

Licensure and International Medical Graduates

Arthur Osteen, PhD

JAMA. 1991;266(7):956-958. doi:10.1001/jama.1991.03470070084010.

ABSTRACT | REFERENCES

Since 1988, at least 12 bills directed toward prohibiting discrimination against graduates of foreign medical schools have been introduced in Congress. Earlier bills were primarily concerned with the endorsement of licenses to practice medicine. More recent bills have dealt with discrimination in residency appointment and in employment. The legislative proposals have led to lively debate over the actual extent of discrimination against international medical graduates (IMGs), particularly by licensing boards. The debate includes the extent to which the perceived problem results from differences in legislation and rules among licensing boards and from the board's local focus. Certainly, the perception of discrimination exists and is taken seriously by IMGs. An unpublished survey undertaken by the

American Medical Association (AMA) Advisory Committee on International Medical Graduates in June 1990 indicates that 83% of IMGs consider **antidiscrimination legislation** to be the most important goal for IMG organizations.

● EMOTIONAL IMPACT OF MEDICAL SCHOOL AND RESIDENCY

Moderator: Darrell G. Kirch, MD

Racial and Ethnic Discrimination during Residency: Results of a National Survey

DEWITT C. BALDWIN, JR., STEVEN R. DAUGHERTY, and BEVERLEY D. ROWLEY

The increasing racial and ethnic diversity of the U.S. population is a fact of life. To fully serve the community at large, medicine must respond to changing demographic needs. Two avenues of response are possible. First, we need to sensitize and train current physicians in issues of cultural diversity. Second, we must expand access to medical education by increasing the cadre of physicians representing diverse ethnic backgrounds. Both of these approaches require the creation of an environment hospitable to a range of racial and ethnic differences. Recent reports of racism and ethnic discrimination in institutions of higher learning, however, have raised concerns over the prevalence of such attitudes in medical education.

In an earlier study of perceived mistreatment among senior medical students at ten regionally distributed medical schools, Baldwin et al.¹ reported that 114 of 581 respondents (19.7%) claimed to have experienced some form of racial or ethnic harassment or discrimination while in medical school. Most of the cited instances involved the behaviors of superiors in clinical teaching situations. However, because over 88% of the sample identified themselves as "white non-Hispanic," a separate analysis of the responses of minority students was not deemed reliable. The low number of minority students enrolled in the schools sampled may be considered an issue in its own right.

Concurrently, using a similar questionnaire, Sheehan et al.² surveyed 75 third-year medical students at a single school. Results showed that half of the students identifying themselves as non-white or Hispanic reported experiencing racial or ethnic slurs, most frequently from classmates (50%), although clinical faculty (33%) and residents (25%) were also mentioned. This study is suggestive of a relatively high prevalence, but unfortunately is limited to a relatively small sample at a single medical school.

While local studies are suggestive, they do not paint a national picture. The present study sought to expand on previous research by establishing the current prevalence of racial-ethnic-based harassment or discrimination as reported by a representative national sample of second-year residents. Just how salient are racial and ethnic issues to persons in postgraduate medical training? At the same time we also want to determine, whatever the prevalence, when racial-ethnic discrimination does occur, what form this discrimination takes, and what the most common sources are.

Method

In 1991, we embarked on a national survey of residents' working conditions. A 10% random sample ($n = 1,773$) was drawn from among all second-year residents included in the Medical Education Research and Information (MERI) database of the American Medical Association, secured annually as part of the annual survey of Graduate Medical Education (GME) programs. A second sample consisted of 857 second-year residents who had been senior medical students at the ten schools in the medical student mistreatment study noted above.¹ The anonymous nature of both

studies makes it impossible to know the exact overlap between the medical student and the resident surveys, but did allow us to assess association between reports of mistreatment in medical school and subsequent residency experiences. For the purposes of this report, the two samples are treated as one ($n = 2,630$).

The 13-page anonymous survey instrument was similar to the questionnaire used in the medical student study except for additional questions about the quality of learning experiences and the work environment, unethical and unprofessional behavior, and several forms of perceived harassment and discrimination. Questionnaires were sent to participants along with a letter of explanation, a return envelope, and a postcard that was to be mailed back separately indicating that a questionnaire had been returned. There were two follow-up mailings. Returned forms were coded and entered in the computer. The final response rate was 72%.

Among the questions on the survey were several on racial and ethnic discrimination. The first asked, "How often, if ever, did any of the following persons subject *you to any racial or ethnic discrimination?*" No additional text was included to define what was meant by the term *racial or ethnic discrimination*. Respondents were left to apply their own standards. Options were provided for recording both the source and the extent of the discrimination, from never to often (five times or more). A second question queried, "How often, if ever, have you *observed* any racial or ethnic discrimination at your medical center?" This was ranked from 1 (not at all) to 5 (a lot). The third question asked those who had responded affirmatively to the above questions to identify, from a list of six types or forms of discrimination, the particular form such discrimination had taken. A category of "other" was provided to elaborate on forms that were not specified. Responses to these questions were received from 1,847 residents, of whom 1,825 clearly indicated their racial-ethnic backgrounds.

Results

Twenty-three percent of the 1,825 responding residents reported at least one experience of racial or ethnic discrimination during their first year of residency training. The group responding affirmatively to this question included 13.6% of all white residents, 37.2% of Hispanic residents, 62.9% of Asians/Pacific Islanders, 68% of those from the Indian subcontinent, 77.4% of African Americans, and 77.8% of those from the Middle East. These residents ascribed such experiences to patients (46.3%), attending faculty (37%), residents at a higher level (34.4%), nurses (32.5%), residents at a lower level (24.8%), and medical students (15.5%). The predominant form such behavior took was racial or ethnic slurs (49.8%), followed by favoritism toward members of another group (37.8%), poor evaluations (23.9%), being denied opportunities (22.8%), malicious gossip (22.3%), racist teaching materials (4.5%), and other (4.7%).

Table 1 details the unique experiences of minority residents. Sixty-one percent of the minority respondents reported at least

Table 1
Sources and Types of Racial–Ethnic Discrimination during First Year of Residency

	White (<i>n</i> = 1,492) (%)	Underrepresented Minority* (<i>n</i> = 143) (%)	Asian† (<i>n</i> = 163) (%)	Middle Eastern (<i>n</i> = 27) (%)
Source				
Medical students	1.8	14.7	12.9	22.7
Residents at same or lower level	2.9	23.1	22.1	48.1
Residents at higher level	4.2	36.4	31.3	36.4
Attending faculty	5.4	40.6	33.1	51.9
Nurses	5.4	26.1	36.8	48.1
Patients	8.2	35.9	54.6	59.3
Type				
Denied opportunities	7.5	24.6	21.0	25.9
Racial or ethnic slurs	32.1	38.7	33.3	29.6
Racist teaching materials	1.3	5.6	2.5	3.7
Malicious gossip	13.6	17.6	13.6	18.5
Favoritism toward other groups	16.2	32.4	25.3	40.7
Poor evaluations	6.4	26.8	20.4	33.3

* Underrepresented minorities are Blacks, Hispanics, and Native Americans.

† Asian includes all Asians and Asian Americans, including those from the Indian subcontinent.

one experience of discrimination. In all categories, the residents who identified themselves as from the Middle East recorded the highest levels of perceived discrimination, ranging from a figure of 23% from students to 48% from nurses, 52% from attending faculty, and 59% from patients. Underrepresented minorities reported more discrimination from all sources than Asians except for that from nurses and patients.

These data are presented, as is customary in the literature, in terms of percentages reporting “at least one” instance of racial–ethnic discrimination. More detailed examination of the percentages reporting “sometimes” or “often” from some source (more than one or two instances) shows a lower, but still noticeable, prevalence. Roughly 5% of white residents, 17.7% of Hispanic residents, 29.3% of Asians/Pacific Islanders, 44.7% of those from

the Indian subcontinent, 38.7% of African Americans, and 48.1% of those from the Middle East reported racial–ethnic discrimination as occurring more than just once or twice.

There were also differences in the types of discrimination reported by the different groups (see Table 1). White residents perceived discrimination largely in terms of racial or ethnic slurs (32.1%), favoritism (16.2%), or malicious gossip (13.6%), while minority groups tended to additionally report high levels of poor evaluations and being denied opportunities. Those from underrepresented minorities and the Middle East were especially concerned about favoritism (32.4% and 40.7% respectively). None of the groups reported much in the way of racist teaching materials.

In response to the question about seeing racial or ethnic discrimination directed at others, over 60% of all residents reported

Table 2
Reports of Racial–Ethnic Discrimination during First Year of Residency, by Type of Medical School of Graduation

	LCME-accredited (<i>n</i> = 1,598) (%)	Osteopathic (<i>n</i> = 69) (%)	International (<i>n</i> = 173) (%)
Source			
Medical students	3.1	2.9	19.1
Residents at same or lower level	4.7	8.7	28.3
Residents at higher level	6.7	11.6	39.9
Attending faculty	7.8	10.1	47.4
Nurses	7.7	7.2	40.1
Patients	13.0	13.0	39.5
Type			
Denied opportunities	8.2	15.9	30.6
Racial or ethnic slurs	33.9	31.9	22.5
Racist teaching material	1.5	2.9	4.0
Malicious gossip	13.7	14.5	15.6
Favoritism toward other groups	17.4	17.4	32.4
Poor evaluations	7.6	10.1	28.9

personal observations of racial or ethnic discrimination at their places of work. However, the reported frequencies were low. Except for white residents, the modal response for observed discrimination was 2 on a scale of 1 (none) to 5 (a lot) for all ethnic groups. Surprisingly, 30% of those from the Middle East recorded levels of 4 or 5 (a lot).

Table 2 lists the residents' responses by type of school of graduation. Graduates of schools accredited by the Liaison Committee on Medical Education (LCME) and of osteopathic schools reported much less discrimination from all sources than did international medical graduates. International medical graduates also reported more favoritism, poor evaluations, and denied opportunities than did graduates of LCME-accredited or osteopathic schools.

Discrimination was most likely to be observed by residents in the specialty of surgery, followed by those in medicine, pediatrics, and obstetrics-gynecology. Reports of racial or ethnic discrimination were not affected by age of the resident or by the presence of a physician family member.

Discussion

While there is wide recognition that the problem of racial and ethnic discrimination is endemic in the population, the recent rise in racially motivated incidents on campuses of higher learning belies the comfortable assumption that significant progress has been made in recent years. Indeed, concern in the early 1970s over the low percentage of minority students in medicine, which resulted in a well-publicized commitment to increase such representatives, failed to achieve its promise and even slipped backwards after some initial successes.³⁻⁵ Renewed concerns over this issue in this decade have led to the Association of American Medical Colleges' (AAMC's) current 3000 by 2000 Project, the success of which will not be known for several years.⁶

People holding these continuing concerns must be discouraged to know that a significant percentage of residents in a national survey reported personal experiences as well as personal observations of racially or ethnically oriented discrimination in their own places of education and training. It is further discouraging to note that persons from minority backgrounds reported much higher levels of such discrimination, and that certain minority groups experienced such events more than other minorities. Both the size and the diversity of the sample lend weight to these findings.

Of course, this survey, like all surveys of this type, must be interpreted with care. We stress again that the determination of what constitutes racial or ethnic discrimination was left entirely to the discretion of the respondents. This means that any report of discrimination was the result of an actual event and the respondent's interpretation of the event. In self-report surveys, the two cannot be distinguished. While we can be sure of the prevalence of reported discrimination, we cannot be sure of the reasons for those reports. For example, some respondents reported poor evaluations as a form of discrimination. It is possible that some of these poor evaluations were objectively deserved and

not the result of discrimination at all. At the same time, we cannot escape the fact that they were *labeled* discriminatory by the respondents and undoubtedly contributed to a sense of continuing injustice.

Of special interest is the finding that the reports of discrimination varied according to where the residents went to medical school, as well as by identifiable racial-ethnic characteristics. This may result from differing perceptions and expectations on the part of international medical school graduates and their U.S.-trained colleagues. The similarities of reports from osteopathic and LCME graduates suggest that it is variations in cultures, not differences in schools, that produce these conflicting perceptions. These conflicts may be exacerbated by misunderstandings resulting from deficiencies in language and differences in communication styles.

Perhaps there is some small comfort for the profession in the fact that patients are viewed as the greatest source of such discrimination, but the figures for nurses, fellow residents, and attending physicians are both sizeable and disheartening. For members of the minorities, discrimination by health care professionals is not only one more form of perceived mistreatment but may aggravate the problem of equal opportunity in a profession that aspires to high moral ground and is committed to equal access and service to all.^{7,8}

Much has been accomplished as a result of the civil rights movement, and the numbers of minorities in medical school and in the profession have risen over the past several decades. The data presented suggest that there is still a long way to go.

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Correspondence: Steven R. Daugherty, PhD, Director of Program Evaluation, Rush Medical College, 600 South Paulina St., Chicago, IL 60612.

References

1. Baldwin, D. C. Jr., Daugherty, S. R., and Eckenfels, E. J. Student Perceptions of Mistreatment and Harassment during Medical School: A Survey in 10 United States Schools. *West. J. Med.* **155**(1991):140-145.
2. Sheehan, D. H., Sheehan, D. V., White, K., Leibowitz, A., and Baldwin, D. C. Jr. A Pilot Study of Medical Student 'Abuse': Student Perceptions of Mistreatment and Misconduct in Medical School. *JAMA* **263**(1990):533-537.
3. *Report of the Task Force on Expanding Educational Opportunities for Blacks and Other Minorities*. Washington, DC: Association of American Medical Colleges, 1970.
4. Shea, S., and Fullilove, M. Entry of Black and Other Minority Students into U.S. Medical Schools. *N. Engl. J. Med.* **313**(1985):933-940.
5. *AAMC Data Book*. Washington, D.C.: Association of American Medical Colleges, January 1994.
6. Petersdorf, R. G. Not a Choice, an Obligation. *Acad. Med.* **67**(1992):73-79.
7. Bullock, S. C., and Houston, E. Perceptions of Racism by Black Medical Students Attending White Medical Schools. *J. Natl. Med. Assoc.* **79**(1987):601-608.
8. Frierson, H. I. Black Medical Students' Perceptions of Academic Environments and of Peer and Faculty Interactions. *J. Natl. Med. Assoc.* **79**(1987):737-743.

Confronting Racial and Ethnic Disparities in Health Care



Rodney G. Hood, MD

The National Medical Association (NMA) is the oldest and largest national organization representing African American physicians and health professionals in the United States. Established in 1895, the NMA is the collective voice of more than 25,000 African American physicians and the patients they serve. Since its inception, the NMA has been committed to improving the quality of health and health outcomes of minority and disadvantaged people. While throughout its history the NMA has focused primarily on health issues related to African Americans and other medically underserved populations, its goals, initiatives, and philosophy encompass all sectors of the population. More than 100 years since its founding, the NMA has become firmly established in a leadership role in medicine and serves as a catalyst for the elimination of disparities in health and the leading force for parity in medicine.

The race- and class-based structuring of the health delivery system has combined with other factors, including racism, to establish a “slave health deficit” that has never been eliminated. Historically, racism in medicine and health care has operated at institutional, intellectual, policy, and personal levels and is deeply ingrained in the fabric of the U.S. medical-social culture. Racism has thus played a major role in the creation and perpetuation of the continuum of poor health status and outcomes for African Americans and other minority populations.

Throughout U.S. history, two periods of health reform specifically addressed the correction of race-based health disparities. Both had dramatic and positive effects on African Americans’ health. The first period, which was linked to Freedmen’s Bureau legislation, lasted from 1865 to 1872. The “First Reconstruction in Black Health” led to the establishment of black medical schools, hospitals, and clinics throughout the South. These improvements somewhat slowed shockingly high black death rates, improved many health status and outcome parameters, and may have, ultimately, spared U.S. blacks from predicted extinction by the year 2000.

The “Second Reconstruction in Black Health” lasted from 1965 to 1975, and was actually an offshoot of the black civil rights movement. It was tantamount to the modern health system’s opening gambit to solve its racial health dilemma and included hospital desegregation rulings in the courts; passage of the 1965 Civil Rights Act, which eventually outlawed racial discrimination in government-funded

health programs; passage of Medicare/Medicaid legislation, which allowed huge blocks of blacks access to health care for the first time; the establishment of the community and neighborhood health care movements; and legally forced the racial desegregation of hospitals and the admission of black physicians to most hospital staffs for the first time. African American health improved dramatically in virtually every measurable health status, utilization, and outcome parameter for ten years. Stagnation occurred after 1975, and relative and/or absolute deterioration (compared with whites) began after 1980. However, both of these periods of progress, each lasting less than a decade, failed to eliminate race-based health disparities.

If these persistent health disparities are ever to be eliminated, there must be dramatic health system policy, financing, and structural changes, and directed efforts to produce a culturally competent health system and workforce. For these improvements to take place, it is vital and necessary that the use of race continue as a variable in tracking health status and outcomes to serve as a basis to direct all ameliorative efforts.

In 1999, the Centers for Disease Control and Prevention (CDC) analysts documented that accurate race and ethnic data in the public health surveillance systems are critical to developing and implementing appropriate public health interventions. Their review of contemporary health data from 1980 through 1999 (1996 and 1997 data being the latest available) suggests that the “slave health deficit” has never been corrected.

On October 6, 2000, at the invitation of the U.S. Surgeon General, Dr. David Satcher, and of Dr. Mohammad N. Akhter, the Executive Director of the American Public Health Association, the NMA's president and 35 other national leaders met in a "Call to the Nation" to eliminate racial and ethnic health disparities. The conveners of this historic meeting emphasized that the goal of Healthy People 2010 could not be achieved with governmental efforts alone but would require the collective efforts of the American people and the organizations forming this national coalition. The NMA and the other represented organizations were called upon to form this new coalition to develop and implement specific strategies that would address the needs of their constituents that would coincide with the national strategy to eliminate racial and ethnic disparities in the United States.

The NMA has established a Commission for Health Parity for African Americans composed of distinguished health scientists and activists who are committed to this agenda. This commission has created a foundation for the Health Policy and Research Institute, which will develop, study, and recommend corrective actions to eradicate these health disparities. Key recommendations include:

- Creation of a Health Policy and Research Institute that would focus on documenting racial bias as a major contributor to the delivery of unequal health care for people of African descent. The institute would serve as a think tank, focusing on (1) racism

and its impact on health care disparities; (2) developing policies focused on eliminating racism in the health care delivery system; (3) developing a community-focused action center to mobilize the community; and (4) becoming a repository for research and studies on the issue of racial and health disparities.

- Racial bias and racism in medicine in the United States must be accepted as contributing causes and risk factors for the current disparate health status and poor outcomes of African Americans and other affected populations of color.
- The goals of Healthy People 2010 must address the impact of racial bias and racism in medicine in order to achieve health parity for African American and other populations of color.
- Legislation must be created that supports tax incentives for small businesses to provide insurance for low-wage workers.
- Medicaid and Medicare programs must be reformed to restructure eligibility requirements, especially for the elderly and disabled, so that their benefit allocations are more closely related to their medical necessity rather than their socioeconomic status alone.
- Medicaid and Medicare programs must be reformed so that provider compensation is tied to severity of illness and co-morbidity.
- Congressional hearings on racial bias and the impact of racism in health care in America must be held.
- A national presidential and/or Con-

gressional advisory committee on racial bias and ethnic health disparities must be established. It should report annually on the status of health care parity to the president and/or Congress through consolidated reports to the Department of Health and Human Services from the Council of Graduate Medical Education, the National Institutes of Health, and the Office of Minority Health.

- The American Association of Health Plans, the Joint Commission on Accreditation of Health Care Organizations, the National Committee on Quality Assurance, and other accrediting agencies—including those on a state level—must adopt uniform standards to collect health care outcome data based on race and ethnicity. These standards should include data on health care participants and providers and should take into account severity of illness, patient confidentiality, methods of collection, and nondiscriminatory use of the data.
- The NIH Center for Minority Health Disparities must receive increased funding to coincide with its expanded mission and the growing population it serves.

Successful implementation of these recommendations will be difficult. But the goal is no less than the creation of a third period of health reform to correct race-based health disparities—one that will last.

—Rodney G. Hood, MD

Dr. Hood is president of the National Medical Association, located in Washington, D.C.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

		:	
		:	
CLAIRE MORIN, M.D.		:	
Plaintiff,	:	:	
	:	:	
v.	:	:	C. A. No. 0912022
	:	:	
UNIVERSITY OF MASSACHUSETTS,	:	:	
UNIVERSITY OF MASSACHUSETTS	:	:	
MEDICAL SCHOOL, and BOARD OF	:	:	
TRUSTEES FOR UNIVERSITY OF	:	:	
MASSACHUSETTS, plus individual defendants	:	:	
:	:	:	
Defendants.	:	:	

Abbreviation
Ara: appellants reply to appellee; dna: did not affirm; dnr: did not refute; npd: did not produce discovery; rf: refuted

I Introduction

This prima facie case of discrimination, based on race and national origin with retaliation and a hostile work environment, [*Dktn 10/19/2010*] involves the termination of the only black, foreign born physician in the Worcester family medicine residency program, the only person born in Zambia. It adds defendants and charges of defamation with intentional infliction of emotional distress, tortious interference with business opportunities, breach of the covenant of good faith and fair dealing, and violation of 42 U.S.C §§§ 1981, 1983, 1985(3) & the 13th Amendment. Plaintiff reserves her rights to add or remove the Massachusetts and Maryland licensing board as defendants for injunctive relief pending document review.

II. Parties

1. Plaintiff, Claire Morin MD, MPH is a US citizen residing in Gaithersburg MD.
2. Defendant, the University of Massachusetts (UMass) is a public institution of higher education comprised of campuses in Amherst, Boston, Dartmouth, Lowell, and Worcester at 55 Lake Avenue North Worcester, MA 01655. The named individuals were supervising doctors, state actors, employed by UMass.

III. Jurisdiction

3. This Court has jurisdiction over this action pursuant to diversity jurisdiction, Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e-2000e-17, 42 U.S.C §§ §1981, 1983, 1985(3), 28 U.S.C. § 1331, § 1343, Defamation, Infliction of emotional distress and violation of the 13th Amendment charges. The damages are in amounts sufficient to invoke the jurisdiction of this Court [*Dkt 21; RBr p.10*].

IV. Exhaustion of Administrative Remedies

4. The Plaintiff was terminated on May 1, 2006, filed discrimination charges based on national origin and retaliation on October 26, 2006 [*Dkt 21 p.1¶2 Id.*] at the EEOC in Boston and amended to include race and continuing violations around April 30, 2009.
5. She received an August 28, 2009 [*Id.*] right to sue letter for both the Charge and Amended Charge letter and filed suit on November 24, 2009 [*Id.*] Claims of defamation, civil conspiracy with tortious interference with contract and business opportunity, and 42 U.S.C §§§ 1981, 1983, 1985(3) discovered in August 2011, fall within statute of limitations [*dna, rf.*] The Plaint has been amended in May 2010, and September 2011 [*rf*] to incorporate new evidence.

V. Facts

6. The Plaintiff graduated from the University of Zambia in 1988 with a Bachelor of Medicine and Bachelor of Surgery degree [Dkt 21 p.2¶2] started residency at the University Teaching Hospital, and worked at Mutti and Monica Chiumya Memorial clinics in Lusaka Zambia [dnr, dna].
7. Thereafter, she studied Biostatistics and Applied Epidemiology in France. She worked for the National AIDS Reference Laboratory and the Peace Corps Health Unit in Togo before obtaining a Masters in Public Health from Johns Hopkins University. [Dkt 21 p.2¶2] The Plaintiff worked in public health organizations like the World Bank, and was district epidemiologist for (13) counties for over (3) years at the Macon District Health Office, interested in chronic disease. [Dkts 43 at 1.4, 1.5; 101 p.4 and corresponding exhibits]
8. While district epidemiologist, the Plaintiff became Adjunct Assistant Professor at Fort Valley State University [dna, UMass has appointment letter]. She passed the US Medical Board Exams and completed Post-Graduate Year one, (PGY1), in family medicine at the Medical Center of Central Georgia in Macon, Georgia. [Dkt 101-1] She planned to research Integrative Medicine (IM) remedies for chronic disease at Harvard. US residency was a pre-requisite [Dkts 31-1 pp.10-11; 43 at 18; dna, dnr].
9. The Plaintiff and Dr. James transferred to the Family Health Center (FHC) as the first and only black PGY2 residents [dna, dnr, npd]. Unaware the only black faculty member had sued for racial discrimination [dna, dnr, npd]. The Defendant knew the Plaintiff's goal [supra, Dkt 85-3 p.9¶3]. After interviews and observation of clinical skills it attested her previous training was comparable to UMass and warranted PGY2

placement [Dkts 121-1 p.75]. Within (3) days of arriving, the Plaintiff worked the July 4, 2003, call [Dkt 121-1 p.76, dnr,] and thereafter busier and less supervised calls than peers [Dkts 43 at 8; 121-1 p.74; 124-2 p.82; dna, npd]

10.A sixth PGY2 resident [Dr. Rosetti] was hired around November 2003, exceeding the five funded PGY2 spots at FHC [Dkts 43 at 8; 137; dna]. Dr. Shields, the Plaintiff's advisor and director of obstetrics, told the Plaintiff she would not graduate [Dkt 21 p.2¶3] without specific examples or a corrective action plan, as due [Dkt 43 at 35, dna]. FHC felt she could not graduate though data was limited [Id.] Dr. Shields agreed to provide objective data then postponed meetings indefinitely [Id.].

11.Around November 2003, Dr. Rathmell, a FHC supervisor missed a precipitous delivery in obstetrics and screamed at the Plaintiff [Dkt 21 p.15¶3; npd], who was unaware Dr. Rathmell lived far away and needed extra travel time. Dr. Rathmell said the Plaintiff would fail without specifying a corrective action plan [Dkt 97-2 p.49]. Obstetricians reported the hostility of the interaction as unprecedented to Dr. Gleich... [Id; Br p.17¶2; Dkt 97-2 p.49; dna; npd;].

12.FHC said the Plaintiff would not graduate although she performed acceptably, similar or better than peers [Dkts 85-3 p.1; 43 p.8, dna, dnr, npd].

In July 2004, Dr. Manno, a supervising ER director ranked the Plaintiff very good: "Thorough, careful, detail oriented and organized, wonderful communication skill. Knowledge base clearly improved throughout this rotation." In August Dr. Greenberg, a supervising cardiologist ranked her very well: "a dedicated physician. I think she will make a wonderful physician." In October 2003 [Dkts 121 pp.2-9].

During Family Medicine In-patient (FMIS), the Plaintiff passed USMLE 3. This exam permits licensing for unsupervised practice and promotion to PGY3 [Dkt 43 p.6¶2]. In November 2003, Dr. Blount, a FMIS supervisor commended the Plaintiff's novel approach to patient management [Dkts 121-1 p.15; 97-2 p.40.]

"I believe it was a very effective health behavior intervention. When we left the room, the woman wanted to give Claire a hug. I told her how impressed I was with her work." [Id.]

13.Although only FHC where the Plaintiff worked eight hours a week felt she was failing, on January 26, 2004, after Dr. Rathmell's misconduct was reported, the program prescribed remediation [cf. Dkts 97-2 p.10; 121-1 p.21]—an individualized education plan (IEP) to: assess learning needs, formulate an education plan and provide extra supervision and evaluation. [Dkt 21 p.3¶2]

Dr. Gundersen was assigned to supervise progress monthly [Dkt 97-2 p.10]. Neither Dr. Gundersen nor Dr. Shields reviewed the progress or expectations of the IEP. [Dkt 97-2 p.60; dna, dnr]

14.The Plaintiff started remediation although her performance was acceptable, similar or better than peers. Concurrently, Dr. Magee a supervising obstetrician for women's ambulatory health ranked the Plaintiff outstanding for skills that overlap with FHC [Dkts 121-1 p.21; 97-2 p.42; 124-2 p.86, dna]

"relates well to peers and patients, excellent background education and experience in public health." [Dkt 121-1 p.21]

15.When the Plaintiff started remediation, Dr. Candib, a FHC doctor who influenced program decision imputed

“The unevenness, memory problems, gaps, blanks, and occasional clear moments are very confusing...she has functioned better at other times, but appears unrealistic in the present. The differential diagnosis includes: ADD, panic attacks, anxiety disorder, PTSD and other dissociative disorders; drug abuse must be in the differential.” February 1, 2004 [*cf. Dkts 97-7 p.9 ¶18; 121-1 pp. 26, 33¶3; 97-2 p.49;*]

(Ms. Quiros, a reader of Dr. Candib’s editorial *Si Doctora* in the Annals of Family Medicine warned: “Although I realize working with other cultures may be a challenge at times, I would like to emphasize that although particular behaviors may seem to be inherent to a particular ethnic or cultural group, generalizations that attempt to describe all patients within an ethnicity may lead to stereotyping... I only encourage the reader to resist the temptation to associate the behavior she [Dr. Candib] describes with a specific ethnic group or to make generalizations about an ethnic group based on one’s own experiences. (www.annfammed.org/cgi/eletters/4/5/460) [*Dkt 124-2 p.68; rf. relevance*]

16. The allegations of mental disability and drug use followed statements that linked race to poor performance. During obstetrics that day, Dr. Candib deemed the Plaintiff substandard and said she would not graduate without offering a corrective plan [*Dkts 21 p.3¶2; 121-1 p.26*]. The Plaintiff asked what “It’s not that the program does not want people of color,” [*Dkt 21 p.3 ¶2; a*] meant. Dr. Candib emailed that she personally, wanted people of color to do better than others and shine [*Id; a*]. On February 3, 2004, (2) days later, the program wrote the Plaintiff an official letter expressing concerns about her performance [*Dkt. 121-1 p.25, and deferred promotion, refuted that action was retaliatory*] The Plaintiff shared Dr. Candib’s email with Drs. Blount and Gleich [*Dkts 21 pp. 11¶2, 12¶¶1, 2; 124-2 p.72¶2, UMass inferred that Dr. Candib’s email exists*]. There was no follow-up. Dr. Blount asked if the Plaintiff realized who she was dealing with as Dr. Candib trained many faculty members [*Id*]. The Plaintiff was held to higher expectations and scheduled more weekend and holiday calls than peers—calls that tend to be busier and less supervised [*supra*].

17. Despite allegations of mental disability and drug abuse, the Plaintiff was not evaluated per protocol [*cf. Dkt 121-1 p.33, 'she declined services' Adm 1*]. Moreover she performed acceptably, similar or better than peers. Concurrently, Dr. Blake a community physician wrote to Dr. Gleich [*Dkt 124-2 p.83; Br p.18¶2*]

“I’d like to mention Dr. Claire Morin for her work in regard to my patients. In both cases she showed a maturity of medical judgment and a willingness to evaluate the emotional aspects of the case as well as the physical evidence. The result was a very creditable and well organized study that led to proper management. She certainly is a credit to your program.” [*Id.*]

18. On March 29, 2004 Dr. Candib reiterated the Plaintiff cannot pass to faculty [*Dkts 121-1 p.36; 124-2 p.71¶2, dna*], although the IEP had not assessed learning needs despite (2) months of remediation [*Dkt 97-2 p.60*]. The Plaintiff performed acceptably, similar, or better than peers. Concurrently, critical care unit (CCU) experts unanimously ranked the Plaintiff very good. Drs. Davis, Sailer and Sakkenon noted [*Dkt 121-1 pp.2-5, 38-49*]:

“excellent rotation, hard worker, got along well with her colleagues, pleasure to work with, compassionate, has the patient’s wellbeing as her goal, well-grounded in fundamentals, will do well.” In April 2004, Dr. Miotto, a supervising surgeon rated the Plaintiff’s professionalism and competence outstanding: “a very mature resident who asks appropriate questions, is interested in learning and does not shy away from the work that needs to get done.” [*Id.*]

19. Like Dr. Candib, FHC doctors alleged mental disability. On May 21, 2004 Dr. Gundersen reported: “Her inability to properly care for her patients is frightening. I feel she has shown consistent failure at proper management of patients.” [*Dkt 97-2 p.45*]

The program decided not to reappoint the Plaintiff [*Dkt 97-2 p.60*]. Although from the time she started remediation to when the Defendant decided not to promote her to PGY3, she worked Dr. Bates’ PGY3 call [*Dkt 124-2 p.82; 105-6 p.6*], had no IEP review meetings [*w. Dr. Gundersen Dkt 97-2 p.60*] and passed all the rotations [*Dkt 121-1 p.*

80]. The June 14, 2004 directors meeting confirmed: “Claire has not failed any clinical rotations but has failed in her health center performance.” *[Id.]*

The Defendant decided to fire the Plaintiff although her direct supervisor Dr. Ballard gave a favorable report that month *[Dkts 97-2 p.60; 43 at 5; 13-12]*:

“Claire Morin is a very strong resident. On rounds she was efficient and had appropriate differentials. She worked well with her intern, giving her room, but providing excellent supervision. Claire had several very difficult patients this block. She was able to navigate their issues well. Claire was energetic and enthusiastic. She participated in conferences and lectures. She worked well with other residents and is a team player. It was a pleasure working with Claire this month.” *[Id.]*

This was the Plaintiff’s eighth FMIS block without failing. Peers graduate with (7) FMIS blocks under equal protection and due process.

[cf. Adm 2; Dkt 121-1 p.61; 43 at 18; the dismissal is void. Dr. Morin exceeded (7) FMIS blocks without failing. UMass subjected Dr. Morin to higher expectation of four PGY2 FMIS blocks instead of three and a total of (14) FMIS blocks instead of (7). Dr. Candib said blacks must work twice as hard as whites Dkt 124-1 p.5, dnr]

21. The Defendant decided to rescind the Plaintiff’s residency in May 2004 *[Dkt 97-2 p.60;]*. Yet, scheduled (3) blocks with FHC doctors until August 2004 claiming the Plaintiff had (8) weeks to improve *[Dkts 97-2 p.13; 121-1 p.61; dna]*. On June 11,

2004, Dr. Gundersen wrote: “I was appalled at her total lack of knowledge and ability...She CANNOT be trusted... everything we have tried to teach her is totally LOST!!! She is dangerous to our patients and we cannot continue to allow this. Her exams are off. The nurses DON’T trust her...She often does not make sense” *[Dkt 97-2 p.45]*. On June 16, 2004 he added “I must state my protest to allowing Claire on...MMCH...She does not possess a level of skill or competence to be working on this rotation.” *[Id.,]* On June 29, 2004: “It is my recommendation that she fail this rotation.” And on July 7, 2004 “Overall, she functions at LESS than a 3rd year medical student and makes a lot of effort to cover up her knowledge deficits.” *[Dkt 21 pp.3¶3, 4]*

In July 2004 Dr. Gundersen warned the Plaintiff repeatedly by fabricating that her name was on a dictation deficiency face sheet [*Dkt 124-2 p.73-80*]. Supervisors knew PGY1s not PGY2s dictated FMIS charts and said nothing. The Plaintiff dictated the chart to stop harassing emails [*Id.*]

Dr. Kosteki who worked with Dr. Gundersen on June 29, 2004 wrote: “I would not recommend that she pass the rotation or the residency. I think there is an underlying problem in her knowledge/ learning/ style/ experience/ judgment that is likely not able to be fixed and probably presents a significant safety risk to patients.” [*Dkts 21 pp.3¶3, 4; 97-2 p.45*]

The Plaintiff was fired on August 3, 2004 before (8) weeks lapsed [*Dkts 21 p.4¶2; 97-2 p.13*].

22. Employees were surprised. Dr. Sharma a GI specialist wrote to Dr. Lasser, the program chairman on September 16, 2004:

“Her oral presentations, assessments and plans of care were excellent and she had a sound knowledge base, so I was surprised to learn that she is being dismissed from the program due to poor performance.” [*Dkt 43 at 2.1*]

The letter of dismissal described [*FMIS*] performance Dr. Ballard ranked outstanding as marginal [*Dkts 97-2 p.13; 43 at 5*]. FMIS blamed the Plaintiff for a death in May 2004, while she was off-duty and Drs. Williams and Dey on call [*Dkt 97-2 p.39¶1; 85-3 p.3¶7 (n); dna*]. Surprised, Ms. Mayers, the FMIS charge nurse wrote the Chancellor on October 5, 2004 [*Dkt 121-1 p.50*]

“Claire is a highly intelligent, perceptive young woman ... Claire grew in learning showing a good grasp of the material and was able to develop excellent rapport with her colleagues and other disciplines in the hospital. She seeks truth in each and every area of her practice whether in learning discussing or relating to patients and family members. Claire is a high energy self-starter who quickly assumes responsibility and is not afraid to face new challenges and situations; she was quick to fit in with staff and was readily accepted by them. At our institution we are expecting big things from Claire in the way of leadership... Thank you for the opportunity to recommend such a special and impressive young lady.” [*Id.*]

23. The Plaintiff appealed, complaining of discrimination. On October 25, 2004 after a fellowship interview for Integrative Medicine at Harvard, [Dkt 31-1 p.11, *dna*] the UMass Appeal Committee reversed the dismissal and suggested re-hiring the Plaintiff as a PGY1 at another clinic or institution. [Dkt 97-2 p.60]

24. Reluctant, Dr. Lasser wrote to Dr. DeMarco, the Director of Graduate Medical Education (GME) on October 27, 2004 [Dkt 121-1 pp. 59, 60]:

“You are suggesting rehiring her...with a very drastic change in her status...The ambiguity of this decision (suggestion) is very concerning, and I think we need a lawyer to interpret it. For instance if we decide to assist her in finding another job, and fail, have we complied with your decision? If I were in her shoes, I’d get a lawyer pronto. I think Gerry and I need one.” [Id.,]

Dr. DeMarco insisted on November 15, 2004: “I think you do have to take her back...the level you take her back at is the real issue here and also the location. Do you think that it’s possible that she could ever succeed at the same health center or are the faculty too biased against her? You don’t need to answer here but its food for thought.” [Id.]

Dr. Lasser replied: “Option 1 is confusing we already gave her credit for her first year...that option 1 is in fact a viable option, then let’s choose option II—assisting her to find another position. The letter does not say “guarantee her a position somewhere else;” it says “assist” her. If we choose this option and she does not find a position elsewhere, would that satisfy the findings of the review committee? Could she appeal it? Would we be upheld?” [Id.]

25. Opining the Plaintiff a liability, the program *atypically* hired (2) black female doctors for the incoming PGY1 year and interviewed another one for PGY2 with no opening [Dkt 21 p.10¶2; Ara p.25¶2]. In lieu of demotion at FHC, the Plaintiff proposed a competency based education plan to preserve the integrity, coherence, and progression of training [cf. Dkts 43 at 22; 121-1 p.33¶5]. However, despite 12/13 successful PGY2 rotations, in January 2005 the Defendant coerced the Plaintiff to repeat (1) medical school, [Dkt 43 p.6¶2] (5) PGY1, and (9) PGY2 rotations again [Id., Dkt

121-1 p.61]. The Plaintiff did not consent [or sign the plan Dkt 97-2 p.61,]. She worked without a viable option [Dkt 121-1 pp. 59, 60].

26. FHC doctors regrouped as FMIS hospitalists and coerced (6) more FMIS blocks, despite (8) FMIS blocks already (§20, 34). Two were scheduled at a PGY1 level, where the Plaintiff's name circulated spelled *Moron* on call schedules

[Dkt 121-1 p.34; UMass misrepresented to licensing boards that Dr. Morin failed (2) PGY1 rotations Dkt 121-1 p. 72 and misled federal agencies EEOC and court, that she was rehired in March 2005 to mask discriminatory animus infra cf. Dkts 13-7; 21 p.8§ 3; 97-1 p. 1§3; 97-2 p.61]

27. In February 2005 Dr. Shields wrote: "She will be on the rotation [obstetrics] functioning at the level of a medical student. Dr. Morin's role will be to follow along learning the cognitive aspects of management of labor and delivery... If there is additional feedback that the resident prefers not to give directly to Dr. Morin at the time, the resident should contact either Dr. Shields, Dr. DiLorenzo, or Dr. Gleich, as soon as possible to review this." [Dkt 121-1 p.18 *emph. added*]

Dr. Parikh a junior the Plaintiff supervised was assigned as a supervisor [cf. *Id.*, Dkt 124-2 p.79]. Reasonable programs honor USMLE 2 results to assess the cognitive aspects of management. The Plaintiff scored above the US average (86 percent) [Dkt 43 at 18] performing very well in obstetrics. Peers who scored less were not demoted infra.

[USMLE is a valid indicator of professional success cf. *Adm* p.57§7; *RBr* p.35§1 npd, r. Licensed peers e.g., Drs. Bates, Ahmed, James remarked that they scored less or failed once or twice and were licensed. UMass subjected Dr. Morin to higher expectations].

27. In February 2005, Dr. Candib declined the Plaintiff's invitation to discuss issues, expressed disappointment over her reinstatement and said FHC would not change its position [Dkt 97-7 p.10§21, *dnr*]. That month, FHC dropped the Plaintiff's patient list from as many as (10) to as low as (2) each afternoon [Dkts 90 p.6 *last box; dnr, dna, npd*]

Dr. Rathmell reviewed: "Communication is a weak point for Claire as well. She speaks beautifully, but English is not her first language (learned

it as a teen, I believe). Her verbal and written communication is often awkward to the point where comprehension is difficult. It sometimes seems that her thought process is going faster than her words and thus not every thought is coming out completely.” [Dkts 97-11; 112 p.9, the court censored the review to pass judgment]

Dr. Kosteki wrote: “There is a communication problem in that instruction and suggestions made to her as a learner do not always appear to be understood” [Dkt 13-10; dnr]

for a procedure the Plaintiff observed [*Id.*, *UMass fabricated negative reviews and stereotyped Dr. Morin’s performance to race and national origin*]]. Dr. Shields failed the Plaintiff as a medical student and changed Dr. James’s review, although Dr. James had not done the rotation for over a year [Dkt 121-1 p.23; 43 p.10¶1 *dna, omitted from judicial records*] Dr. James was not foreign born and did not complain [*Id.*].

Comparatively the Plaintiff scored higher on in-service exams [*dna, npd though Dr. James consented*] Drs. Kosteki and Shields ignored the Plaintiff on rounds. Dr. Mahoney asked how the Plaintiff could function, remarking she would leave or be unable to function [Dkt 43 p.11]. Dr. Mahoney reported the misconduct to Drs. Earls and Gleich in February 2005 [*Id.*, *dna, npd*]. In March 2005, Dr. Kedian the FHC education director, suggested that the Plaintiff leave UMass and recommended (12) months of PGY1 [Dkt 121-2 pp.20-21].

28. Concurrently, the Plaintiff’s performance was acceptable, similar or better than peers. After weekly hours of (3) at FHC versus (70) at FMIS Dr. Golding and Mahoney advised a promotion to PGY2 [Dkts 121-2 p.7; 97-2 p. 67]

“Claire Morin excelled ...found her to be a dedicated, knowledgeable, enthusiastic and capable physician...strong work ethic...Her admission and progress notes were outstanding: comprehensive, detailed and well organized. She was able to synthesize information well and to communicate it effectively...I have not had an intern that was so diligent or comprehensive in their work...a compassionate physician with a sound

knowledge base who provides excellent care to her patients. I look forward to working with her again.” *[Id.]*

30. Although the review matched Dr. Ballard, who left the program before Dr. Mahoney came. In April 2005, the Defendant did not promote the Plaintiff *[Dkt 97-2 p.65]*. It opposed full licensing and inclined denial of the Plaintiff’s license, pursuant to regulation 243 CMR 1.03(5) *[Dkt 101-8]*. This provision includes complaints of gross incompetence, substance abuse, mental instability and crime. Yet the Plaintiff passed her first attempt at the licensing exam and peers who passed after failing once or twice were licensed *[supra]*.

31. ACGME policies stipulate “Situations that consistently produce undesirable stress in residents must be evaluated and modified.” The Defendant did not “implement prompt and appropriate corrective action,” *[Dkt 43 at 4.3]* although the Plaintiff asked to leave FHC, due to hostility and unfair reviews *[Dkt 43 p.11¶2]*. She stayed at FHC *[Dkt 97-2 p.65]* with adverse outcome, commuting daily to Milford for pediatrics then to Boston for (2) months of obstetrics. Dr. Leonard, an obstetrician, noted multiple skills were above expectations for PGY1 in May 2005 *[Dkt 43 at 37]*. Dr. Boudreau, Chairman of Obstetrics at Tuft University affirmed *[Dkts 124-2 p.86; 13]*

“She has met all qualifications and criteria expected. In addition she has been a truly conscientious physician in her relationship with patients and staff.” *[Id.]*

32. The Plaintiff was unlicensed, on unpaid leave in July 2005 *[Dkt 91 p.8 ¶4]*. New reviews secured a license that required monitoring *[Dkt 43 at 30]*. The Plaintiff moved to Barre Health Center (BHC) in August 2005. Dr. Lillard a peer had done Integrative Medicine (IM) rotations. The Plaintiff asked for some—in vain. In

September 2005, BHC hired a fifth PGY2 resident [Dr. Eilert], although only four PGY2 positions were funded, and scheduled an eleventh FMIS block in October 2005.

33. FMIS changed its normal pattern and failed the Plaintiff for the first time— after (11) FMIS blocks. The supervisors—Drs. Deignan, Gundersen, Kim, Mancini, and Rathmell—were from FHC. Drs. Gundersen and Rathmell shouted publically at the Plaintiff. FMIS gave the Plaintiff and her intern, Dr. Jaquith, (11) patients on the first day and credited the intern for teamwork [*Dkt 43 p.3*]. The Plaintiff was evaluated poorly with stereotypes of race and national origin—disability, poor communication, and provably false assertions. Drs. Rathmell and Kim graded the Plaintiff’s medical knowledge 2/10. Dr. Golding first passed then changed his mind and failed the block

surmising “She should also consider undergoing formal testing to explore the ‘disconnect’ between what she “knows,” and how she practices. This may represent a learning disability, an anxiety disorder, or both” [*Dkt 97-6 p.34, last lines*]

Dr. Potts, the assistant program director remarked: “I am disappointed you have decided that she deserves a failing grade this month when the initial feedback at the unit director’s meeting was so much more positive.” [*Br p.23; Dkt 43 at 44*]

34. Although the Plaintiff ‘failed’ due to perceived disability, her performance was acceptable, similar or better than peers. Drs. Catalina and Walsh from the preceding blocks in September ranked the Plaintiff outstanding [*Dkts 121-1 pp.17-20; 43 at 11.1.9*]

“Good PEDI ED rotation. Eager to see patients. Good medical decision making. Worked well with colleagues.” “Dr. Morin proved to be a perceptive and thorough clinician. Her knowledge of pediatric medicine was superb and she would quickly seek further information when needed. Dr. Morin’s bedside manner placed children at ease and reassured the parents that their children were well taken care of. Dr. Morin was well liked by our nurses and by fellow physicians.” [*Id., dna*]

The Plaintiff appealed October 2005 FMIS, outlining opportunities for effective feedback, noting that reviews did not engage her and therefore unnecessarily portrayed her negatively [*Dkts 43 at 16*]. The evidence was destroyed and the IEP upheld although this was the only way she failed.

35. Holding the Defendant to standards on December 27, 2005 the Plaintiff wrote: “Evaluations suggested I consider formal testing for a learning disability. In over 37 years of formal training no other group of trainers has suggested this. However, I have agreed to consider testing.” [*cf. Dkts 121-1 p.33; Adm 1*] There was no follow up. In January 2006 the Plaintiff did a PGY3 call for Dr. Duro [*dna*]

The Plaintiff asked for and attained objectives of the 12th FMIS block in February 2006 under 24/7 surveillance [*Dkt 43 at 49*]. Remediation was not lifted, as due [*Dkt 97-2 p.65*]. After commending the Plaintiff on February 28, 2006, Dr. Gleich changed his mind and scheduled FMIS blocks (13) and (14) in April and June 2006 respectively, planning to use an objective assessment tool for April 2006 (March 24, 2006 letter) [*Dkt. 121-2 p.26*] The Plaintiff stated she had exceeded FMIS requirement to Drs. Gleich and Potts and asked for IM [*when would she be promoted? How many FMIS rotations were enough? dna, dnr, npd.*].

36. The Plaintiff was subjected to unnecessary and unreasonable jobs with interchangeable medical student, PGY1, PGY2 and PGY3 roles. Around April 26, 2006 Dr. Golding and Mancini coerced the Plaintiff a PGY2, to work overnight as a PGY1.[*dna, dnr, npd*] She was not on Dr. Cao’s March 26, 2006 FMIS emergency back-up list yet admitted (8) patients and covered the service without intern support [*Dkt 121-1 p. 74*]. Supervisors did not stay in house, or divert admissions for patient safety. [*Id.*] Hospitalists called in admissions [*dna*].

37. The Plaintiff filled service obligations at the expense of training; completing (5), (7) and (13) blocks of acute care, obstetrics and FMIS rotations respectively, the most arduous blocks in residency. She admitted patients in the ER during time restricted for education in April 2006, *[Dkt 121-1 p.77]* when Drs. Khan and Lu reported that Dr. Kim, a FHC doctor was paging an admission *[Id.]*. The Plaintiff called saying she did not receive the page only to be text paged: *LIAR [Id.]*. Drs. Khan and Lu looked on speechless *[Id.]*. The incident was reported with no follow up *[Dkt 121-1 p.34. UMass could have verified information with Drs. Khan & Lu who saw the text]*. The Plaintiff completed [was scheduled] (14) FMIS versus (1) IM rotation *[Dkt 121-1 p. 61; 43 at 18]*.
38. Drs. Alhabaal and Khan, peers supervisors, asked the Plaintiff what she did to be treated this way in February and April 2006 respectively. Dr. Alhabaal advised that being foreign trained doctors did not position them to ask about racial comments [dna, dnr].
39. The Plaintiff never welcomed the harassment she was subjected to.
40. With no objective assessment tool, on April 28, 2006, Dr. Golding asked for no comments as he charged the Plaintiff with unsafe critical care and dismissed her, without explaining the evidence or giving her a chance to explain herself. She felt misjudged and emailed for evidence *[Adm 3]*. Subjective reviews (10) days later blamed the Plaintiff for other doctors' errors *[Dkt 121-1 p.62 dna]*. Dr. Gundersen surmised: "She cannot recognize acutely ill patients or problems. Her abilities fall well below that of our 4th year medical student sub-interns." *[Dkt 121-2 p.22]*

Dr. Golding wrote: “There is no systematic bias here. For some reason, you seem to be unable to rapidly and efficiently process complex information to make good clinical decisions when the pressure is on. This is a core skill...in residency.” [*Br. Adm UM001342*]

The letter of dismissal concluded: “We do not feel that you are able to improve your performance enough to successfully and safely complete residency or practice clinical medicine.” [*Dkt 97-2 p.73*]

41. Senior physicians mismanaged patients and then blamed the Plaintiff. In April 2006 Dr. Mancini, a FHC doctor rejected her clinical reasoning with fatal outcomes [*Dkt 37 p.2 (2)*]. The Plaintiff discontinued a blood transfusion in a patient treated for Rhabdomyolysis explaining the anemia was dilutional and warned of likely adverse outcomes. Dr. Mancini, restarted the transfusion. The patient died with a hematocrit of 47.9 [*double the required level in CCU patients*]. Another patient had a ‘cancer’ the Plaintiff assessed to be an acute abdomen and suggested surgery [*Dkts 37p.2 (3); 121-1 p.73¶2 line 13*]. Rejecting this, Dr. Mancini paged Dr. Khan (Hena) [*Id.*] who took over management [*Id.*]. The patient died from an acute abdomen. The Plaintiff was fired. Dr. Golding called this the most egregious example of mismanagement:

“she wanted to obtain a surgical consultation as her next step. Although not frankly wrong, surgical consultation would take a second priority to stabilization in this situation, and that stabilization needed to occur in CCU...I can understand why Dr. Mancini called hena.” [*Dkt 121-1 p.73¶2*]

“she fails to recognize the import of certain signs and symptoms, and does not proceed aggressively enough in her evaluation and treatment.” [*Dkt 97-6 p.44¶2*]

The Plaintiff suggested the diagnosis to Dr. Deligiannedes at sign out based on history [*npd, court refused to extend discovery to allow depositions*]

Specialists would confirm Plaintiff work-ups that supervisors rejected [*Dkt 85-3 p.2, npd*]. When the Plaintiff did Dr. Duro’s PGY3 call in January 2006, Dr. Mancini scolded and canceled the Plaintiff’s esophageal cancer work up for FC, a patient [*Dkt 85-3 p.3 (i)*,

npd]. Specialists confirmed esophageal cancer [*Id.*]. In April 2006 Drs. Gleich and Ali scolded the Plaintiff for ordering a cancer screen in a patient who developed a clot on therapeutic levels of Coumadin [*Dkt 85-3 p.2 (c); npd*]. They consulted hematologists, who ordered the same thing—a cancer screen [*Id.*] The program called the Plaintiff a *good guesser*. Dr. Golding wrote: *she anticipates and responds to questions well*—not that she is competent [*Dkt 97-6 p.43¶5*].

42. ACGME policies stipulate: “The psychometric characteristics of summative evaluation tools are important. That is, both the evaluator and resident should believe that an assessment tool used for summative evaluations provides evidence that can be used to make valid and reliable decisions.” [*Dkt 31-1 p.7¶1 line 9*]

Yet subjective, formative reviews from family doctors failed specialty skills against the judgment of experts who invariably passed them. Dr. Davis an expert wrote: “I am finishing my 19th year here at UMASS Memorial Health Care as a staff pulmonologist/Intensivist and sleep specialist. Our group is responsible for the medical intensive care unit and for all of the residents who rotate through the unit. Claire...got along tremendously well with everyone in the unit, not always the case in such a pressure packed and busy place. I thought she was smart, bright and energetic. I never had any concerns about her ability to perform well as a resident physician...I have run into Claire from time to time since on the routine care wards and I have always felt the same about her in this setting.” [*cf. Dkt 124-2pp.81, 86, contrary to UMass Dkt 21 p.6¶1 this was the opinion of almost all experts*]

The Plaintiff asserted: “Because I was denied due process and not shown how my critical care management deviated from standard practice or given specific, objective substantiating evidence, I cannot accept this decision to terminate my residency.” [*Dkt 43 at 10c to 10g; quoting 10f ¶2; cf. Supreme Ct Cleveland Bd. Of Educ. v. Loudermill 470 U.S. 532, 546 (1985)*]

At the May 1, 2006 dismissal meeting in the program office, with Drs. Gleich, Golding and Potts in attendance, Dr. Golding asked what would happen if the Plaintiff won on appeal [*dna, dnr, npd*] Dr. Gleich said she would not get licensed. [*dna, dnr*]

Dr. Golding wrote “none of us believes that you have the ability to do clinical medicine...I and my colleagues believe that you are dangerous when unsupervised.” [Ara p.26]

43. Damaging statements to third parties include a May 2006 report to the licensing board to be released in September 2011 [*the Ct. refused to compel these subpoenaed HCFD reports Dkts 63; 124-2 p.55-61;*] Upon information and belief it incriminates the Plaintiff about events from ¶41,42) [*Id.*] without due diligence to ascertain the truth. It has unjustly blocked licensing since 2006. Unaware, the Plaintiff wasted resources applying for licenses and residencies that invariably lost interest after contacting the Defendant [*See e.g., Dkt 107-6*]. Alleged poor communication disqualified the Plaintiff [*When Maryland ignored poor communication reviews (speech is a critical job function) to license Dr. Morin, UMass retracted training to make Dr. Morin ineligible Dkts 121-1 pp.71-72; 124-2 pp.62-63; and denied preventing licensing to the EEOC, a federal agency to secure adverse outcome for Dr. Morin’s charges Dkt 97-1 p.2*]

because she is not a native English speaker [*National origin discrimination*].

The EEOC asserted: “while you have knowledge of the learned materials, you had a difficult time communicating that knowledge to nurses, doctors and patients.” [*Id.*]

Maryland closed the Plaintiff’s license application in 2010. UMass reviewed “she had multiple incidents where evaluators documented poor performance where there was poor communication and errors in medical management.” [*Dkt 121-1 p.71 ¶8 ln3*]

UMass denied full and equal enjoyment of benefits, privileges, terms, and conditions of the contractual relationship that peers enjoyed by refusing to credit any UMass training, [*Dkts 121-1 pp.71-72; 124-2 pp.62-63*] yet the Plaintiff worked as a Chief Medical Officer for over a year and maintained CME’s. [*Dkt 101-9*] Depriving credit for (2.5) years at UMass wasted (8) years towards IM. Peers graduate with (39) rotations including (13) PGY2 blocks. The Plaintiff completed (41) rotations including (19)

successful PGY2 [Dkts 43 at 18; 121-1 p.61 UMass omitted 7/04 & 7/05] blocks in violation of the 13th Amendment that prohibits involuntary servitude.

[UMass refused to credit training after scheduling twice the required number of FMIS rotations]

44. Records were altered in response to references or investigations, to justify violations, including: August 18, 2009 assertions to the EEOC that listed (3) failed

rotations from July 2003 to February 2004: “Many of these rotations were duplicates because Dr. Morin did not successfully complete the rotation the first time.” (¶ 20, 25, 34) [cf. Dkt 124-2 p.1¶2; 121-1 p.80]

The program’s October 17, 2006 letter discredited obstetrics in December 2003 [Dkt 121-1 p.61]. Yet it’s May 26, 2004 letter states [Dkt 97-2 p.11¶2]

“While you have not received an official failing grade for any block rotation to this point, your performance on the health center has been failing.” [Id.]

August 2009 the EEOC wrote: “Respondent has no record of receiving any requests for information verifying your employment, and if it did, Respondent would have only provided information pertaining to your dates of employment and job title. Respondent further stated that it cannot fill out a form that requests credentials because you did not successfully complete anything other than a PGY1 level...there is no evidence that Respondent provided negative references or information to prevent you from being licensed as a doctor in other states.” (¶ 20, 43) [Dkts 97-1 p.2¶3; 121-1 pp.71-72]

“Dr. Morin was demoted to PGY1 level as part of her competency based educational plan,” (¶ 25). [Dkt 121-1 p.33¶5,]

“Dr. Morin’s allegations of mistreatment were investigated...there was no evidence of mistreatment...rather Dr. Morin’s opinion that she was being judged unfairly was divergent from the opinions of her evaluators.”(¶ 11, 18, 22, 27, 28, 37) [Dkt 121-1 p.34], “Dr. Morin was never suspected of nor was an allegation made of illicit drug use. There is no information of this nature contained in her file,” (¶15) [Dkt 121-1 pp. 26, 33¶4]

“We were not aware of a psychiatric evaluation and Dr. Morin did not say she was suffering from any psychiatric disorder. We did ask Dr. Morin if she might be suffering from undue stress or a psychiatric disorder in the course of our evaluation of her performance. We advised her of the availability of free and

confidential counseling services. She declined these services and maintained that she had no problems.” [Dkt 121-1 pp. 26, 33¶3]

The Plaintiff: “evaluations suggested I consider formal testing for a learning disability. In over 37 years of formal training no other group of trainers has suggested this. However, I have agreed to consider testing.” (¶35) [Adm1]

Many assertions contradicted material facts.

45. Decision makers based critical decisions on unreliable information. The August 18, 2009 letter to the EEOC lists Dr. Gundersen evaluating Geriatrics, a rotation he never taught

[Dkt 124-2 p.1; dna or show eval; UMass was untruthful to a federal agency to secure adverse outcomes for Dr. Morin’ charges].

The termination was based on evidence from (¶40, 41.). The December 16, 2003 meeting asserted that Dr. Gundersen met the Plaintiff monthly [Dkt 121-1 p.57]. The requirement started after January 26, 2004 (¶13) [Dkt 97-2 p.10] and failure to comply reversed the dismissal. [Dkt 97-2 p.60] The May 18, 2004 meeting with CCU concerns from Dr. Saltin, a chief resident who never worked with the Plaintiff [cf. Dkts 124-2 p.80; 121-1 p.43; 85-3 pp.8¶¶6, 9] belied reviews from direct supervisors like Drs. Sailer and

Saukkenon who confirmed the rotation was excellent: “Compassionate, has the patient’s well-being as her goal. Well-grounded in fundamentals. Will do well. Its looks like I already completed this evaluation. I will submit it again.” [Dkts 121-1 pp. 43, 46]

46. The actions were intentional [Dkts 97-6 p.10¶18; 97-7 p.10¶21] done with malice, fraud [See e.g., Dkts 91 p. 4¶12; 97-1 p.2¶13; 97-6 p.39(23); 121-1 p.33 denying preventing licensing; alleging drug use; & learning disability] or oppression in reckless disregard of inalienable rights because the Plaintiff is a black foreign born doctor [Dkt 124-1 p.5; dnr], and extended beyond UMass to deny rights and privileges protected by the Constitution and laws of the United States [Dkt 50; 50-1] Consequently

the Plaintiff and her family lost wages, salary, benefits, employment related opportunities, and monies she would have received if UMass had not discriminated. The family suffered parental deprivation *[Death]*, homelessness, humiliation, mental anguish, emotional and physical distress *[Dkt 140; 140-1]* that injured mind and body in ways no reasonable person should endure *[Dkt 46-1]*.

47. UMass discriminates based on race and national origin. In June 2011, MCAD found the University liable for discrimination based on race and national origin with retaliation and ordered UMass to promote the plaintiff Dr. Sun. She wants an order to increase the recruitment of women of color. In multiple instances UMass minimized the achievement, capability and privileges of people of color. All black residents, Drs. James, Morin, Service and Williams, were placed on probation. *[Dkt 105-6; dna it can be inferred that a group of four black doctors could confer and discover they were all on remediation]* UMass recommended Dr. James for in-patient care privileges only after this complaint was filed

[dna, After Dr. James reported a 2010 letter from Dr. Potts permitting inpatient work at an Indian reserve, UMass contacted her. She fears UMass may retract the letter. She consented review of her personnel file. Her emails also changed font and tone to courier and formal Dkt 121-1 p.23]

Around September 2005, FMIS retrogressively failed a rotation she passed months earlier, repeated it, and demeaned her by assigning Dr. Ali, a junior she had supervised as supervisor *[Dkt Id.]*. A newspaper article commending Dr. Service was displayed at BHC *[DNA]*. He was the last doctor to finish among peers *[Dkt 121-1 p.1]*. The only black faculty member at FHC sued for racial discrimination *[dna, although FHC employees ended up paying part of the lawyer fees]*. An African born manager at UMass

Mr. Martins, was verbally abused demoted, humiliated and terminated by Mr. Zanette, a junior he previously supervised infra. In October 2009, the Appeals Court reversed summary judgment for UMass on multiple counts including racial discrimination and breach of the covenant of good faith and fair dealing. See Martins v. University of Massachusetts Medical School No. 08-P-1343. From 2003 to 2006 (6) out of (7) doctors terminated, was foreign born [Adm 4]. In October 2006, a nurse practitioner complained that she had never encountered such overt racism after an UMass employee said, “Go back to Africa you fool.”

[Like Dr. James, Ms. Banigo consented release of her complaint. Like Dr. Rung she acknowledged UMass’s bias and declined to testify.]

Claire Morin MD, MPH
84111 Arbor Drive
Shrewsbury MA, 01545
December 27, 2005

Dear Dr. Gleich:

I thank the Promotions Committee for meeting with me on December 15, 2005. During the meeting I appealed a failing grade in Family Medicine In-service (FMIS), stating that key assertions considered in this evaluation came from events which were misunderstood or did not happen. I said that the events did not justify failing a resident without understanding their perspective, ensuring a safe, supportive, learning environment and exhausting principles of effective feedback. I then quoted the assertions and explained pertinent references. (The materials are included with this letter).

I asked what measures would ensure a safe, supportive, learning environment during the FMIS rotation in February 2006. (FMIS is the first failed rotation since I resumed residency in January 2005. Notably, almost all the attendings who evaluated this performance have recent, close-affiliation with the clinic that dismissed me in July 2004; which is the clinic from which the Appeals Committee urged I be transferred).

I volunteered to continue using the priority list and clarify communication; I understand the need to listen more, ask more questions and supervise my intern. Further, I recognize the willingness of faculty to train me. However, the specifics of what I am remediating are unclear. Based on the evaluations, could you help me formulate a specific, objective, evaluation tool in the form of a competency check list that will be used to assess my performance weekly? Please alert me in a timely fashion, to allow for improvement, if my performance is deemed failing; not three weeks after completing the rotation as was the case with FMIS.

The evaluations suggested I consider formal testing for a learning disability. In over 37 years of formal training no other group of trainers have suggested this. However, I have agreed to consider testing.

Thank you for your willingness to continue working with me. I am determined to do what it takes to succeed.

Sincerely,
Claire Morin MD, MPH

ADULT MEDICINE/FAMILY MEDICINE

The Adult Medicine curriculum consists of one month of critical care at the Memorial CCU, seven months of inpatient medicine on the Family Medicine Inpatient Service (FMIS) at Memorial, 2-3 months of Health Center Chief (3rd year) acting as attending for the Health Center's inpatients, as well as ongoing training in the Health Centers where residents manage their own panel of outpatients. There is one month of outpatient family and community medicine. In addition, there are months in geriatrics and cardiology.

GOALS

Graduating residents will:

1. Demonstrate skills and knowledge base for management of adult patients with single or multiple organ system disease in a multidisciplinary care model.
2. Demonstrate knowledge and experience of community, public health and practice management issues adequate for entry into independent practice.
3. Demonstrate medical, interpersonal, procedural and psychosocial skills necessary for excellent outpatient care of adult and elderly patients.

LONGITUDINAL

Health Center Experience

Conferences, Workshops, Grand Rounds

PGY-1

Family Medicine Inpatient Service (FMIS)

Critical Care Unit

PGY-2

Family Medicine Inpatient Service (FMIS)

Geriatrics

Cardiology

PGY-3

Family Medicine Inpatient Service (FMIS)

Health Center Chief

FAMILY MEDICINE INPATIENT SERVICE**PGY-1****General**

Three blocks of adult inpatient medicine at Memorial overseen by 2nd and 3rd year family medicine residents, teaching attendings, and by the Inpatient Services Director.

Director: Jeremy Golding, MD – (508) 334-5560

Coordinator: Diane Moloney – (508) 334-5661

Objectives

By the end of the experience, residents will:

1. Demonstrate diagnostic and management skills in the management of hospitalized patients.
2. Demonstrate proficiency in comprehensive history-taking and examination skills in a condensed, efficient, and patient centered manner.
3. Demonstrate the ability to present patients in the standard format.
3. Demonstrate skills for common procedures including lumbar punctures, arterial punctures, paracentesis, thoracentesis, EKG interpretation, and ABG interpretation.
4. Participate in codes when on call, and maintain current ACLS.
5. Coordinate care of patients by communicating with attending physicians and consultants and gathering diagnostic results to formulate a comprehensive plan of care.
6. Demonstrate skills in evaluating and treating urgent patient-related conditions and seeking appropriate backup.
7. Function as part of a multidisciplinary team.
8. Demonstrate sensitivity and compassion in dealing with patients and their families.
9. Demonstrate accurate, efficient, conscientious sign-out practices.

Schedule

Start at 7:30am weekdays, 6:30am on Mondays and Tuesdays, 8:00am weekends and holidays. Residents meet in the South 6 conference room at 7:30 on weekdays for brief sign-in rounds. Call is every third day. When there are four teams night float works Tuesday through Friday, 7pm - 7am. Hospitalists cover call on Sunday and Monday nights with the intern on-call. Health Center session is once per week on pre-call day.

Conferences

Morning Report, where cases are reviewed is at 10AM. Subspecialty Lectures, Behavioral Rounds, Teaching Attending Lectures, Journal Club, Radiology rounds, OB lectures, EKG teaching conferences, and Pharmacy lectures occur on a regular schedule. Noon lectures held by the Department of Medicine are also open to House staff members. Family Medicine Grand Rounds is Tuesday from noon to 1:00PM.

Directions

Memorial Campus, 6th floor, meet in conference room

FAMILY MEDICINE INPATIENT SERVICE

PGY-2 AND PGY-3

General

Three months for PGY2, and one month for PGY3, of adult inpatient medicine at Memorial, supervised by teaching attendings and the Inpatient Services Director.

Director: Jeremy Golding, M.D. - (508) 334-5660

Coordinator: Diane Moloney - (508) 334-5661

Objectives

By the end of the experience, residents will:

1. Demonstrate advanced skills in the management of adult patients with single or multiple organ system diseases.
2. Demonstrate proficiency at supervision of a team, consisting of junior House staff and/or medical students.
3. Demonstrate skills for common procedures including lumbar punctures, arterial punctures, EKG interpretation and ABG interpretation, thoracentesis and paracentesis.
4. Run codes when on call and maintain current ACLS.
5. Coordinate care of patients by communicating with attending physicians and consultants and gathering diagnostic results to formulate a comprehensive plan of care.
6. Participate in morning report by presenting cases or articles that have been reviewed, as well as participating in discussion about patients' diagnoses and work-up.
7. Function as part of a multidisciplinary team.
8. Demonstrate ability to work with patients and families regarding sensitive issues, including advanced directives.
9. Provide teaching and support to junior House staff and medical students.

Schedule

Start at 7:30am weekdays, 6:30am on Mondays and Tuesdays, 8:00am weekends and holidays. Residents meet in the South 6 conference room at 7:30 on weekdays for brief sign-in rounds. Call is every third day. When there are four teams night float works Tuesday through Friday, 7pm - 7am. Hospitalists cover call on Sundays and Monday night such that on call residents are in-house overnight only on Saturdays. Health Center session is once per week on pre-call day.

Conferences

Morning Report, where cases are reviewed is at 10AM. Subspecialty Lectures, Behavioral Rounds, Teaching Attending Lectures, Journal Club, Radiology rounds, OB lectures, EKG teaching conferences, and Pharmacy lectures occur on a regular schedule. Noon lectures held by the Department of Medicine are also open to House staff members. Family Medicine Grand Rounds is Tuesday from noon to 1:00PM.

Directions

Memorial Campus, 6th floor, meet in conference room

Message

Page 2 of 2

Jeremy Golding, MD

28

-----Original Message-----

From: mwall66@aol.com [mailto:mwall66@aol.com]

Sent: Friday, May 05, 2006 6:49 AM

To: GoldingJ@ummc.org

Subject: Evaluation file

I was at the program office reviewing my evaluation file searching for specific, documented examples from nurses & colleagues about the many instances I allegedly jeopardized patient safety. Apart from the handwritten note from the nursing supervisor which I addressed, nurses and colleagues denied any specific concerns about patient safety when I asked them during the rotation. So in requesting specific examples from you I am trying to keep objective. I realize that it is easy to fall victim to perceptions and how people would like to think without even realizing it & actually communicate this inaccurate perception.

For example, did you note that the email the nursing supervisor sent in reference to South 6 treatment room is addressed to 'Claire MORIA at UMassMed' not 'Claire MORIN at UMassMemorial'? I informed you that I did not receive this email. Yet in an email to several supervisors, requesting a copy of this email, you write that I probably lost the e-mail; tacitly communicating to several supervisors, in your capacity as Service Director, that I was not not candid in saying I did not receive the email-- I probably lost it. It would then appear that my efforts to learn the contents of this communication are a charade. Again, these inaccuracies, unnecessarily portray me in a negative light.

Likewise, in estimating the time my co-resident, attending and I met to discuss a patient. I would like you to be aware that I had called my co-resident for an estimated time of the discussion we had, which probably corresponds to the time the order for Flagyl was written.

Thanks and have a nice day.
Claire

The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, transmission, re-transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you received this in error, please contact the sender and delete the material from any computer.

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8/3/2006

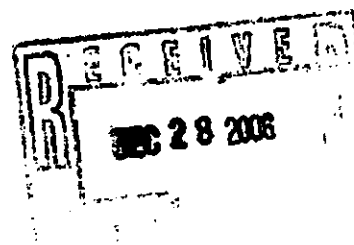
UM001596



Diversity and Equal Opportunity Office
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655-0002 USA
508.856.2179 (office) 508.856.1810 (fax)

December 27, 2006

Linda E. Ingle, Investigator
U.S. Equal Employment Opportunity Commission
Boston Area Office-523
John F. Kennedy Fed Bldg
Government Center, Room 475
Boston, MA. 02203



RE: Claire Morin vs. University of Massachusetts Medical School
EEOC Charge #: 523-2007-00119

Dear Ms. Ingle:

Enclosed, please find the additional information you requested in the above-referenced complaint.

1. Submit a list of all residents who have been involuntarily terminated from the Residency program due to performance related issues, for the past three years. Identify each employee by name, date entering program, national origin, and date removed from the training program.

Response:

We object to providing the names of the residents who were involuntarily terminated as personnel information protected from disclosure under Chapter 66A. However, without waiving this objection, we will provide the information as submitted on Attachment A.

2. Submit a list of all residents who are currently in the same Family Practice Residency program that Charging Party was in i.e., PGY 1, PGY 2 and PGY 3. Identify each resident by name, date entered into program, and national origin.

Response:

We object to providing the names of the residents as personnel information is protected from disclosure under Chapter 66A. However, without waiving this objection, we will provide the information as submitted on Attachment B. Please note that the Medical School does not request or track national origin information and the attached is based on information volunteered by residents or based on visa status.

Please contact me should you need additional information.

Sincerely,

A handwritten signature in cursive script that reads 'Marlene S. Tucker'.

Marlene S. Tucker, Assistant Director

ATTACHMENT A

Gender	National Origin	Hire Date	Termination Date	Department
Male	Russian	07/01/03	06/03/04	Internal Medicine
Female	Albanian	07/01/04	03/25/05	Pediatrics
Female	Indian	07/01/04	05/27/05	Surgery
Male	Indian	07/01/05	06/30/06	Neurology
Male	Lebanese	07/01/01	06/30/05	General Surgery
Male	USA	07/01/05	05/30/06	Vascular Surgery