UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
OFFICE OF THE CHIEF ADMINISTRATIVE HEARING OFFICER

October 15, 2008

GURPREET KAUR SODHI, Complainant, v. MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT, Respondent.	)))))))))	8 U.S.C. § 1324b Proceeding OCAHO Case No. 06B00001

FINAL DECISION AND ORDER

I. PROCEDURAL HISTORY

Dr. Gurpreet Kaur Sodhi, a physician from India, filed a complaint in which she alleged that the Maricopa Integrated Health System (MIHS or Maricopa), through its Department of Psychiatry, failed and refused to rehire her for the third year component of its Psychiatric Residency Training Program (the program) in retaliation for her having previously filed a charge of discrimination with the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC), and that she was threatened with additional retaliation when she protested. Maricopa denied the material allegations of the complaint and raised various affirmative defenses. Dr. Sodhi filed a reply to the affirmative defenses as permitted by applicable rules.[1] 28 C.F.R. § 68.9(d). The action arises under the provisions of the Immigration and Nationality Act (INA), 8 U.S.C. § 1324b(a)(5) (2006).

After a failed mediation process and a period devoted to discovery and motion practice, a partial summary decision was entered finding additional claims Dr. Sodhi sought to raise to be untimely under the standards set out in *Ledbetter v. Goodyear Tire & Rubber Co.*, _U.S._, 127 S.Ct. 2162 (2007) and *Nat'l R.R. Passenger Corp. v. Morgan*, 536 U.S. 101 (2002). *Sodhi v. Maricopa*

[1] Rules of Practice and Procedure, 28 C.F.R. Pt. 68 (2008).

County Special Health Care Dist., 9 OCAHO no. 1124 (2007).[2] As to Dr. Sodhi's timely claims, a four-day hearing was commenced beginning at 8:50 a.m. on February 25, 2008 in Phoenix, Arizona. Witnesses were sworn, evidence was heard, exhibits were admitted, and a transcript was prepared consisting of 1162 pages exclusive of the exhibits. Testifying in this matter in addition to Dr. Sodhi were Dr. Lisa Jones, Dr. William James, Dr. Maricela Moffitt, Dr. Lydia Torio, Dr. Carol Olson, Dr. Andrew Parker, Dr. Carla Denham, and Dr. Domiciano Santos.

The parties were notified when the transcript became available and were given a period of time until April 15, 2008 in which to file motions for correction of the transcript pursuant to 28 C.F.R. § 68.48(b). No such motions were made at the time, but on July 23, 2008 Maricopa filed a Motion to Obtain Copy of Audio Record of Hearing. The motion was denied on August 7, 2008. The parties were also given a schedule for the filing of proposed findings of fact and conclusions of law, which was extended twice pursuant to their request. Both parties filed their proposed findings and conclusions as well as their posthearing briefs.

Respondent filed a reply brief on September 10, 2008, attached to which were three tendered exhibits. Posthearing submissions authorized at the close of the hearing were limited to proposed findings of fact and conclusions of law, and posthearing briefs. Rules permit document submission after a hearing only under strictly limited conditions. 28 C.F.R. § 68.50. Those conditions have not been met, and the proffered documents are not accepted as part of the record. The record was closed as of September 10, 2008 upon receipt of respondent's reply brief.

II. BACKGROUND INFORMATION

MIHS is a 500-bed general hospital responsible for the care of the indigent population of Maricopa County, Arizona. Dr. Maricela Moffitt was at all relevant times both the Director of Academic Affairs and the Director of Medical Education for MIHS. Through its Department of Psychiatry, MIHS is the parent for a four-year specialized educational program in which physicians are trained to become psychiatrists. Dr. Glenn Lippman was the Chair of the Department of Psychiatry at all relevant times up until November of 2004, when Dr. Carol Olson

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[2] Citations to OCAHO precedents reprinted in bound Volumes 1 through 8 reflect the volume number and the case number of the particular decision, followed by the specific page in that volume where the decision begins; the pinpoint citations which follow are thus to the pages, seriatim, of the specific entire volume. Pinpoint citations to OCAHO precedents subsequent to Volume 8, where the decision has not yet been reprinted in a bound volume, are to pages within the original issuances; the beginning page number of an unbound case will always be 1, and is accordingly omitted from the citation. Published decisions may be accessed in the Westlaw database "FIM-OCAHO" or on the website at (http://www.usdoj.gov/eoir/OcahoMain/ocahosibpage.htm#Published).

became the Acting Chair. Dr. Olson was named Chair in August 2005. Dr. Lisa Jones was the Director of the Psychiatric Residency Training Program from 1999 until January of 2004; her successor in that position was Dr. William James, who became the Director on January 26, 2004. Drs. Torio, Parker, Denham, and Santos were attending psychiatrists in the program during the relevant time period. Other attendings during the period included Dr. Samuel Hand, Dr. Michael Brennan, Dr. Jacqueline Pynn, Dr. Jennifer Weller, and Dr. Michael Hughes.

The program is housed at the MIHS Desert Vista Campus in Mesa, Arizona, and also maintains liaisons with other mental health programs and institutions. The program includes a variety of supervised "hands on" medical and psychiatric rotations, as well as a didactic component consisting of classroom learning experiences. A rotation is an assignment in which a resident works under the direct supervision of an attending physician or psychiatrist seeing patients in one of the program's medical facilities. Rotations are regarded as the heart and soul of the program, with four days a week being devoted to them, and only one day a week to classroom work.

The individual years of the residency program are generally referred to as PGY-1, PGY-2, PGY-3, and PGY-4. The PGY-1 and PGY-2 rotations are standard in most programs. PGY-1 generally includes six months of primary care medical rotations (divided into four months of internal or family medicine and two months of neurology), and six months of inpatient psychiatry rotations. Residents also take night, weekend, and holiday calls periodically. PGY-2 rotations typically include several months of inpatient psychiatry, a few months of consultational liaison psychiatry, and a short period of emergency psychiatry. Residents are expected to complete all the standard rotations. The PGY-3 year of the MIHS program usually consists of twelve months of continuous outpatient psychiatry during which a resident assumes more responsibility and works more independently without the close supervision which characterizes the first two years. The fourth year provides a resident with the opportunity to pick up any missed rotations or to obtain additional training and explore special interests in elective rotations, as well as to do more outpatient work.

Generally speaking, each PGY year starts on July 1 and ends on June 30 of the following year, but residents are occasionally taken "off-cycle" for various reasons. A new resident entering the program is retained on a one year contract for the first year, then renewed on a year-to-year contract basis for successive program years. Typically there are about 18 residents enrolled in the program at any given time, that is, an average of four or five residents in each of the four years. For a variety of reasons this balance is not always achieved, but ideally there would be no fewer than three and no more than five residents in a particular PGY year.

The governing body for the program is a residency committee chaired by the Director.[3] Pursuant to MIHS policies, the committee is responsible for establishing the curriculum as well as for reviewing faculty credentials, and for dealing in executive session[4] with issues involving resident performance. The executive committee tracks and monitors the performance of each resident, and when necessary makes recommendations for dealing with misconduct or inadequacies. The committee is advisory to the Director. The executive committee also rates each resident annually using a report captioned "Development of Personal Program of Self Study and Professional Growth." The report employs a five point scale to describe the ability of the resident to perform each of a number of specific tasks when presented with a clinical problem, for example the ability to interview a client with a psychiatric illness or substance abuse problem, to define a problem, to make treatment recommendations, to evaluate a patient, and to establish rapport with a patient. Each resident also completes an annual self-evaluation using a similar format and criteria.

Residents in the MIHS psychiatric residency training program receive ongoing feedback regarding their performance in a number of other ways as well. In addition to the annual global assessment by the executive committee, each resident receives a written evaluation of his or her class participation and performance for each academic course or seminar taken, and written evaluations are done by the attending physicians for each of their rotations. Periodic meetings and discussions are had with the course instructor or the attending physician. Rotation evaluations rate residents in the categories of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. Various subcategories listed under each of these major headings can be checked off as "at expectations" (AE), "needs improvement" (NI), or "not applicable" (NA), and space is provided for comments. A final section, the overall impression, is graded as either at expectations or needs improvement, and space is also provided in this section for additional comments.

Twice a year, each resident meets with the program director for a comprehensive Biannual Review of the resident's progress, which includes a summary of all the didactic and rotation activity during the period. The form used for Biannual Reviews rates residents in the same categories as are contained in the rotation evaluations, and additional sections are provided to

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[3] At different times, this committee was also referred to as the resident development committee or the progressions committee. The committee includes the assistant director, the chairperson of the department, the service chiefs, the psychiatrists from the facilities that support training, the chief resident, the administrator of the hospital, the residency coordinator and sometimes some guests.

[4] The executive session of the committee is limited to members of the faculty. Others are excluded so that candid and confidential discussions may be had about the progress of individual residents.

note the resident's particular strengths and to identify any specific areas requiring individual remediation. Because more than half of the residents in MIHS's program are not native speakers of English, it is not uncommon for language issues to be identified as a problem area for some new residents, and some took classes in English as a Second Language (ESL) at a community college at MIHS's expense.

The Accreditation Council for Graduate Medical Education (ACGME) is the governing body for a variety of medical residency training programs in the United States, including psychiatric residency programs. The ACGME establishes accreditation guidelines and coordinates numerous programs, which must comply with the ACGME standards in order to be accredited. An applicant for admission to such accredited residency programs may complete and submit an Electronic Residency Application Service ("ERAS") application on the ACGME website, and be entered into a National Residency Matching Program ("the Match"). The ACGME then matches applicants with ACGME-affiliated programs.

The United States Medical Licensing Examination (USMLE) consists of a series of examinations which must be taken and passed as a condition of practicing medicine in the United States in any specialty. Under ACGME rules, aspiring physicians are required to pass Parts 1, 2, and 3 of the USMLE at various stages. Part 1 tests knowledge of basic sciences, Part 2 tests basic medical knowledge, and Part 3 tests the application of medical knowledge to clinical situations.

Residents in MIHS's psychiatric residency program are required to pass Step 3 of the USMLE by March 1 of their PGY-2 year in order to be eligible for a PGY-3 contract. The March 1 date was established in order to ensure that any resident who would not be renewed for failure to pass the exam would receive four months notice of nonrenewal as is required by the terms of the PGY-2 contract.[5] USMLE Step 3 is not administered by MIHS but by a third party organization whose rules permit a resident to take the Step 3 exam only three times in an academic year. The exam is administered throughout the year at various test centers, including one in Phoenix. A candidate may sign up for the test at any time and schedule it at his or her convenience as long as the test center is open at the time. It is not uncommon for a resident to fail the Step 3 examination at least once, and each PGY-2 class at MIHS usually has one or two residents who struggle with it.

Program policies provide that a resident can also be removed from the program involuntarily by nonrenewal of the contract for cause (nonprogression), in which case the contract provides a right of appeal. The program's policy for "Dealing with Resident Misconduct and/or Inadequate Performance" provides that acute or persistent substantial misconduct or inadequacies will be brought to a resident's attention by the Director, and the resident will be counseled. If major

[5] In actual practice, if a resident obtained a passing score by the end of the PGY-2 contract year on June 30, he or she would ordinarily get a new contract for July 1.

disciplinary action is anticipated, the residency committee will be consulted and the resident will be notified in writing. Lesser remedies available to address resident misconduct or performance deficiencies include coaching, oral counseling, written reprimand, concern status, probation status, or other interventions such as an improvement plan. Informal interventions can also be made either verbally or in writing whenever serious or significant problems are noted. Major disciplinary action rarely occurs however, and few if any residents have ever been nonrenewed for performance reasons. There have been, however, instances where a resident was counseled to seek training in a specialty other than psychiatry, and Dr. Jones remembered one resident who was terminated from the program for cause.

Dr. Gurpreet Sodhi is a physician who completed her basic medical training and practiced general family medicine in India for seven years. Dr. Sodhi came to the United States in 1997 where she worked initially as a tax preparer and then in a day care center. In 2001 Dr. Sodhi started applying for residency programs in order to become licensed to practice in the United States. She applied for psychiatric residency programs through the ACGME Match by completing an ERAS application on the website for admission in 2002. She was admitted to MIHS's Psychiatric Residency Training Program, but her admission was withdrawn for reasons disputed by the parties. Dr. Sodhi then filed a charge with OSC and after negotiation the parties resolved their dispute and entered into a confidential settlement agreement in May of 2002. Dr. Sodhi thereafter withdrew her charge, was admitted, and matriculated into the program beginning in the summer of 2002.

Upon entering the program Dr. Sodhi was provided with a copy of the House Manual containing various program policies and procedures. Dr. Sodhi completed all the didactic and rotational components for her PGY-1 contract, including rotations in internal medicine, neurology, and psychiatry, as well as academic classes in Interviewing, "Toolbox" (covering the basics of different topics first year residents need during their initial months of working in a hospital), Basic Psychopharmacology, and Introduction to Psychology.[6] Dr. Sodhi was accordingly given a new contract for the PGY-2 year. She completed her didactic components that year, but some adjustments and accommodations were made in her rotation schedule. In January of 2004 Dr. Sodhi was given a month's rotation in "directed study," which provides a resident with the opportunity to study and prepare for the USMLE Step 3 exam without having to perform clinical duties. In February of 2004 Dr. Sodhi was failing Dr. Hand's rotation in geriatric psychiatry, and after some discussion Dr. James reassigned her to an adult psychiatry rotation with Dr. Santos. Although Dr. Sodhi had been scheduled for the PGY-2 rotation in emergency psychiatry that spring, Dr. James assigned her to another adult psychiatry rotation with Dr. Pynn instead.

During her PGY-2 year Dr. Sodhi took and failed the USMLE Step 3 three times, and she was

[6] An evaluation appears in the record for an additional PGY-1 course the name of which is illegible. It appears to be "Stew."

thus ineligible to take it again before the end of that program year. Dr. Sodhi was accordingly informed that her contract would not be renewed for the PGY-3 year. Dr. Sodhi did not appeal the nonrenewal and her PGY-2 contract ended or about June 30, 2004. Although no longer enrolled in the program, Dr. Sodhi continued to study for and retake USMLE Step 3 until she passed it. Dr. Sodhi then notified Drs. James and Olson by letter in February 2005 that she had passed the exam and wanted to be readmitted.

On March 17, 2005, an executive session of the residency committee met and considered Dr. Sodhi's request. After discussing Dr. Sodhi's performance during her residency, the members present voted not to readmit her to the program. None of the members present voted in favor of Dr. Sodhi's readmission. Dr. James, Dr. Weller, Dr. Hughes, Dr. Olson, Dr. Hand, Dr. Santos, and Dr. Parker voted no; Dr. Torio participated in the discussion but abstained from voting because of her religious calendar. She testified that had she voted she would have concurred with her peers. Dr. James telephoned Dr. Sodhi that same evening and told her that there was no PGY-3 position currently available, but that even in the event a position did become available, her performance history did not support returning her to the program. He also told her that the consensus of the executive committee was that she was unsuited to psychiatry and should pursue a different specialty.

Dr. Sodhi went to Dr. James' office the next day and spoke with him. She asked him for a letter of recommendation and he agreed to prepare one. Dr. Sodhi also went to Dr. Olson's office, but Dr. Olson was leaving for a meeting, so Dr. Sodhi spoke with Dr. Olson in the parking lot, and asked her for a recommendation letter as well. Dr. Olson agreed to prepare a letter. Dr. Sodhi then went to Dr. Moffitt's office and attempted to see her immediately. That effort was unsuccessful, but an appointment was scheduled for her for April 18, 2005. Dr. Moffitt spoke with Dr. James in the interim to inquire about the basis for the committee's decision, and Dr. James explained the committee's reasoning to her. Dr. Sodhi finally did meet with Dr. Moffitt in mid-April. The participants to the conversation differ in their recollections as to precisely what was said.

Dr. Sodhi thereafter applied to other psychiatric residency programs, but was not successful in obtaining a PGY-3 placement. It is Dr. Sodhi's contention that the executive committee's decision to deny her readmission into the program was made in retaliation for her having filed a charge with OSC in 2002. She also says that when she met with Dr. Moffitt in April of 2005, Dr. Moffitt threatened her with further retaliation. Dr. Sodhi subsequently went to EEOC and attempted to file a new charge; that agency referred her to OSC where she filed the charge which is the predicate for this proceeding.

III. APPLICABLE LAW

Because § 1324b was expressly modeled on Title VII of the Civil Rights Act of 1964 as

amended, 42 U.S.C. § 2000e et seq. (2006), *Jones v. DeWitt Nursing Home*, 1 OCAHO no. 189, 1235, 1251 (1990), case law developed under that statute has long been held to be persuasive in interpreting § 1324b. *See, e.g.*, *Fakunmoju v. Claims Admin. Corp.*, 4 OCAHO no. 624, 308, 322 (1994). That case law directs that once a case has been fully tried on the merits as in this instance, there is no need to focus on the familiar burden shifting analysis established by *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973) and the inquiry proceeds directly to the ultimate factual issue of whether the employer engaged in prohibited conduct. *U. S. Postal Serv. Bd. of Governors v. Aikens*, 460 U.S. 711, 714-15 (1983).

The governing statute provides in relevant part that it is unlawful for an entity to intimidate, threaten, coerce, or retaliate against any individual because the person intends to file or has filed a charge. 8 U.S.C. § 1324b(a)(5). The necessary elements which must be established to support a claim of retaliation are 1) that the individual engaged in an activity protected under the section, 2) that he or she suffered an adverse employment action, and 3) that a causal connection exists between the protected activity and the adverse action. *Vasquez v. County of Los Angeles*, 349 F.3d 634, 646 (9th Cir. 2003). The burden of proof on the ultimate question remains at all times on the complaining party. *See generally Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 142-43 (2000); *Saint Mary's Honor Ctr. v. Hicks*, 509 U.S. 502, 510-11 (1993); *Tex. Dep't of Cmty. Affairs v. Burdine*, 450 U.S. 248, 252-53 (1981). The linchpin of a retaliation claim is the causal connection between the protected conduct and the adverse employment action; to show the causal link, there must be sufficient evidence to raise an inference that the protected activity is the likely reason for the adverse action. *Cohen v. Fred Meyer, Inc.*, 686 F.2d 793, 796 (9th Cir. 1982). Essential to that showing is evidence that the decisionmaker was aware that the employee engaged in the protected activity. *Id., citing cases*.

The paradigmatic circumstantial evidence giving rise to an inference of retaliation is temporal proximity between the protected conduct and the adverse action; where the adverse action follows closely on the heels of the protected conduct, an inference of causation ordinarily arises. *Bell v. Clackamas County*, 341 F.3d 858, 865 (9th Cir. 2003) (finding evidence sufficient where a lowered performance review followed immediately after plaintiff's complaints). *See generally* Justin P. O'Brien, *Weighing Temporal Proximity in Title VII Retaliation Claims*, 43 B.C. L. Rev. 741 (2002). Generally speaking, the greater the temporal gap, the more attenuated the inference. *See, e.g., Clark County Sch. Dist. v. Breeden*, 532 U.S. 268, 274 (2001) (noting that adverse action 20 months after protected conduct "suggests, by itself, no causality at all"). *But see Porter v. Cal. Dep't of Corrs.*, 419 F.3d 885, 895 (9th Cir. 2005) (noting that though lack of temporal proximity may make it harder to show causation, inference may nevertheless arise where there is an intervening pattern of antagonism shown throughout the gap period). There is no bright line rule that a particular time is either per se too long or per se sufficiently short to establish the connection. *Coszalter v. City of Salem*, 320 F.3d 968, 977-78 (9th Cir. 2003).

It is causation however, and not just temporal proximity per se, which is vital to the employee's case. *Porter*, 419 F.3d at 895. Just as in any discrimination case, the employee may show by

circumstantial or direct evidence that the employer's proffered explanation was not the real reason for the employment decision, but was a cover-up for a prohibited motive. *Stegall v. Citadel Broad. Co.*, 350 F.3d 1061, 1066 (9th Cir. 2004). *See also Wallis v. J.R. Simplot Co.*, 26 F.3d 885, 890 (9th Cir. 1994). In order to show pretext, a complainant must provide evidence showing that the asserted reason was false and that a prohibited motive was the real reason. *See Hicks*, 509 U.S. at 515.

IV. DENIAL OF READMISSION TO THE PROGRAM

Dr. Sodhi contends initially that the committee's refusal to permit her to re-enter the program is the "functional equivalent" of nonprogression for performance reasons, and that she therefore should have had the notice and due process procedures required by the contract and by program policies in the event of nonprogression of a resident for cause. That premise is flawed because the contractual provisions and program policies governing progression and graduation of residents make no reference to applicants for readmission, and Dr. Jones testified that those policies apply only to residents actually enrolled in the program. Dr. Moffitt testified that there were no ACGME policies with respect to a former resident's application for readmission either. Program policies and contractual rights[7] accordingly are not implicated when the committee considers an application for readmission to the program.

Dr. Sodhi identified no policy which would provide the same rights to applicants for readmission as are available to residents enrolled in the program. Granting or denying readmission to a former resident who is no longer actively enrolled in the program appears therefore to be a wholly discretionary decision. As Dr. James explained, if someone is actually enrolled in the program, there is an ongoing responsibility to help that person graduate, but once someone is out of the program the only responsibility at that point is to make a hiring decision that works for the program. Thus while Dr. Sodhi implies that the criteria that must be satisfied before denying her application should be the same as would be required for nonprogression of a resident for cause, there is no basis for such an assumption. It was uncontested that Dr. Sodhi was never at risk for nonprogression at any time during her tenure, and that but for her failure to pass the USMLE Step 3 exam in a timely manner, she would have received a contract for the succeeding year.

Accordingly, the question is not whether the provisions of the employment contract or of the program policies governing nonprogression of existing residents were followed when Dr. Sodhi, as a former resident, was considered for readmission to the program. The only question is instead whether retaliatory motives were behind the program's discretionary decision to deny her

[7] The employment contract provides that termination of a residency may occur only after remedial efforts have been undertaken, and that a resident has a contractual right of appeal in the event of nonprogression.

readmission.

Dr. Sodhi contends that MIHS's ostensible reason, that her performance as a resident did not support returning her to the program[8], is unworthy of belief because it is contradicted by her evaluations during her residency, by the fact that other residents with similar performance issues were more favorably treated than she was, and by MIHS's failure to put her on notice of the alleged performance problems and use formal remediation procedures to correct any deficiencies during her residency.

A. Dr. Sodhi's Performance in the Program

Dr. Sodhi contends that because her performance as a resident was sufficient to meet program requirements she should not have been denied readmission. She pointed in particular to her outstanding academic performance, to the many positive comments in her evaluations, and to the fact that her evaluations for the rotations she actually completed showed ratings of "at expectations" on all of the major categories on the form. Dr. Sodhi points as well to her many favorable letters of recommendation, some of which were written by the same people who voted against readmitting her. Dr. Sodhi said that her Biannual Reviews are at odds with her rotation-specific evaluations and with her letters of recommendation, and that these inconsistencies show that MIHS's putative reason for not readmitting her is a pretext.

The evidence reflects that Dr. Sodhi was well-liked by others, and was for the most part seen as a courteous and hard working resident who, although quiet and unassertive, was concerned about her patients and excelled in much of her academic work. Other evidence, however, suggests that despite her academic successes, Dr. Sodhi was less successful in applying her knowledge when dealing with psychiatric patients in clinical settings. Some of her evaluations reflect that Dr. Sodhi had difficulty integrating basic knowledge into everyday patient care, and that some of her attendings thought she lacked "psychological mindedness." There was general agreement that she was very reserved, even to the point of being described as "profoundly passive," and some thought her insufficiently assertive to perform effectively as a psychiatrist. A significant number of Dr. Sodhi's rotation evaluations contain comments reflecting persistent difficulties with patient interviewing and history gathering, as well as with interpersonal and communication skills.

Dr. Jones said that Dr. Sodhi's communication problems seemed to be more in the area of receptive rather than expressive language; that is, people generally understood what Dr. Sodhi was saying, but it was not clear that she always understood what was being said to her. There

[8] The parties dispute whether there actually was a position available at the time Sodhi applied for readmission. Whether or not there was an open position, the committee made clear that it would not have been available to Dr. Sodhi.

was a consensus that Dr. Sodhi was not performing at a level consistent with her peers in this area. Dr. Jones said receptive language is important in psychiatry because if one is unable to understand the patient's description of symptoms and experience, one is likely to make the wrong diagnosis and apply the wrong treatment. Dr. Torio testified that interviewing is the essence of psychiatry, because you have to gain the alliance of a patient on the initial contact, and that interviewing technique is a crucial key to being able to understand the patient, come to a diagnosis, and treat the patient. Dr. Olson testified that Dr. Sodhi had trouble interacting with patients and couldn't put data together to figure out what was important. She also needed as a second year resident to be able to take the lead with a team, and she was not close to being able to do that.

Dr. Hand raised concerns in the middle of Dr. Sodhi's PGY-2 year about her inability to perform such basic tasks as conducting a psychiatric interview, formulating a diagnosis, or developing a treatment plan. Dr. James said that Dr. Sodhi first came to his attention three weeks into his directorship because Dr. Hand had notified him that she was failing the geriatric psychiatry rotation. This rotation, also referred to as geropsychiatry, is a demanding rotation because the patient population typically has multiple and complex physical illnesses as well as psychiatric problems. While there was general agreement that geriatrics is a challenging rotation, it is nevertheless a standard PGY-2 rotation which all residents are required to complete, and Dr. James indicated that Dr. Hand's expectations of Dr. Sodhi were the same as they were for any other resident in this rotation.[9]

The parties disagreed about the specific nature of the problems Dr. Sodhi had with the geropsychiatry rotation, but everyone, including Dr. Sodhi, agreed that failing a rotation was a big deal. Dr. Hand told Dr. James that Dr. Sodhi had difficulty doing interviews or understanding the psychological motivation of patients, and in constructing or understanding a treatment plan. When Dr. James discussed the situation with Dr. Sodhi, he asked her if she understood what Dr. Hand's concern was. Dr. Sodhi told Dr. James she thought Dr. Hand expected her to do psychotherapy, which she did not feel she was prepared to do. This was not, however, what Dr. Hand had said to Dr. James, or what he noted in Dr. Sodhi's written mid-rotation evaluation.

Dr. James said he told Dr. Sodhi that what Dr. Hand said to him was similar to what he had seen in some of her other evaluations, that she had difficulty doing interviews and understanding the psychological motivations of patients - what is called psychological mindedness. He told Dr. Sodhi that her ability to conduct an interview and formulate a psychological understanding of a patient was not at the level necessary to pass the geriatric rotation. Dr. James said it was not clear that Dr. Sodhi understood what he was telling her. He suggested that she move from

[9] Notwithstanding the challenging nature of the geropsychiatry rotation, residents voted Dr. Hand "attending of the year" during Sodhi's PGY-2 year.

geropsychiatry to a rotation on a general adult inpatient unit with Dr. Santos where she could focus more on developing skill in interviews and formulations rather than on patient care, and Dr. Sodhi agreed to the move. Dr. James testified that moving Dr. Sodhi to Dr. Santos' rotation was intended as a remedial measure. The memo he prepared about their meeting indicates that he asked Dr. Sodhi if she had any other ideas for addressing the situation but that she did not.

Dr. Sodhi testified that in an average day of psychiatry rotation a resident will see five or six patients, so by the mid-point of her second year she would already have seen literally hundreds of patients and had many opportunities to practice interviewing. Her self assessment on the form for Development of Personal Program of Self Study and Professional Growth at the end of her PGY-1 year indicated that she rated herself as not competent to perform most of the tasks listed on the form when presented with a simple clinical problem. The executive committee's assessment on that scale was in accord with hers. For the PGY-2 year, Dr. Sodhi's self-assessment of her abilities improved substantially, but the assessment of the committee did not; Dr. Sodhi was still rated by the committee as being not competent to perform virtually all the specific tasks listed on the form. Her own PGY-2 self-assessment reflected that she was not competent to interview an adult patient in a "board style" interview.

Dr. Jones testified that she was the person who did Dr. Sodhi's first three Biannual Reviews, and that before completing them she met with all the supervisors and did a consensus input evaluation. She then transferred the information to the Biannual Review form, together with any other needed feedback. Dr. James completed Dr. Sodhi's fourth and final Biannual Review. He said his procedure was to review all the rotation evaluations and course evaluations for the particular period to extract the material relevant to the six competencies listed on the form. Dr. Sodhi's Biannual Reviews consistently reflect that she had problems with both interviewing and history gathering, and with interpersonal communication generally.

Dr. Sodhi's fourth Biannual Review acknowledges that there had been some improvement in her interviewing at the end of her PGY-2 year, but reflects that she was still below expectations in interpersonal and communications skills and she still had difficulty probing psychological issues, including psychosocial considerations. Dr. Santos testified that when Dr. Sodhi rotated with him she was behind where she should have been, she lacked organization in interviewing, she mixed up information, and she was unable to determine the patient's chief complaint. The evaluation he completed for that rotation reflects a need for organization in Dr. Sodhi's interviewing, for more sophistication in questioning, and for more depth in probing psychological issues or problems presented by the patient. It states also that Dr. Sodhi needed to heighten her awareness of the biopsychosocial issues' interplay in the emerging psychological symptoms, and needed as well to be more assertive. Dr. Santos said he voted against readmitting Dr. Sodhi based in part upon her performance in his rotation.

Dr. Sodhi testified that she disagreed with the comment in her first Biannual Review that she

needed to work on language enhancement and facilitate communication. She said she believed she had no serious problems during her residency and that she was never told of any serious deficiencies. She did acknowledge that she had been told by others that she had trouble understanding and interpreting information, but in her view this was true only at the beginning of the program. With respect to her PGY-2 Biannual Reviews she said she believed she had improved and corrected her problems by that time and did not believe she was below expectations in interpersonal communications. She thought those evaluations were simply wrong. With respect to the difficulties Dr. Hand identified, she said, "I didn't perceive them as difficulties. Those were perceived as difficulties by Dr. Hand." Dr. Sodhi said she disagreed with Dr. Hand's observation that she was having trouble with psychological mindedness, and with Dr. Santos' comments on the evaluation for the rotation she did with him as well. She pointed out that Dr. Pynn's evaluation for her final rotation in the program showed improvement in her interviewing.

MIHS made reference to two specific incidents as examples of how Dr. Sodhi's academic knowledge did not necessarily lead to good clinical performance, and/or how Dr. Sodhi may have misinterpreted or misunderstood data presented to her. The first involved a call Dr. Sodhi received while on night duty during her PGY-2 year. An attending nurse called about a patient with a life-threatening level of lithium toxicity. Dr. Sodhi made no effort to go and see the patient, but instead instructed the nurse to withhold the next dose of lithium and continued to do paperwork. The nurse had told Dr. Sodhi that the patient's lithium level was 2.75. Proper protocol for a patient with a lithium level over 2.0 indicates that 911 should be contacted and the patient should be gotten to the emergency room. As soon as the attending physician saw the patient, that is what was done.

Dr. Sodhi had done very well on the final exam in "Toolbox," a class which covered, among other topics, psychopharmacology. In the Basic Psychopharmacology class she received a grade of 98% on the final exam, the highest in the class, and was described as the best prepared resident in that class. Nevertheless when faced in a clinical setting with a practical problem in psychopharmacology, Sodhi failed to respond appropriately. Faculty member witnesses testified that any second year resident ought to have been able to deal with the situation, and at minimum would have gone to see the patient.

The second incident involved Dr. Sodhi's referral of a new patient for services for which the patient was not eligible. The patient was seen on the consultation service and Dr. Sodhi wrote a note indicating a plan to send the patient for additional evaluation after the medical evaluation. Because the patient was a resident of Pima County and not eligible for these additional services, this created a problem. Dr. Lippman had to become involved, and he referred the incident to Dr. Jones' attention. Dr. Sodhi had staffed the patient with Dr. Bailon but failed to inform Dr. Bailon about the Pima County issue.

No one suggested that Dr. Sodhi did not have numerous strengths or that she would not be a

capable physician in a different specialty, but the consensus was that she was not well suited to psychiatry. Dr. James said he wrote a letter of recommendation for Dr. Sodhi which, although it did not recommend further training in psychiatry, emphasized her strong points and omitted reference to her weak ones. He said he wrote the letter because Dr. Sodhi asked him to, and because he wanted to help her progress in her career. Dr. Olson said she too wrote a letter of recommendation for Dr. Sodhi in which she tried to focus on the positive things and not the negative. She also thought Dr. Sodhi would be better suited to family practice, or internal medicine, or ob/gyn. She said she wrote the letter because she liked Dr. Sodhi and wanted to help her pursue a career she could do a competent job at. Other attendings wrote letters for Dr. Sodhi as well.

Dr. Sodhi argues that there is no legitimate reason to deny her readmission when she was rated as "at expectations" for all the major categories for all the rotations she actually completed, and some of her rotation evaluations showed no check marks at all for areas in need of improvement. In light of these facts and of her letters of recommendation, she concludes that her performance could not have been as deficient as Maricopa claims.

B. Whether Dr. Sodhi Was Treated Differently

Dr. Sodhi identified four other residents she said failed to pass the USMLE Step 3 on time in their respective PGY-2 years, who subsequently were granted readmission into the program. One of these residents was in Dr. Sodhi's same entering class, while the other three were in classes that preceded or followed hers. Although Dr. Sodhi contends that "anyone else who did not timely pass the USMLE Step 3 either returned or remained in the Program," the statement is not entirely accurate. Dr. James remembered at least one such resident while he was Director who went to another program and never sought readmission, and there was no evidence as to whether there were others as well who, for whatever reason, did not apply for readmission after failing to pass the exam on time.

Dr. Sodhi contends that the more favorable treatment of the four residents she identified, none of whom had filed charges with OSC, is evidence that a retaliatory motive was at work in her case because readmission was denied to her but not to them. Dr. Sodhi says that she was similarly situated to these residents because some also had gaps of several months between the time when they failed the Step 3 exam and when they reapplied to the program, some also had problems with language or with interviewing, or had other areas in which they needed improvement, and some had problems with Dr. Hand's geropsychiatry rotation just as she did.

Resident 1,[10] the only comparator actually in Dr. Sodhi's own cohort, developed a progressively worsening medical condition during the PGY-2 year of the residency and became unable to

[10] For reasons of privacy, these residents are identified by number rather than by name.

work. Dr. James put this resident on a short-term disability leave, which eventually developed into six months of medical leave because of surgery and ensuing complications. Because this resident passed the Step 3 exam while out on medical leave, it is not clear that the resident was ever actually dropped from the program or needed to reapply. Resident 1 was described as being a good clinician, well rounded, having good or excellent interviewing skills, being a good team player, good on call, in working well with others, and in communicating effectively. Dr. Torio testified that everyone was shocked when this resident didn't pass the Step 3 exam because the resident was perceived as highly competent, very bright, and viewed at "the top" compared to others in the class. Dr. Torio's evaluation noted even in the PGY-1 year that this resident had excellent interviewing techniques, was able to understand the psychodynamics of patients and had excellent psychopharmalogical skills. Dr. Torio said resident 1 was a very rare resident, and was respected by all, including staff. Dr. Hand described this resident as at or above expectations in all areas, demonstrating a biopsychosocial perspective and having good rapport with patients and staff.

An extension of resident 2's contract had to be made because the Arizona Medical Board made an error in determining the eligibility of the resident to sit for the USMLE Step 3 exam. Because the state's error was not the resident's fault, the contract was extended for six months, but the resident still did not pass on time and had to reapply. This resident too, was described as very talented with good diagnostic and clinical skills, but the resident had problems with English. Dr. Hand noted at the midpoint of the geriatric residency that resident 2 had very good psychiatric skills, but was hampered by written and spoken language barriers. Dr. Jones thought resident 2 was underperforming relative to Dr. Hand's expectations of the resident's abilities. Dr. Jones said she had resident 2 on a rotation for six months and thought the resident was very talented, with good clinical and diagnostic skills and good relationships to and communications with patients. Dr. Jones thought that the language difficulty showed up more in the resident's written work. Dr. James said he had resident 2 for the first psychiatry rotation, and he too noted a significant problem with language, however he said the problem got considerably better over the time the resident was in the program. He also said this resident did not have the difficulty Dr. Sodhi had with psychological mindedness or with formulating an understanding of a patient's situation.

Resident 3 actually did pass the Step 3 exam prior to the expiration of the contract year on June 30, but did not get the results of the exam until two weeks after that. No contract was issued to the resident until after the exam results were received. This resident had issues that were related to behavior or conduct rather than to performance as such; Dr. Jones said the consensus was that the resident was competent, bright, and capable, but had attendance issues and tended not to work hard enough. At the midpoint in the resident's geropsychiatry rotation Dr. Hand had checked 19 areas in need of improvement, and expressed concerns about the resident's commitment to the field, noting that the resident "is too bright to allow this behavior to be condoned." Dr. Jones and Dr. Hand met with the resident and discussed the need to take responsibility, follow through on tasks, and be consistently available to the unit. Another month

was added to the geropsychiatry rotation during which the resident's attendance was monitored, and the resident did pass the rotation.

Resident 4 also had a period of medical leave, after which the resident returned to the program but was dropped shortly thereafter for not timely passing USMLE Step 3. The resident's performance in rotations was consistently good and the resident's clinical and diagnostic skills were described as excellent. Dr. James said resident 4's only language issue was a foreign accent, but that the accent did not interfere with the resident's performance. He said that resident 4 was very positively regarded, did well on rotations, and did not have any problems with psychological mindedness. Dr. Torio described this resident as having excellent communication skills and the knowledge, skills, and dedication to become an excellent psychiatrist. The executive committee gave this resident very high to outstanding ratings as to the ability to perform each of the clinical tasks listed on the global evaluation form. Dr. Hand indicated that the resident had no areas in need of improvement, and had made major strides in interview skills, differential diagnosis, and case management during the geropsychiatry rotation.

C. Whether Appropriate Procedures Were Followed

Dr. Sodhi next suggests that MIHS's failure to use formal remediation processes to address her performance problems during her residency is also evidence of pretext because MIHS was required to provide her with notice and the opportunity to improve her performance while she was enrolled in the program. She testified that, unlike some other residents who had performance problems, she was never told of any serious deficiencies in her performance and was not afforded the benefit of progressive discipline.[11]

Despite Dr. Sodhi's testimony that she was never told of serious deficiencies in her performance, written comments by Drs. Jones and James in her Biannual Reviews, by the residency committee in her global assessments, and by Drs. Torio, Brennan, Olson, and Hand in her rotation evaluations specifically identify in writing the same or similar persistent problems. Dr. Sodhi testified that she did not take the comments in her Biannual Reviews as "formal concerns," but

[11] In support of this theory, Dr. Sodhi sought to make comparisons between her situation and that of another group of residents she conceded were not similarly situated to her. All of these residents passed the USMLE Step 3 exam on time, did not leave the program, and consequently never had to reapply for admission. Each, however, came to the attention of the executive committee at some point during their respective residencies for reasons related either to their conduct or to their performance. Sodhi contends that MIHS' motion in limine as to evidence about these residents should not have been granted because MIHS had placed resident performance in issue. The motion in limine was granted as to these residents as a group, subject to reconsideration if a proper foundation was shown with respect to a particular resident. That foundation was not established and this group of residents was not considered.

these problems were nevertheless communicated to her both orally and in writing. Dr. Sodhi discussed all those evaluations with the relevant faculty and her signature appears on them acknowledging that she received them.

Witnesses testified that Dr. Sodhi received such coaching and oral counseling during her residency as was appropriate to her circumstances. Dr. Jones testified that not every resident problem was referred to the residency committee, and that she did not believe that a committee referral would have benefitted Dr. Sodhi. At least during Dr. Jones' tenure, she said that committee referral was largely reserved for people who weren't trying or weren't listening, or who needed "a stronger impetus." Dr. Jones thought Dr. Sodhi was receptive to feedback and tried hard, so that disciplinary methods were not appropriate to her circumstances. Dr. James agreed that there was a distinction between performance issues and discipline issues, and that the same remedial path was not used in every case.

No one told Dr. Sodhi that she was at risk of nonprogression because she never was, and attempts were made to deal with Dr. Sodhi's performance problems at an informal level. Dr. Torio testified, for example, that during Dr. Sodhi's rotation with her she took great pains to help Dr. Sodhi, that she engaged in extensive role playing trying to help Dr. Sodhi learn how to conduct an interview, and that she spent a lot of time teaching Dr. Sodhi to write a progress note and to differentiate between terminologies in psychiatry. Dr. Torio said Dr. Sodhi was the only resident for whom she had to do these things. Dr. Santos testified that during the rotation Dr. Sodhi did with him, he consulted with Dr. Torio about her, and what should be done. Dr. Torio indicated that it was not unusual for attendings to discuss residents with their colleagues, and Dr. Jones said that mentoring was often done informally by a member of the faculty telling the next rotation supervisor to address the resident's specific difficulties. Dr. James told Dr. Santos the reasons why Dr. Sodhi was being assigned to his rotation instead of the geriatrics rotation, and stressed the need for emphasis on interviewing.

Dr. Sodhi denied vigorously that any of the efforts made with her were remedial in nature, and characterized interventions as "educational tools," rather than remediation efforts. She denied, for example, that her reassignment from Dr. Hand's rotation to Dr. Santos' was remedial in nature, because Dr. James did not tell her at the time that it was remedial. Dr. Sodhi similarly characterized the in-service presentation she was assigned to do following the lithium toxicity incident as an educational tool, not a remedial measure, although Dr. Jones said it was considered a remedial action and her contemporaneous memo about this incident reflects that "the concerns and remediation plans will be reviewed at the residency committee in executive session."

The memo reflects that the lithium incident was brought to Dr. Jones' attention by Dr. Premkumar, after which Dr. Jones met with Dr. Sodhi to discuss it. Dr. Sodhi took responsibility for the error, acknowledged that she should have gone to see the patient, and offered to do whatever would be appropriate to address the deficiency. The issue was addressed by having Dr.

Sodhi participate in an in-service presentation to other residents on the assessment and management of lithium toxicity. Minutes of the executive committee reflect discussion of this incident as well as others, and reflect that Dr. Sodhi's progress was monitored and discussed by the executive committee from time to time, just as was done for other residents.

Individualized curriculum changes are among three specific types of interventions identified in the program's policy on Evaluation Processes to be used where a pattern of unsatisfactory performance in a rotation indicates a need for intervention. Apart from having been assigned to the directed study rotation, there are two other instances in which Dr. Sodhi was given such individualized curriculum changes by Dr. James. First, she was taken off the geropsychiatry rotation she was failing in February, and assigned to Dr. Santos for further concentration on interviewing. Next, although she was scheduled for the PGY-2 emergency psychiatry rotation after that, Dr. James changed her assignment so she could continue with Dr. Pynn's adult psychiatry rotation instead, because emergency psychiatry is a very busy rotation with no leeway and Dr. Sodhi needed to be able to study for the USMLE Step 3 exam.[12]

D. Analysis and Discussion

There is no dispute as to the protected nature of Dr. Sodhi's activity in filing a charge with OSC in April of 2002. Neither is there any dispute that the executive committee's decision to deny her readmission into the program in March of 2005 was an adverse employment decision. With respect to establishing a causal connection between these events however, Dr. Sodhi faces a built-in headwind in view of the length of time between the filing of her charge and the denial of readmission. The inferential leap required to connect the two events is simply too vast. While there is no magic number of days after which no inference of causation can arise, a period of almost three years is simply too long to provide circumstantial evidence of causation.

Not only is temporal proximity lacking between the protected conduct and the adverse decision, it appears as well that Dr. Sodhi's 2002 OSC charge was handled at an altogether different and higher institutional level than the 2005 readmission decision, so that the same actors were not involved in both events. While Dr. Sodhi argues generally that "Respondent" was aware of Sodhi's charge, an artificial person like MIHS can act or have awareness or motivation only through its authorized agents. *Cf. Ipina v. Mich. Jobs Comm'n*, 8 OCAHO no. 1036, 559, 576

[12] Dr. Sodhi also faults the procedures of the executive committee meeting of March 17 as "seriously flawed" because of the brevity of the meeting, the failure of the committee to consider written evidence, and the fact that some members of the executive committee were absent. There was no showing, however, that this meeting of the executive committee differed in any way from any of its other meetings, or that the procedures used at that meeting were a departure in any way from previous practices.

(1999). It is not enough to say that "Respondent" knew of the charge, it is necessary to show that the actual decisionmakers were aware of it. *Reeves*, 530 U.S. at 152-53 (stating that the focus of the inquiry is on the actual decisionmaker). In order to establish that the executive committee members who were present and voted on March 17, 2005 acted with a retaliatory intent, there must first be some showing that they actually had knowledge of Sodhi's prior protected activity. *See Raad v. Fairbanks N. Star Borough Sch. Dist*., 323 F.3d 1185, 1197 (9th Cir. 2003).

There was no such showing. The persons involved in the decision to withdraw Sodhi's initial admission were Dr. Moffitt and Dr. Lippman, and Dr. Sodhi's PGY-1 year contract was issued through Dr. Moffitt's office. The persons who signed the settlement agreement for MIHS were Mark Hillard, CEO, and Joseph Campbell, Risk Management Claims Manager. There is no evidence that the faculty members who voted to deny Dr. Sodhi's readmission in 2005 had any involvement in the 2002 matter, or that they were even aware that Dr. Sodhi had filed a charge with OSC in 2002. Neither Dr. Lippman nor Dr. Moffitt participated in the executive committee's decision; Dr. Lippman had already left MIHS in 2004, well before the decision was even made, and Dr. Moffitt was approached by Dr. Sodhi only after the fact. Dr. Moffitt had no role in making the decision and was not consulted about it beforehand.

In *Miller v. Fairchild*, 885 F.2d 498, 505 (9th Cir. 1989) the management personnel who participated in the EEOC settlement negotiations were the same individuals who were responsible for the decision to lay off the plaintiffs two months later. Under those circumstances, an inference could reasonably be drawn that the filing of the charges triggered the layoff. Here, in contrast, the persons who were involved in the settlement were not involved in the executive committee's decision almost three years later not to readmit Dr. Sodhi to the program. There was no evidence that any of the faculty members present and voting at the meeting on March 17, 2005 had knowledge either of the 2002 charge or of the settlement agreement, or that any of them participated in the events related to Dr. Sodhi's admission in 2002. *Cf. Cohen*, 686 F.2d at 797 (stating it did not matter that the vice president of the defendant company had knowledge of the employee's EEOC complaint, when he did not share that knowledge with the plaintiff's supervisors or participate in the supervisor's decision to implement a scheduling policy which resulted in changes adverse to the employee). *Accord Gunther v. Washington County*, 623 F.2d 1303, 1316 (9th Cir. 1979), *aff'd sub nom. Washington County v. Gunther*, 452 U.S. 161 (1981).

While minutes of the residency committee in the spring of 2002 reflect that the original offer to Dr. Sodhi was withdrawn and then reinstated, nothing in those minutes refers to a legal proceeding, a charge, or a settlement agreement, and Dr. Sodhi proffered no evidence showing that Drs. Torio, Santos, Parker, Hand, Weller, or Hughes either would have had personal knowledge of the 2002 OSC charge or could have formed any bias against Dr. Sodhi because of it. Like Dr. Lippman, Dr. Jones left the program in 2004 and was not involved in the 2005 decision. Dr. Olson did not become the acting chair of the department until late in 2004. She

said she had some memory that Dr. Sodhi's original offer was withdrawn by mistake, and that the mistake was corrected so that Dr. Sodhi could enter the program. Dr. Olson thought the mistake was about Dr. Sodhi's immigration status and whether she could work. Dr. Olson said she only learned about the prior legal case much later on, after this case was initiated and she was given a packet of materials. Dr. James said he could not remember what he knew, but Dr. Moffitt testified that Dr. James would not have been involved in a decision to reject Dr. Sodhi in 2002, or in any decision made at that level.

The question in this proceeding is not whether the executive committee made a good decision or a bad decision when it declined to readmit Dr. Sodhi to the program. Neither is the question, as Dr. Sodhi seeks to present it, whether the executive committee's perceptions of her performance as substandard in significant respects are more accurate than her own perceptions. Rather, the question is whether the executive committee's perceptions, accurate or not, were the real reason for denying Dr. Sodhi readmission to the program or whether that decision was made in retaliation for her having filed a charge with OSC in March of 2002.

For the reasons stated more fully herein, I conclude that the decision was not retaliatory in nature. That Dr. Sodhi performed some aspects of her job as a resident competently does not change the fact that in the eyes of a significant number of the faculty Dr. Sodhi lacked some of the basic skills essential to the practice of psychiatry. The committee declined to readmit her for that reason. Dr. Sodhi's subjective personal judgments of her own competence cannot overcome the committee's exercise of discretion in making that decision, *cf. Bradley v. Harcourt Brace & Co*., 104 F.3d 267, 270 (9th Cir. 1996), nor can the fact that some of her evaluations were better than others.

The comparisons Sodhi sought to make with other residents do not, moreover, suggest that the reason given is pretextual. In order to establish an inference of discrimination based on disparate treatment of similarly situated individuals, the employee must show that the potential comparators are similarly situated in all material respects. *Moran v. Selig*, 447 F.3d 748, 755 (9th Cir. 2006), *citing Aragon v. Republic Silver State Disposal, Inc*., 292 F.3d 654, 660 (9th Cir. 2002). Here, two of the residents Dr. Sodhi pointed to as potential comparators had medical problems necessitating a period of leave, and one had a contract extension because of a mistake made by the Arizona Medical Board. One of the purported comparator residents actually did pass the USMLE Step 3 exam while out on medical leave, and another passed before the end of the contract year on June 30, but simply did not get the results - or a new contract - until two weeks later. Unlike Dr. Sodhi, each of these residents did complete and pass Dr. Hand's rotation in geropsychiatry. Despite the surface similarities between Dr. Sodhi and the residents she identified, examination of their respective records reflects that these residents were not sufficiently similarly situated to Dr. Sodhi to make the comparisons meaningful because in each instance there are material respects in which they differ. Any performance issues presented by those residents were of a different character, both quantitatively and qualitatively, from the issues presented in Dr. Sodhi's case.

Finally, the procedures used to address performance problems during Dr. Sodhi's residency appear to have been well within the program's discretion. That these measures were not part of a "formal remediation program" does not mean that they were not undertaken.

V. POST-DECISION RETALIATION

It is undisputed that, unlike the members of the executive committee, Dr. Moffitt not only was aware of Dr. Sodhi's prior OSC charge in 2002, she also had formed a negative opinion about Dr. Sodhi as a result of the underlying dispute. Dr. Sodhi contends that Dr. Moffitt retaliated against her because of that charge, as well as for protesting the committee's decision, first by threatening her ability to obtain a position in another institution's residency program, and second by failing to investigate and assist her in obtaining reinstatement to the program. In support of these allegations, Dr. Sodhi relies on the meeting she had with Dr. Moffit in April.

A. Testimony About the Conversation Between Dr. Sodhi and Dr. Moffitt

Dr. Sodhi testified that at their meeting, Dr. Moffitt reviewed her file with her and expressed surprise about her "glowing" letters of recommendation when the program was saying that she wasn't competent enough to proceed to PGY-3, and that Dr. Moffitt told her she was upset to see that. She said Dr. Moffitt told her she could not assist her in anything because Dr. James was "adamant" about not rehiring her, but that she could easily go to other programs.

Dr. Sodhi also testified that Dr. Moffitt said she couldn't see any serious deficiency in her file, and that she had "wonderful evaluations and letters." Dr. Sodhi said that Dr. Moffitt nevertheless told her "many times" that if she tried to get the position or got it back by legal assistance she wouldn't achieve much. Dr. Sodhi also testified that Dr. Moffitt told her that MIHS no longer asked for permanent resident status when interviewing applicants.

Dr. Moffitt denied having made many of the statements Dr. Sodhi attributed to her. Dr. Moffitt said she did not believe that she reviewed Dr. Sodhi's file with her, and said that she did not tell Dr. Sodhi that she saw no serious deficiencies. She also testified that although she did read Dr. Sodhi's file at some point, and was in fact irritated to read glowing letters, she would not have made such a statement to Dr. Sodhi. She said she was irritated because what she was hearing was that Dr. Sodhi did not complete those months of training competently and was having great difficulty in the program, and her own view was that if you can't say what is truthful, you shouldn't say anything at all.

Dr. Moffitt also testified that she did not tell Dr. Sodhi that she was upset or shocked that Dr. Sodhi was not readmitted to the program, nor did she say that Dr. Sodhi had great evaluations. Dr. Moffitt said that although Dr. Sodhi made vague statements about seeking legal recourse, she did not suggest that the committee's denial of readmission was in retaliation for her filing the

earlier OSC charge, nor did she say anything about the possibility of filing another charge with OSC. Dr. Moffitt testified that had Dr. Sodhi made any specific threat she would have picked up the phone and called risk management or the county attorney's office. Dr. Moffitt said that when they get nonrenewals residents are angry and they make vague statements about legal action all the time; her usual response is to tell them to take a deep breath and consider their options with other programs. She thought that since Dr. Sodhi had been a family practitioner in India, family practice or internal medicine might be a better fit for her. Dr. Moffitt denied as well that she told Dr. Sodhi that permanent residency was no longer required to become a member of the program, and said the term was not even in her vocabulary.

B. Discussion and Analysis

When Dr. Sodhi testified about her meeting with Dr. Moffitt, she did not say that she told Dr. Moffitt she thought the committee's decision was related to her prior OSC charge in 2002. She did not say that she told Dr. Moffitt she intended to file another charge with OSC about the denial of readmission or that she initiated a discussion about any prospective litigation against MIHS on any particular legal basis. It was Dr. Moffitt who testified that Dr. Sodhi made a vague reference to taking legal action about the denial of readmission.

In order to support a claim of retaliation under § 1324b(a)(5), the individual must first have engaged in the exercise of rights and privileges specifically secured by § 1324b. While Dr. Sodhi's filing of the 2002 OSC charge clearly constitutes protected conduct under the statute, vague and generalized statements of intent to pursue some legal action of an undefined character in the future ordinarily do not, because not every threat of litigation is protected by § 1324b(a)(5). *Harris v. Haw. Gov't Employees Ass'n*, 7 OCAHO no. 937, 291, 295-96 (1997) (stating that unless a right or privilege protected under § 1324b is implicated, the requirement is not satisfied); *see also Yohan v. Cent. State Hosp.*, 4 OCAHO 593, 13, 21-22 (1994) (requirement not satisfied where retaliation is for asserting right or privilege not secured under § 1324b or filing charges with agencies other than OSC). Thus it appears that the only protected conduct Dr. Sodhi established was the filing of the original charge in 2002.

As explained in *Zarazinski v. Anglo Fabrics Co., Inc.*, 4 OCAHO no. 638, 428, 448 (1994), the terms of the statute do not provide clarification as to what constitutes a threat, and neither the legislative history nor the applicable regulation sheds light on the matter. In common usage, the term means the expression of an intention to inflict pain, injury, evil, or punishment. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000). Here, Dr. Sodhi does not contend that Dr. Moffitt expressed any intention to personally inflict any harm upon her, or to engage in any activity at all. Rather, she says that Dr. Moffitt's statement about burning bridges is per se retaliation. She testified that what Dr. Moffitt said was that if she sought legal assistance,

> You will just be burning your bridges because Dr. James is the director. He

> works more with PGY-3 and PGY-4 residents, so you might not be comfortable working with him if you go back to the program. And if you don't go back, he might not be willing to give good recommendations to the program where you apply. . .

The second element of a retaliation claim is a materially adverse employment action or the threat of a materially adverse employment action. That is, the adverse action or threat must be sufficient to deter a reasonable person from making or supporting a charge of discrimination. *Burlington N. & Santa Fe Ry. Co. v. White*, 548 U.S. 53, 68 (2006). The standard is an objective one, and the significance of any given act depends upon the circumstances, so context matters. *Id*. at 69.

Here, it is difficult to construe the statement that if Dr. Sodhi were to come back she might not be comfortable working with Dr. James as a threat because it involves no statement of intention by Dr. Moffitt to take any action at all. Similarly, the prospect that Dr. James might not write a favorable recommendation letter to another program at some point in the future is highly speculative in light of the fact that Dr. Moffitt herself had no ability herself to carry out such a "threat." Inasmuch as Dr. Sodhi had already received favorable letters of recommendation from Dr. James as well as from Dr. Olson and several other members of the faculty, such a statement, moreover, is lacking in deterrent power under any objective standard. That Dr. Sodhi was not in the least deterred from filing a charge is further evidenced by the fact that within a matter of days after the meeting, she went to EEOC and sought to do just that. Dr. Sodhi was then referred to OSC by EEOC. I cannot conclude under these circumstances either that there is any causal connection between Dr. Sodhi's 2002 charge and Dr. Moffitt's statement about burning bridges, or that the statement itself constitutes retaliation per se as Dr. Sodhi urges.

Dr. Sodhi testified that her purpose in seeking the meeting with Dr. Moffitt after she spoke with Dr. James and Dr. Olson was twofold: she wanted to get into the details of why she was not being rehired, and she wanted to ask Dr. Moffitt if she could assist in getting her back into the program. Dr. Sodhi had already discussed the reason for the decision with Dr. James and Dr. Olson, who were participants in the decision, so it is unclear why she thought that Dr. Moffitt, who was not a participant, would have knowledge of those details.

Similarly unelaborated was the question of why Dr. Sodhi thought that Dr. Moffitt could assist her in getting back into the program. As the Director of Medical Education, Dr. Moffitt had oversight responsibility for all the residency programs, but no policy was identified which conveyed any authority for the Director of Medical Education to overrule a particular program's decision to deny readmission to a former resident. Neither was there any evidence to suggest that Dr. Moffitt had ever intervened in similar decisions made by any other residency program. It appears instead that it is the program director who actually has the final authority to make the decision with respect to readmission of a former resident, but that in practice the committee's decision is ordinarily accepted by the program director.

Although Dr. Sodhi asserts that Dr. Moffitt had the ability to review the committee's decision and intervene, no source of authority was identified from which that ability would arise. While Dr. Sodhi's brief characterizes her meeting with Dr. Moffitt as an appeal and makes reference to an "internal appeal" process, there was no evidence of any policy permitting an appeal of right from the residency committee's denial of readmission, and no specific procedures for doing so were identified. It is thus not clear that Dr. Moffitt could have done anything to alter the committee's decision. While Dr. Sodhi contends that Dr. Moffitt's failure to overturn the committee's decision was itself a new decision, that conclusion is not supported by the evidence.

C. Conclusion

Although it is possible to conceive of circumstances where speculation about the future conduct of other persons could be construed as a "threat," or where doing nothing at all could be construed as retaliation, those circumstances are not present here. Even assuming arguendo that Dr. Moffitt could have intervened with the committee on Dr. Sodhi's behalf, there was no duty for her to do so when the committee's discretionary decision was not made on any prohibited basis. Dr. Moffitt's speculation about what others might do in the future does not, in the context described, amount to an objective threat to Dr. Sodhi's ability to obtain a position in another institution's residency program.

VI. FINDINGS, CONCLUSIONS, AND ORDER

A. Findings of Fact

1. Dr. Gurpreet Sodhi was licensed as a physician in India, where she practiced general family medicine for seven years.

2. Dr. Sodhi came to the United States in 1997.

3. Dr. Sodhi was required to complete residency training before she could become a licensed physician in the United States.

4. Dr. Sodhi applied for a residency through the Accreditation Council for Graduate Medical Education ("ACGME") in 2001 or 2002.

5. The ACGME is a medical accreditation council that coordinates numerous medical residency programs throughout the United States, and establishes accreditation guidelines for such programs.

6. Residents applying for residency positions associated with the ACGME submit Electronic Residency Application Service ("ERAS") applications to the ACGME.

7. These applications are provided by the ACGME and are completed on the ACGME website.

8. After completing an ERAS application, applicants are entered into the National Residency Matching Program (the "Match").

9. The Match is a program administered by the ACGME for residency programs throughout the United States.

10. Those applicants completing an ERAS application for the Match identify in their application those ACGME-affiliated residency programs for which they are applying, according to preference.

11. The ACGME then "matches" residents completing the ERAS application with a preferred ACGME-affiliated residency program.

12. The MIHS Psychiatry Residency Training Program (the "program") is one such ACGME-affiliated residency program.

13. When the program receives its match list from the ACGME, it interviews the resident applicant.

14. Dr. Sodhi applied through the ACGME Match in 2001 to 2002 by completing an ERAS application on the ACGME website.

15. MIHS's Psychiatric Residency Training Program ("the program") is a medical residency program in which physicians are trained to become psychiatrists. The program consists of a variety of supervised hands-on medical and psychiatric rotations, as well as didactic classes.

16. Dr. Sodhi applied for and was admitted to the MIHS Psychiatry Residency Training Program in 2002.

17. Dr. Sodhi's admission to the program was withdrawn for reasons currently in dispute between the parties.

18. Dr. Sodhi filed a complaint with the Department of Justice about the withdrawal of the offer for a residency position with MIHS.

19. After negotiation, the parties resolved the dispute, Dr. Sodhi withdrew her complaint, and MIHS agreed to admit Dr. Sodhi into the program.

20. The Program at MIHS is a psychiatry residency training program requiring residents to complete four years of residency to graduate from the program.

21. The program is broken down into four distinct resident years, identified as PGY-1, PGY-2, PGY-3, and PGY-4.

22. The academic year in the program generally runs from July 1 to June 30, although residents are sometimes taken "off-cycle" for various reasons.

23. At the time that Dr. Sodhi joined the program, she was given a copy of the program policies and house manual.

24. The residents sign one-year contracts for each resident year.

25. Dr. Sodhi signed a year-to-year contract for her PGY-1 year in the program.

26. She signed another year-to-year contract for her PGY-2 year in the program.

27. Residents elected for the Program are retained on a year-to-year contract and are allowed to complete their contractual term absent cause for dismissal from the program.

28. Dr. Sodhi completed both her PGY-1 and PGY-2 contract years.

29. At the end of the particular year, MIHS may renew a resident for the next year by presenting a new contract to the resident and having the resident sign the new contract.

30. The program is a residency program in which physicians participate in didactic classes, and patient rotations to develop psychiatric skills.

31. A "rotation" is an assignment, usually one to two months in length, where a resident works with an attending physicians on patient rotations in one of MIHS's medical facilities.

32. Pursuant to program guidelines in place during the 2003/2004 academic year, residents were required to take and pass a standardized test known as the USMLE 3 no later than March 1 of their PGY-2 year to proceed into the PGY-3 academic year.

33. Dr. Sodhi was informed at the time she entered the program that she had to complete to USMLE 3 before she would be admitted to the PGY-3 year of the program.

34. The USMLE 3 is administered by a third-party accrediting organization and, according to the organization's rules, residents may only take the USMLE 3 three times per academic year. It is not administered by MIHS or the program.

35. The USMLE 3 is administered throughout the year at various test centers.

36. There is a test center located in Phoenix, Arizona.

37. A test-taker may sign up for the USMLE 3 at any time, and schedule the test at his or her convenience, so long as the test center is open at the time.

38. A test-taker, however, may only take the USMLE 3 three times per academic year, pursuant to rules set forth by the body administering the USMLE 3.

39. Dr. Sodhi took and failed the USMLE 3 three times during her PGY-2 year.

40. After failing the USMLE 3 for the third time, Dr. Sodhi could not take the USMLE 3 again before the end of her PGY-2 year.

41. The program administrators informed Dr. Sodhi that she would not be renewed for a PGY-3 year because she did not timely pass the USMLE 3.

42. Dr. Sodhi completed her PGY-2 academic year in the program on June 30, 2004, and was not renewed for a subsequent year.

43. After the non-renewal, Dr. Sodhi continued to study for and take the USMLE 3.

44. Dr. Sodhi passed the USMLE 3 in February, 2005.

45. Dr. Sodhi spoke with the Program Director, Dr. William James, in February, 2005, and told him that she wanted to reenter the program.

46. Dr. James informed Dr. Sodhi that he would inform the Residency Committee for the program of her request and would get back to her.

47. On March 17, 2005, the Program Residency Committee met and discussed Dr. Sodhi's request to reenter the program.

48. The Residency Committee voted on whether to readmit Dr. Sodhi to the program, and the vote tally was against readmitting her to the program.

49. On March 17, 2005, Dr. James told Dr. Sodhi that the Residency Committee declined her request for readmission to the program for two reasons: (a) that there currently were no open, available, PGY-3 positions in the program for the 2005/2006 academic year; and (b) that her performance history did not support returning her to the program.

50. Dr. Sodhi filed a Complaint with the Department of Justice on or about April 21, 2005, alleging that MIHS retaliated against her in violation of the Immigration and Nationality Act,

8 U.S.C. § 1324(b).

51. The individuals directly involved with the resolution of Dr. Sodhi's OSC charge in 2002 were Mark Hillard, CEO; Joseph Campbell, Risk Management Claims Manager; Dr. Maricela Moffitt, Director of Academic Affairs and the Director of Medical Education for MIHS at all relevant times; and Dr. Glenn Lippman, Chair of the Department of Psychiatry from at least 2001 until November of 2004.

52. Dr. Carol Olson became the acting Chair of the Department of Psychiatry in November of 2004 and was named Chair in August of 2005.

53. Dr. Lisa Jones was the Director of the Psychiatric Residency Training Program at all relevant times until January of 2004.

54. Dr. William James became the Director of the Psychiatric Residency Training Program on January 26, 2004.

55. Members of the executive committee of the program's residency committee who participated in the discussion at the meeting on March 17, 2005 were Dr. William James, Dr. Jennifer Weller, Dr. Michael Hughes, Dr. Carol Olson, Dr. Samuel Hand, Dr. Domiciano Santos, Dr. Andrew Parker, and Dr. Lydia Torio.

56. Drs. James, Weller, Hughes, Olson, Hand, Santos and Parker voted not to readmit Dr. Sodhi to the program; Dr. Torio abstained.

57. Drs. James, Weller, Hughes, Olson, Hand, Santos, Parker, and Torio reached a consensus that Dr. Sodhi was unsuited to the practice of psychiatry and should seek training in a different specialty.

58. Drs. James, Weller, Hughes, Olson, Hand, Santos, Parker, and Torio did not know that Dr. Sodhi had filed a charge with OSC in 2002.

59. The day after the executive committee decision, Dr. Sodhi discussed it with Dr. James and Dr. Olson, both of whom agreed to write letters of recommendation for Dr. Sodhi to assist her in applying for other programs, and each did so.

60. Dr. Sodhi was well-liked and was seen as a courteous and hard working resident.

61. Dr. Sodhi was successful in some areas of her residency, and performed especially well in her academic work.

62. Despite some areas of success, Dr. Sodhi had difficulty applying her academic knowledge

when dealing with psychiatric patients in clinical settings.

63. Dr. Sodhi had persistent difficulties with patient interviewing and history gathering, and with interpersonal and communication skills.

64. Dr. Sodhi was notified of deficiencies in her performance by written comments in her Biannual Reviews, by global assessments in writing by the residency committee, and by comments of the attendings in her rotation evaluations.

65. Dr. Sodhi received such coaching, oral counseling, and remedial measures during her residency as faculty thought appropriate.

66. Dr. Sodhi received individualized curriculum changes during her residency, including directed study; reassignment from the rotation in geropsychiatry, which she was failing, to an adult psychiatry rotation where she could focus on interviewing; and another adult psychiatry rotation in lieu of emergency psychiatry.

67. Other residents who had to seek readmission to the program did not have comparable problems with psychological mindedness, with receptive language, or with the ability to gather information from a patient, come to a diagnosis, and formulate a treatment plan.

68. There were no specific program policies or ACGME policies which dictated the procedures or criteria to be used when considering an application for readmission into a residency program.

69. Dr. Maricela Moffitt did not participate in the executive committee's decision not to readmit Dr. Sodhi to the Psychiatric Residency Training Program.

70. Dr. Moffitt did not become aware of the committee's decision until well after it was made.

71. Dr. Sodhi made an appointment and met with Dr. Moffitt about a month after the committee's decision.

72. Dr. Moffitt was aware of Dr. Sodhi's prior charge in 2002 and had formed a negative opinion of Dr. Sodhi as a result of the underlying dispute.

73. Dr. Moffitt attempted to counsel Dr. Sodhi to seek training in another specialty, and advised her not to burn her bridges with Dr. James in case she wanted a favorable reference from him.

74. Dr. Sodhi did not tell Dr. Moffitt that she believed the denial of readmission was linked to the 2002 charge; in fact she did not mention that charge in their conversation, nor did she tell Dr. Moffitt that she intended to file another charge.

75. Dr. Sodhi made a vague reference to legal action during her conversation with Dr. Moffitt.

76. Dr. Moffitt did not suggest to Dr. Sodhi that she intended to engage in any action which would create an impediment to Dr. Sodhi's ability to obtain a position in another institution's residency program.

77. Dr. Moffitt did not tell Dr. Sodhi that she personally would do anything at all.

78. There were no specific program policies or ACGME policies which provided an appeal process after the denial of an application for readmission to a residency program.

B. Conclusions of Law

1. Dr. Gurpreet Sodhi is a protected individual within the meaning of 8 U.S.C. § 1324b(a)(3).

2. Maricopa County Special Health District is an entity within the meaning of 8 U.S.C. § 1324b(a)(1).

3. All conditions precedent to the institution of this action have been satisfied.

4. Filing a charge with the Office of Special Counsel for Immigration-Related Unfair Employment Practices is a right or privilege protected by 8 U.S.C. § 1324b.

5. Dr. Sodhi's filing of the OSC charge in 2002 was conduct protected by § 1324b.

6. In order to establish a violation of 8 U.S.C. § 1324b(a)(5), a complainant must show 1) that the individual engaged in an activity protected under the section, 2) that he or she suffered an adverse employment action, and 3) that a causal connection exists between the protected activity and the adverse action. *Vasquez v. County of Los Angeles*, 349 F.3d 634, 646 (9th Cir. 2003).

7. Denial of Dr. Sodhi's request to be readmitted into the Psychiatric Residency Training Program was an adverse employment action.

8. Dr. Sodhi's evidence failed to establish a causal connection between the filing of her 2002 OSC charge and the executive committee's denial of her request for readmission into the program.

9. In order to establish a causal connection between protected activity and an adverse action, a complainant must produce evidence that the decisionmaker was aware that the employee engaged in the protected activity. *Cohen v. Fred Meyer, Inc.*, 686 F.2d 793, 796 (9th Cir. 1982).

10. Dr. Sodhi's evidence failed to establish that Drs. James, Weller, Hughes, Olson, Hand,

Santos, Parker, and Torio knew that she had engaged in conduct protected under 8 U.S.C. § 1324b.

11. In order to establish an inference of discrimination based on disparate treatment of similarly situated individuals, the employee must show that the potential comparators are similarly situated in all material respects. *Moran v. Selig*, 447 F.3d 748, 755 (9th Cir. 2006), *citing Aragon v. Republic Silver State Disposal, Inc*., 292 F.3d 654, 660 (9th Cir. 2002).

12. Dr. Sodhi's evidence failed to show that any of the other residents to whom she sought to compare herself were similarly situated to her in all material respects.

13. Vague statements of intent to pursue legal action of some undefined character do not constitute protected conduct under 8 U.S.C. § 1324b(a)(5).

14. Dr. Sodhi's evidence failed to show that the reason given for denying her readmission to the program was a pretext or that a retaliatory motive was the real reason.

15. This is a final decision and order pursuant to 8 U.S.C. § 1324b(g)(1) and will remain final unless appealed in accordance with § 1324b(I).

To the extent any statement of material fact is deemed to be a conclusion of law or any conclusion of law is deemed to be a statement of material fact, the same is so denominated as if set forth herein as such.

C. Order

The complaint is dismissed. All other pending motions are denied.

SO ORDERED.

Dated and entered this 15th day of October, 2008.

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Ellen K. Thomas
Administrative Law Judge

Appeal Information

In accordance with the provisions of 8 U.S.C. § 1324b(g)(1), this Order shall become final upon issuance and service upon the parties, unless, as provided for under the provisions of 8 U.S.C. § 1324b(I), any person aggrieved by such Order seeks timely review of that Order in the United States Court of Appeals for the circuit in which the violation is alleged to have occurred or in which the employer resides or transacts business, and does so no later than 60 days after the entry of such Order.