

THE COMMONWEALTH OF MASSACHUSETTS  
COMMISSION AGAINST DISCRIMINATION

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MCAD & ZEINAT IBRAHIM,  
Complainants

v.

DOCKET NO. 06BEM02054

NORTH END REHABILITATION &  
NURSING CENTER

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Appearances:

Michael L. Mason, Esquire for Zeinat Ibrahim

Herbert L. Holtz, Esquire and Amie Geary, Esquire for Respondent

DECISION OF THE HEARING OFFICER

I. PROCEDURAL HISTORY

On August 22, 2006, Zeinat Ibrahim filed a complaint with this Commission charging Respondent with discrimination on the basis of race/color and national origin. The Investigating Commissioner issued a probable cause finding. Attempts to conciliate the matter failed and the case was certified to public hearing. A public hearing was held before me on February 10-12, 2010. After careful consideration of the entire record and the post-hearing submissions of the parties, I make the following findings of fact, conclusions of law and order.

II. FINDINGS OF FACT

1. Complainant, Zeinat Ibrahim, is a black woman and a native of Ethiopia. Complainant moved to the United States in 1989, graduated from Malden High School and has an Associate's Degree from Bunker Hill Community College. Complainant became a United States citizen in 2001. (T.1, p. 28,32-5)

2. Respondent North End Rehabilitation & Nursing Center (“Respondent” or “North End”) is a 101-bed skilled nursing facility located in Boston, Massachusetts. (T.3, p.166) Respondent is affiliated with Partners Continuing Care.

3. Spaulding Rehabilitation Hospital (“Spaulding” or “Spaulding Rehab”) is a ‘sister’ hospital to North End and is also affiliated with Partners Continuing Care. From 1998 to 2006 Complainant worked in several positions at Spaulding, including data entry, resource assistant, case management, outpatient clinic and insurance coordinator. She had no disciplinary problems while employed at Spaulding. (T.1, p. 34-5; T. 3, p.60)

4. In 2006, Justin Verge, who is Caucasian, was the Executive Director of Respondent and was responsible for all hiring, training, adherence to policies and procedures, terminations, regulatory compliance, finances, patient satisfaction and clinical outcomes.<sup>1</sup> Verge knew Complainant when they both worked at Spaulding Rehab.

5. In 1986 Nora Arbeene, who is also Caucasian, was the nurse case manager for Respondent’s 40-bed transitional care unit. Arbeene had also worked with Complainant at Spaulding Rehab.

6. In 1986 Kara Bolton, who is also Caucasian, was director of medical records at Respondent. (T.2, p.156-7)

7. Wendy Shea is human resources manager for Respondent. At the time of Complainant’s employment she reported to Oswald Mondejar, the Vice President of human resources for Partners Continuing Care.

8. Marie Pagan has been a unit secretary for seven years on Respondent’s

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<sup>1</sup> Verge is currently the administrative director for the department of surgery at Massachusetts General Hospital.

transitional care unit.

9. Justin Verge testified that Complainant had worked with Nora Arbeene and Jill Harmer in a per diem data entry position on the transitional care unit when it was located at Spaulding Rehab, and she was very familiar with the unit's patient population. In 2006, Arbeene and Verge asked Complainant to consider applying for the position of Resource Coordinator for Respondent's transitional care unit where they felt Complainant would be a "good fit." (T. 1, p. 35; T.3, p. 154)

10. After interviewing for the position with Verge, Arbeene, Jill Harmer and Bolton, Complainant was hired by Bolton. Complainant accepted the job because she would be working with many of the same people with whom she worked at Spaulding and she believed the position would give her the opportunity for promotion. (T.2, p. 157-8; T. 3, p. 154-5)

11. Kara Bolton testified that Respondent constantly re-enforces the importance of patient confidentiality with all its employees. She stated that employees have no general authorization to work in a patient's chart and a manager must authorize such access. Bolton testified that only Respondent's physicians or nurse practitioners can write an order for a patient, including orders for medical appointments. I credit her testimony. (T.2, p. 159)

12. Complainant received and signed for a copy of Respondent's handbook when she began her employment at Respondent. Respondent's handbook contains its policy regarding confidential information. (Ex. 6, p.19) The policy states as follows:

"Except when necessary, during the performance of assigned tasks, any discussion about patients/residents or their care or treatment is a violation of NERNC ethics and the patient's/resident's right to privacy. Such violation constitutes grounds for dismissal. Only persons who are authorized to do so are permitted to read

patient's/resident's record. Unauthorized reading or discussion of a patient's/resident's record may also be cause for dismissal.”

13. On April 10, 2006, Complainant signed a confidentiality agreement that stated, in part: “The North End Rehabilitation and Nursing Center has a legal and ethical responsibility to safeguard the privacy of all patients/residents and to protect the confidentiality of their health information... by signing this document I understand the following...2. I agree not to access any information, or utilize any equipment, other than what is required to do my job, even if I don't tell anyone else...5. I agree not to breach confidentiality of any data within any records or systems...” (Ex.4)

14. On April 6, 2006, Complainant began her job as resource coordinator for case management and MDS.<sup>2</sup> Kara Bolton was Complainant's direct supervisor. Complainant reported to Nora Arbeene with respect to case management matters and to Jill Harmer with respect to MDS. (T. 1, p.37-8) Complainant's position also included clerical back up support for unit secretary Marie Pagan and others. (Ex.8)

15. As nurse case manager, Arbeene assessed the needs of patients on the transitional care unit daily, with particular emphasis on discharge planning. After making patient assessments, Arbeene would meet with Complainant, who assisted her with discharge planning. Arbeene testified that Complainant's duties included assisting with referrals for visiting nurses, applying for RIDE services, developing and identifying community resources, and filing and faxing as directed by Arbeene. Complainant was responsible for ensuring that all patient discharge plans were complete and services were in place before patients were discharged. According to Arbeene, she informed

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<sup>2</sup> MDS is a computer program that gathers information on Medicare patients that is then provided to the state to determine reimbursement rates for medical facilities.

Complainant which patients were to be discharged on a particular day and would provide Complainant with instructions as to each patient. Complainant was permitted to access patient charts only as directed by Arbeene. I credit Arbeene's testimony (T. 3, p.7-8)

Performance Review and Written Warning

16. Arbeene testified that shortly after Complainant was hired, she began spending an excessive amount of time on personal telephone calls that were disruptive to Arbeene, Harmer and two or three other employees who occupied their 6' by 10' office at any given time. (T. 3, p.10) Arbeene testified that these calls disrupted her attempts to make work-related telephone calls (T. 3, p. 12-1) Arbeene and Harmer complained to Bolton about Complainant's excessive personal telephone use. I credit Arbeene's testimony.

17. On July 21, 2006, at the end of Complainant's 90-day probationary period, Complainant met with Kara Bolton and Nora Arbeene for an initial performance review. At the meeting, Bolton told Complainant that her performance was substandard, citing her excessive personal telephone use, her difficulty working independently, and the fact that she required a lot of direction and had difficulty completing tasks. Bolton testified that she felt Complainant's difficulty in completing her tasks was due in part to the frequent personal calls. I credit Bolton's testimony. (T. 2, p. 183-5) Complainant refused to sign the written performance review. (Ex. 9)

18. At the same meeting, Bolton gave Complainant a written warning for "poor work performance" because of her excessive personal phone use, difficulty working independently and inability to finish her work in a timely manner. (Ex. 10) Complainant

refused to sign the written warning and Justin Verge was called into the meeting to initial the documents. (T. 2, p. 185-190)

19. Respondent was not required to utilize progressive discipline during Complainant's 90-day probationary period and Bolton could have terminated Complainant's employment at the end of 90 days. Bolton testified that Respondent's managers did not want to terminate Complainant at that time because they believed Complainant had potential and hoped her performance would improve. (T. 2, p.189) I credit Bolton's testimony.

20. Complainant testified that she refused to sign the performance review and the written warning because she worked hard and did her best, taking into consideration the difficulties of reporting to several supervisors. Complainant's testimony regarding her personal use of a telephone was inconsistent. She testified at the public hearing that she knew personal use of a cell phone was prohibited except in an emergency and stated that she only used her cell phone once at work. However, at her deposition Complainant acknowledged using her cell phone for non-emergencies. (T.2, p. 55-56)

21. Complainant stated that she did not deserve a written warning after having worked for Partners for so many years and she appealed the warning to Verge. At a meeting with Verge in July she gave him a letter setting forth her reasons for disagreeing with the written warning. (Ex. 19) Complainant asked Verge to move her to another office because she was uncomfortable where she was, but Verge rejected her request because there was no other work space available and he thought she should work in proximity to her supervisors. (T.1, p. 26)

22. Complainant testified that after she was issued the written warning, the work environment became negative and her supervisors did not communicate with her and assigned most of her work via e-mail. She testified that she received “negative vibes” from Arbeene and Harmer. (T. 1, p.50) Bolton testified credibly that after the written warning, Complainant’s performance improved (T. 1, p.19-26)

Interaction with Ethiopian Patient

23. During her employment at Respondent, Complainant worked with an Ethiopian patient (“the patient” or “patient x”)<sup>3</sup> who was blind and had other serious medical and cognitive problems. (T.1, p. 19-26)

24. Complainant testified that when patient x was admitted to Respondent, Complainant attended a “patient outcome” meeting that included patient x, his caregivers, doctors, case managers, his guardian and family members. At the meeting Complainant was instructed to assist the patient with translation and issues related to his blindness and was further instructed to keep the patient’s legal guardian up to date on the patient’s needs. In addition to coordinating services such as Medicare and SSI for patient x, Complainant occasionally acted as his translator and sometimes accompanied him to medical appointments, duties that were not contained in her written job description. Complainant testified that her supervisors were pleased that she was able to assist patient x with these duties and she believed she did not require daily instruction from her supervisors as to which tasks to perform for the patient. I credit her testimony. (T. 1, p. T. 2, p. 134-135) Patient x’s legal guardian testified that patient x, an active young man

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<sup>3</sup> So identified to protect his privacy

before his injuries, was very depressed about his medical condition and appreciated Complainant's support.<sup>4</sup> I credit the guardian's testimony.

25. Complainant testified that in order to perform duties related to discharge planning and other clerical tasks related to patient x, she had to access patient x's chart. (T. I, p. 41) Complainant acknowledged that in order to perform such tasks, she needed Arbeene's permission. Complainant also acknowledged that she needed a nurse practitioner's or physician's instruction in order to make a medical appointment for patient x. (T. 2, p.64-65)

26. Complainant testified that on one occasion while discussing patient x, Arbeene commented, "Oh, you people! You just want a free ride." Arbeene denied making this statement. (T. 3, p.16-17). Complainant did not include this allegation in her complaint to the MCAD or in her written discovery responses. She made the allegation about use of the words "you people" for the first time at her deposition. She alleged for the first time at the public hearing that Arbeene made the statement, "You just want a free ride." (T. 1, p.50-51; T. 2, p. 26-28) I do not credit Complainant's testimony that Arbeene made such statements.<sup>5</sup> I find it implausible that Complainant would not have included this potentially significant information in either her complaint to the MCAD or in her responses to discovery if such a statement had been made. I credit Arbeene's testimony that she did not make such a statement.

27. Unit secretary Marie Pagan trained Complainant regarding the duties of unit secretary, including making medical appointments, confidentiality, patient privacy and

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<sup>4</sup> Following surgery on August 12, 2005 at Mass General Hospital to remove a tumor in patient x's arm, complications developed, which required amputation of the patient's arm, and caused blindness and cognitive difficulties.

<sup>5</sup> Complainant's testimony throughout the public hearing was generally vague and inconsistent with her deposition testimony.



HIPAA. Pagan testified that during this training she told Complainant that a unit secretary could access a patient file only with written orders from a North End physician, a nurse practitioner, or nurse, and that such written orders must be written on a particular form called an interim order sheet. (T. 3, p.34-42) Bolton testified that a unit secretary may access a patient's chart to make an appointment for a patient only if the chart has been removed from its usual location on shelves at the nurses' station, "flagged" to indicate that it contains a physician order written on an "interim order sheet" and placed on a cart beside the unit secretary's desk. (T. 2, p.167-9) I credit Bolton's and Pagan's testimony.

#### Events Leading to Complainant's Termination

28. In August 2006, patient x was taken to see a specialist at the Massachusetts Eye and Ear Infirmary ("MEEI").<sup>6</sup> Complainant was on vacation at the time and did not accompany patient x to the appointment. The specialist wrote a letter recommending an evaluation by a neurologist concerning his vision. Arbeene testified that the patient returned from the appointment with the letter. Arbeene relayed the information to patient x's attending physician and nurse practitioner later that day and they determined that there was no medical benefit to scheduling such an appointment. (T. 3, p. 18-22) Arbeene testified that she informed Complainant that the team had decided not to schedule such an appointment for the patient. I credit her testimony.

29. Complainant testified that on Friday, August 11, 2006, after returning from a two week vacation, she checked in with patient x to see how his doctor's visit had gone. Patient x told her that the doctor recommended a consultation with another specialist but the patient did not know whether that appointment had been made. Complainant offered

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<sup>6</sup> MEEI is not affiliated with Partners, as far as can be determined from the Partners and MEEI websites.

to check his record for him. I credit her testimony that the patient authorized her to access his chart, but I do not credit her testimony that his legal guardian had signed a paper stating that she could provide services to the patient. (T. 2, p.141-142)

Complainant never produced such a document and I do not believe that such a document ever existed.

30. Complainant went to the nurses' station where patient files are kept, accessed patient x's file, and saw the MEEI doctor's recommendation. Complainant testified that she then asked Marie Pagan whether the appointment with a neurologist had been made and Pagan told her to check the log. Complainant observed from the log that no appointment had been made and so informed Pagan, who responded that she was very busy and told Complainant to make the appointment herself. Complainant then made an appointment for patient x to see a neurologist. (T. 2, p. 150-152) I credit Complainant's testimony only to the extent that she accessed the patient's file and made the appointment. I do not credit her testimony that Pagan instructed her to check the log and make the appointment, as her testimony in this regard contradicts Pagan's credible testimony.

31. Marie Pagan testified that on August 11 she was at the nurses' station doing paperwork when she observed Complainant at the nearby counter talking on the telephone and became concerned when she heard Complainant giving out patient x's name and medical record number. Pagan interrupted Complainant and asked her what she was doing and if she had an order for a medical appointment. Complainant did not respond, but motioned her away and continued the telephone conversation. (T. 3, p.28-29) I credit Pagan's testimony.

32. Pagan testified that after Complainant brushed off her inquiry, Pagan observed patient x's chart lying open on the counter and saw that it contained no written appointment order. Pagan again asked Complainant whether she had an order and Complainant responded that she would explain later. (T. 3, p.29) I credit Pagan's testimony.

33. Pagan was responsible for fulfilling all of the outstanding physician orders and she testified that no charts had outstanding physician orders at the time because such files would have been "flagged" and placed on her cart, which contained no files at the time. Pagan immediately called Arbeene and Bolton and told them about the incident, because she was concerned about Complainant's actions. I credit Pagan's testimony (T. 3, 30-31) Pagan later made written notes of her observations on that day. (Ex. 21)

34. Bolton testified that when Pagan told her that Complainant had accessed patient x's file and made an unauthorized appointment, she "panicked" because Complainant's actions violated patient confidentiality, which was of paramount importance to Respondent. Bolton testified that as medical records director she is in charge of patient confidentiality and HIPAA matters and protecting patient confidentiality is a huge concern to her. (T. 2, p. 170) She stated there was no reason for Complainant to have gone into the patient's record to make an appointment absent a written order. (T. 2, p.159) Bolton immediately reported the incident to Justin Verge, who testified that he was very concerned about Complainant's having made the appointment for patient x on her own initiative, which he considered a very serious offense, akin to practicing medicine without a license. (T. 3, p.156-7) I credit the testimony of Bolton and Verge.

35. After speaking with Verge, Bolton immediately went to the second floor where patient x's chart was located, looked through the chart, confirmed that it contained no written order from a North End physician, and informed Verge of her findings. Together they contacted human resources manager Wendy Shea for instructions as to how to handle the matter. They determined that Bolton would have to meet with Complainant to obtain her version of events. (T. 2, p.160-161)

36. After consulting with Shea, Bolton met with Complainant to hear her version of events. At this meeting, Complainant told Bolton that she knew the patient had gone to an appointment at MEEI and she wanted to know what had happened. Complainant acknowledged accessing patient x's record to make an appointment with a physician.<sup>7</sup> (T. 2, p.162)

37. After the meeting with Complainant, Bolton consulted with Verge and Shea. They decided to issue a final written warning to Complainant for making an appointment for patient x without the required order. (T. 2, 161-162) On August 15, 2006, at a meeting attended by Jill Harmer and Nora Arbeene, Bolton gave Complainant a final written warning. (Ex. 11) Complainant refused to sign the warning and instead wrote on the document that she was not aware she was doing something outside her job description by assisting patient x, for whom she had previously interpreted medical information.

38. Following the meeting, Complainant went to Shea in order to grieve the warning. Shea scheduled a grievance meeting with Complainant for August 16, 2006.

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<sup>7</sup> Bolton testified Complainant told her a nurse practitioner had instructed her to make the appointment for patient x. However, Bolton could not remember when Complainant told her this. Bolton later asked the nurse practitioner whether she had given Complainant authorization to make the appointment and the nurse practitioner denied doing so. (T. 2, p.164-165)

39. Shea testified that at the August 16, 2006 meeting, Complainant told her that she had not received adequate training with respect to making patient appointments and that as patient x's "advocate,"<sup>8</sup> she did not need a physician's order to access his file. Complainant also told Shea that Respondent's clinical staff encouraged her to make the appointment. However, when Shea asked Complainant who told her to make the appointment, Complainant had no response. Shea then asked Complainant if anyone asked her to access the record or to make the appointment and Complainant said "no." (Ex. 24) Shea testified that at the end of the meeting, she suspended Complainant with pay pending further investigation of the issue. Shea did not document the suspension in writing but she gave Complainant a note dismissing her for the day with pay. I credit Shea's testimony.

40. After the meeting with Complainant, Shea, along with Bolton and Verge continued to investigate the matter and interviewed employees and consulted with other managers. (T. 3, p. 61-64) Bolton testified that to follow up on the grievance of the final written warning, she interviewed Verge, Pagan and the two nurse practitioners. (T. 3, p. 71-74) Bolton learned that the attending physician did not think the appointment was medically necessary. (T. 2, p.215) Verge had asked the attending physician, Respondent's medical director and the nurse practitioners whether they had given Complainant permission to make the appointment and they all said they had not done so. Bolton reviewed her findings with Verge and Shea, and they determined that in addition to making an unauthorized appointment, for which Complainant received the final written warning, Complainant had also violated the patient's confidentiality by going into his file without authorization, which they considered to be a serious violation of patient privacy.

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<sup>8</sup> Respondent's witnesses stated credibly that Complainant was not a patient advocate.

In addition Verge testified that he believed Complainant had lied to Bolton in stating that a nurse practitioner told her to make the appointment.<sup>9</sup> Verge believed that, given the seriousness of the violations, Complainant's inability to see what she did as wrong, and the fact that she lied, he was concerned that Complainant might repeat the behavior and should no longer work for Respondent. In consultation with Verge and Shea, Bolton determined that these serious offenses merited termination of Complainant's employment. (T. 2, p.181-183) I credit the testimony of Verge, Bolton and Shea.

41. On August 18, 2006, Shea met with Complainant and informed her that she was upholding the formal written warning. Shea told Complainant that she could proceed to the next level of grievance with respect to the final written warning. (Ex. 26)<sup>10</sup>

42. Shea then directed Complainant to accompany her to the executive office where Arbeene, Bolton, Shea and Verge informed Complainant that her employment was terminated for making a patient appointment without a physician's order and for violating HIPAA and patient confidentiality by accessing patient x's record without authorization. Bolton also told Complainant at the termination meeting that she had checked with the nurse practitioner who denied giving Complainant permission to make the appointment. (T. 2, p.182-183) Complainant's termination notice stated that she had not been authorized to review medical information or translate medical information for patient x as she had told her supervisors. (Ex. 12)

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<sup>9</sup> On August 17, 2006, the nurse practitioner wrote that she did not ask Complainant to translate a physician's note to patient x and did not give her permission to access patient x's chart. (Ex. 25)

<sup>10</sup> Verge reviewed the final written warning after receiving a written request from Complainant. (Ex. 14) He reviewed the investigation process, talked to the other people involved and reviewed the written documentation. On Monday August 21<sup>st</sup>, 2006, after Complainant had been terminated, Verge upheld her final written warning. (Ex.34)

43. Complainant thought the purpose of the meeting was to grieve her written warning and was shocked that to learn that she was being terminated. Complainant refused to sign the termination notice. She testified that did not believe she had violated privacy rules because she had never discussed patient x's medical information with anyone and had never sent documents from patient x's file to anyone. (T. 1, p.63)

44. Complainant testified that in September 2006, Oswald Mondejar, Vice President of Human Resources for Partners, called and asked her to meet with her and to discuss the matters surrounding her termination. Complainant testified that she was not expecting Mondejar to call her and was surprised. She met with Mondejar at Respondent and presented her version of events. According to Complainant, Mondejar offered to reinstate her to her previous position. Complainant rejected Mondejar's offer because she would not feel comfortable or safe at her former job as she had been "misjudged" and "accused of so many things." I do not credit Complainant's testimony that Mondejar offered to re-instate her although I find it is plausible that he may have suggested he would try to do so.

45. Mondejar testified that he knew Complainant from the time of her employment at Spaulding, and testified that he arranged the meeting with her as the final step in the grievance procedure after receiving her written request to grieve her termination. (T. 3, p.184-6).

46. After meeting with Complainant, Mondejar met with Verge, Shea and Pagan. He also reviewed prior cases where employees were terminated for similar infractions. After his review, Mondejar determined that Complainant had clearly violated Respondent's policy of protecting the privacy and dignity of patients and upheld her

termination in a letter dated September 18, 2006. (T. 3, p. 184-6; Ex. 35) I credit Mondejar's testimony.

47. Respondent engages in "targeted advertising" of open positions, including active recruitment in minority communities, such as advertising in specific local community papers in various languages, attending career fairs targeted toward minority communities and sponsorship of internship programs in minority communities in order to employ a diverse workforce (T. 3, p.196-8)

48. Shortly after Complainant's termination, Bolton hired her replacement, Anna Cosmault, who is black. Bolton testified that at the time Cosmault was hired, Bolton did not know that Complainant had filed an MCAD complaint.(T. 2, p.192) I credit her testimony.

49. In 2005 Verge terminated a Caucasian nursing assistant for discussing a patient in a disparaging manner at the nurses' station. The nursing assistant had previously been given verbal counseling and a written warning. (Ex. 18)

50. Complainant acknowledged receiving and signing Respondent's handbook (Ex. 6). Complainant testified that that she remembered all of the rules contained in the handbook, but claimed that the handbook did not contain the following two sentences under the heading Confidential Information: (T. 2, p.98-104)

"Except when necessary, during the performance of assigned tasks, any discussion about patients/residents or their care or treatment is a violation of NERNC ethics and the patient's/resident's right to privacy. Such violations constitute grounds for dismissal. Only persons who are authorized to do so are permitted to read patient's/resident's record. Unauthorized reading or discussion of a patient's/resident's record may also be cause for dismissal."



I find Complainant's testimony with respect to the handbook incredible and find that Complainant made this claim in order to avoid responsibility for her conduct.

### III. CONCLUSIONS OF LAW

M.G.L.c.151B §4(1) prohibits discrimination in employment on the basis of race, color and national origin. Complainant alleges that Respondent discriminated against her based on her race, color and national origin by subjecting her to unwarranted warnings and ultimately terminating her employment. In order to establish a prima facie case of race, color and national origin discrimination, Complainant must show that she was a member of a protected class, that she was qualified and adequately performing her job and that she was subjected to adverse treatment different from similarly situated employees not in her protected class. McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973); Abramian v. President & Fellows of Harvard College, 432 Mass 107, 116 (2000); Wheelock College v. MCAD, 371 Mass 130 (1976). Complainant has established the first prong of a prima facie case by virtue of her Ethiopian national origin and her race and color, black.

#### First Written Warning

With respect to her first written warning, Complainant has failed to establish that she was adequately performing her job at the end of her probationary period. Complainant began to exhibit performance problems early on in her employment and was given a written warning for making excessive personal telephone calls and for poor performance. There was no credible evidence that the written warning was unwarranted and there was no evidence that Complainant was treated differently from similarly situated persons not in her protected class in this regard. Complainant contends that

Respondent's use of "progressive discipline" during the Complainant's probationary period was evidence of discriminatory animus. However, I conclude that Respondent's use of progressive discipline was not evidence of discriminatory animus, as Respondent could have terminated Complainant for no reason at all during the probationary period but instead, she was given a warning with the hope that her performance would improve. Thus I conclude that Complainant has failed to establish a prima facie case of discrimination with respect to her first written warning.

#### Termination

Subsequent to her first written warning in July of 2006, Complainant's performance improved and she was adequately performing her job. On August 11, 2006, Complainant accessed patient x's file without authorization and made a medical appointment for him without written authority. For this conduct Respondent gave Complainant a final written warning. Respondent then terminated her employment upon determining that Complainant had violated Respondent's patient privacy policy by accessing the patient file without authorization and by making an unauthorized medical appointment for the patient. Complainant does not dispute that she engaged in this conduct. Around the same time period, Respondent terminated a Caucasian nurse's aide for publicly disparaging a patient. Notwithstanding Complainant's argument that the Caucasian aide was given multiple warnings, I find this argument specious since both employees were similarly situated and were both terminated for privacy violations. I find that there was no disparate treatment of Complainant and therefore Complainant has failed to establish that she was treated differently from similarly situated persons not of her protected class. But even if Complainant had established a prima facie case of

discrimination, I find no evidence that Respondent acted with discriminatory motive or intent as discussed below.

Assuming that Complainant has established a prima facie of discrimination, the burden of production shifts to Respondent to articulate legitimate, non-discriminatory reasons for its actions. Abramian v. President and Fellows of Harvard College, 432 Mass 107(2000); Wheelock College v. MCAD, 371 Mass. 130 136 (1976); Blare v. Husky Injection Molding Systems Boston, Inc. 419 Mass 437 (1995). Respondent must "produce credible evidence to show that the reason or reasons advanced were the real reasons." Lewis v. Area II Homecare, 397 Mass 761, 766-67 (1986) Respondent's articulated reasons for giving Complainant a final written warning and terminating her employment were that she accessed a patient's file without permission and made an unauthorized medical appointment for a patient, thereby violating Respondent's confidentiality policies, I conclude that Respondent has met its burden of articulating legitimate, non-discriminatory reasons for its conduct.

Once Respondent has articulated legitimate, non-discriminatory reasons for its conduct, Complainant must show that Respondent's reasons are a pretext for unlawful discrimination. A fact finder may, but need not, infer that an employer is covering up a discriminatory intent, motive or state of mind if one or more of the reasons identified by the employer are false. Lipchitz v. Raytheon Company, 434 Mass. 493, 498, 507 (2001). The employee need not disprove all of the non-discriminatory reasons proffered by the employer for its decision-making, only that "discriminatory animus was a material and important ingredient in the decision making calculus." Chief Justice for Administration

and Management of the Trial Court v. Massachusetts Commission Against Discrimination, 439 Mass. 729, 735 (2003).

Complainant argues that she was not adequately trained and that Respondent's lack of written guidelines for accessing patient files led her to conclude that she had the authority to access patient x's file. While Complainant did perform functions, such as translation, for patient x that were outside the scope of her written job duties, and which could have led her to believe she was authorized to access patient x's file, Complainant admitted at the hearing that she was not authorized to access the patient's file and was not authorized to make a medical appointment for the patient. Even if Complainant reasonably believed she could access patient x's file, when the unit secretary Pagan, whose duty it was to make appointments, tried to intercept her making the appointment, it is likely Complainant knew that she was violating policy, yet she proceeded to make the appointment for the patient.

Complainant further argues that Respondent's submitting her to progressive discipline based on one event is evidence of pretext. I do not concur. Respondent's engaging in concurrent disciplinary and grievance proceedings was puzzling, and Complainant could reasonably have been confused as to why she received a final written warning and was then subjected to termination based on the same infraction, while appealing the written warning. However, there is no evidence that the disciplinary process, however confusing or unorthodox, was motivated by discriminatory animus. I find that Respondent articulated a reasonable belief, based on a thorough investigation, that Complainant had engaged in serious infractions of policy for which she accepted no responsibility and that this justified termination.

Even if I were I to conclude that Complainant's termination was unduly harsh under the circumstances, "it is not the [Commission's] job to determine whether Respondent made a rational decision, but to ensure it does not mask discriminatory animus." Sullivan v. Liberty Mutual, 444 Mass. 34, 56 (2005); *see also* Mesnick v. General Elec. Co., 950 F.2d 816, 825 (1st Cir. 1991), cert. denied, 504 U.S. 985 (1992) ("Courts may not sit as super personnel departments, assessing the merits - or even the rationality - of employers' nondiscriminatory business decisions"). While Complainant argued that Respondent's reasons were a pretext for discrimination, there is insufficient credible evidence to support a conclusion that the reasons Respondent articulated for its actions were not the real reasons for the termination, or that Respondent was motivated by discriminatory intent, motive or state of mind. Lipchitz v. Ratheon Company, 434 Mass. 493, 503 (2001).

Finally, while not dispositive of the issue of whether Respondent was motivated by discriminatory animus, it is difficult to conceive how the very same people who encouraged Complainant to apply for the position and then hired her could have been motivated by discriminatory animus to terminate her employment four and one half months later.

Thus, while Complainant was shocked and disappointed that she was terminated, after she acted out of concern for a very sick patient and felt she did not have the opportunity to complete the grievance process, the facts and circumstances do not indicate that Respondent's decision to terminate Complainant, even if seemingly harsh or unfair, was motivated by discriminatory animus. I conclude that there is no evidence that the arguably harsh penalty meted out to Complainant was on account of her race,

color and national origin. It is clear that the decision to terminate arose from a determination by Respondent that the severity of Complainant's conduct coupled with her unwillingness to accept responsibility for violating important policies merited the discipline imposed.

Therefore, I conclude that Respondent did not engage in unlawful discrimination and I hereby order that this matter be dismissed.

IV. ORDER

For the reasons stated above, the complaint in this matter is hereby dismissed.

This constitutes the final order of the Hearing Officer. Any party aggrieved by this decision may file a Notice of Appeal with the Full Commission within ten days of receipt of this order and a Petition for Review to the Full Commission within thirty days of receipt of this order.

SO ORDERED, this the 14<sup>th</sup> day of October, 2010.

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JUDITH E. KAPLAN,  
Hearing Officer