

H.E. NO. 2009-3

STATE OF NEW JERSEY
BEFORE A HEARING EXAMINER OF THE
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

UNIVERSITY OF MEDICINE AND DENTISTRY
OF NEW JERSEY,
Respondent,

-and-

Docket Nos. CO-2005-220
CO-2007-271

UNIVERSITY OF MEDICINE AND
DENTISTRY OF NEW JERSEY
COUNCIL OF AMERICAN ASSOCIATION
OF UNIVERSITY PROFESSORS CHAPTERS,
Charging Party.

UNIVERSITY OF MEDICINE AND DENTISTRY
OF NEW JERSEY,
Charging Party,

-and-

Docket No. CE-2006-003

UNIVERSITY OF MEDICINE AND
DENTISTRY OF NEW JERSEY
COUNCIL OF AMERICAN ASSOCIATION
OF UNIVERSITY PROFESSORS CHAPTERS,
Respondent.

SYNOPSIS

A Hearing Examiner recommends that the Commission dismiss a Complaint alleging that UMDNJ violated 5.4a(1) and (5) by unilaterally eliminating and/or reducing clinical salary components of Dr. Sanford Klein in 2005 and various other faculty at NJMS and RWJMS in 2007. She determined that UMDNJ acted consistently with its past practice of exercising its discretion in setting and modifying these salary components without negotiations with the AAUP. Additionally, the AAUP sought in recent negotiations to place limits on the University's discretion but withdrew its proposals in exchange for other more

important concessions and a new notification procedure. The Hearing Examiner determined that since the status quo was maintained and considering the negotiations history, the AAUP, by signing an MOA with a zipper clause and a collective negotiations agreement with a fully-bargained clause, waived its right to negotiate mid-contract over the issue of clinical components.

The Hearing Examiner also recommends that the Commission dismiss allegations in the Complaint that the AAUP violated 5.4b(3) by filing the charges in this matter. She found that the filing of the charges was a protected activity and that under these particular facts, there was no repudiation or bad faith demonstrated.

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Appearances:

For the University,
(Michael J. Gonnella, Deputy Attorney General)

For the American Association of University Professors,
Crow and Associates
(Charles S. Crow, of counsel)

HEARING EXAMINER'S REPORT
AND RECOMMENDED DECISION

On February 22, 2005, the University of Medicine and Dentistry New Jersey Council of American Association of University Professors Chapters (AAUP or Association) filed an unfair practice charge against the University of Medicine and Dentistry (UMDNJ or University) (CO-2005-220). The charge alleges that UMDNJ violated the New Jersey Employer-Employee Relations Act, N.J.S.A. 34:13A-1 et seq. (Act), specifically 5.4a(1) and (5),^{1/} when it unilaterally eliminated the clinical component of a unit member's (Dr. Sanford Klein's) compensation without negotiation. On August 4, 2005, UMDNJ filed an unfair practice charge against AAUP (CE-2006-003), alleging violations of the Act, specifically 5.4b(3)^{2/}. UMDNJ asserts that when AAUP filed its unfair practice charge, it acted in bad faith and

1/ These provisions prohibit public employers, their representatives or agents from: "(1) Interfering with, restraining or coercing employees in the exercise of the rights guaranteed to them by this act; (5) Refusing to negotiate in good faith with a majority representative of employees in an appropriate unit concerning terms and conditions of employment of employees in that unit, or refusing to process grievances presented by the majority representative."

2/ These provisions prohibit employee organizations, their representatives or agents from: "(3) Refusing to negotiate in good faith with a public employer, if they are the majority representative of employees in an appropriate unit concerning terms and conditions of employment of employees in that unit."

repudiated the parties' 2004-2009 collective negotiations agreement.

On August 23 and 24, 2005, an Order Consolidating Cases and a Complaint and Notice of Hearing issued (C-1). ^{3/}

On September 9, 2005, AAUP (C-2) and UMDNJ (C-3) filed their Answers. AAUP denies acting in bad faith or repudiating the collective negotiations agreement. It contends that the parties negotiated over clinical salary components but reached no agreement. AAUP asserts that it reserved its right to continue to negotiate the subject. In its Answer, UMDNJ contends that the parties negotiated over the issue of changes to clinical supplements and, pursuant to the understanding reached between the parties, agreed to certain notification procedures. It further alleges that Dr. Sanford Klein's clinical supplement was eliminated pursuant to the negotiated procedures.

On November 9, 2005, AAUP moved for summary judgment in CE-2006-003. On December 1, 2005, UMDNJ filed a response to AAUP's motion and a cross-motion for summary judgment. On January 26, 2006, the Public Employment Relations Commission (Commission) denied the motions, finding that there are material facts in dispute. P.E.R.C. No. 2006-51, 32 NJPER 12 (¶6 2006).

^{3/} "C" refers to Commission exhibits received into evidence at the hearing. "J" refers to the parties' joint exhibits. "CP" and "R" refer to AAUP's and UMDNJ's exhibits respectively.

On April 23, 2007, after 8 days of hearing, I granted AAUP's motion to amend the Complaint to add a new charge under Docket No. CO-2007-271. AAUP alleges that on or about February 2007, the University unilaterally reduced or eliminated clinical components of salary for faculty in various departments without changes to their duties or responsibilities and in response to departmental budget reductions. These unilateral reductions, it contends, are contrary to past practice and without negotiations. Additionally, AAUP contends that the University refused its demand to negotiate the reduction in salaries for the affected faculty in violation of 5.4a(1) and (5) of the Act.

On May 3, 2007, the University filed its Answer to the amended Complaint generally denying that it unilaterally changed past practice regarding clinical components of faculty salary.

The hearing was held on August 7, 8, 9 and 10 and December 7, 2006, and January 17 and 18, February 27, August 1 and 2, September 11 and 12, and October 23 and 24, 2007 at which the parties examined witnesses and presented exhibits.^{4/} Briefs and replies were filed by April 15, 2008. Based on the record, I make the following:

^{4/} Transcript references to hearing dates are "1T" through "14T" respectively.

FINDINGS OF FACT

Background

1. UMDNJ is a public employer, the AAUP is a public employee representative, and Dr. Sanford Klein is a public employee within the meaning of the Act (1T11-1T12).

2. UMDNJ is composed of eight schools, including three medical schools: New Jersey Medical School (NJMS) located in Newark; Robert Wood Johnson Medical School (RWJMS) in New Brunswick, Piscataway and Camden; and the School of Osteopathic Medicine (SOM) in Stratford. UMDNJ is also composed of New Jersey Dental School (NJDS), the Graduate School of Biomedical Sciences, the School of Nursing (SN), the School of Public Health (SPH) and the University Libraries (J-1, J-3).

The AAUP represents all full-time teaching and/or research faculty and librarians, and all part-time teaching and/or research faculty and librarians, who are employed at fifty percent or more of full-time hours, by UMDNJ at these institutions (J-1, J-3).

3. There are two major types of salary components for medical faculty, and within one type, known as clinical supplements or clinical components, there are two sub-types - patient services and faculty practice components (6T78). First, there is an academic base which is negotiated by UMDNJ and AAUP and embodied in the parties' collective negotiations agreement

(1T44-1T45). The academic base is dependent on faculty rank as well as whether a faculty member is a clinician or a basic scientist. All clinical faculty at the three medical schools receive an academic base salary (J-1, J-3; 5T7).

Faculty may also receive one or both of the two sub-types of clinical salary components. Patient services components of salary are received by NJMS faculty for charity care at University Hospital and by department of psychiatry faculty at both NJMS and RWJMS for treatment of charity care patients at University Behavioral Health Care (UBHC), a UMDNJ-owned entity located in Newark, Piscataway and other locations (5T11-5T13, 5T19). It is understood that to get this component of salary faculty are treating patients, but historically there has not been a tie to a specific number of hours of patient care activity and this type of income, in the past, has not varied greatly from year to year, unlike the faculty practice salary component discussed below (6T95, 13T74). Also, the patient services component may be paid for work that is in addition to patient care or used upon hire to attract a prospective new hire with a market-rate salary greater than the negotiated academic base (CP-25).

Faculty at all three medical schools, may receive another type of compensation known as a faculty practice component for treating insured patients whom they can bill for services through

faculty practice plans (1T44-1T45, 1T48, 1T184, 1T188, 5T13-5T15, 5T21, 5T23). There is a correlation between the amount of income paid to a particular physician and the amount of income earned through faculty practice (6T90). Because it is tied to productivity, this type of income varies and changes depending on the success of the individual or department in collecting fees (1T48, 1T184-1T185). Billable funds collected by the faculty plans are used first to pay administrative expenses and any excess funds are returned in various proportions to the schools, the departments and to participating faculty members based on formulas set by the plans (5T18).

In addition to the clinical components of salary and academic base, some faculty may also receive a faculty practice guarantee that guarantees income for a specified period of time and that is set out in the initial appointment letter or reappointment letter (5T11, 5T13-5T15, 5T23, 6T78-6T79, 11T11-11T12, 11T14-11T16). Both the patient services component and faculty practice component of salary assume that the faculty member will be taking part in a clinical activity but are not tied to a specific number of clinic hours (6T79-6T80, 6T94-6T96, 13T74). Neither the clinical components of salary nor the faculty guarantee are negotiated by the AAUP.

4. There are, however, two side-letter agreements in both the current collective agreement (J-1) effective from July 1,

2004 through June 30, 2009 and the previous collective agreement (J-3) effective from July 1, 2000 through June 30, 2004 regarding clinical components of salary.

One side letter of agreement dated December 9, 1994 and entitled "Patient Care Supplements" states:

The University agrees that in letters of appointment to faculty who will receive patient care supplements as part of their salaries, the amount of the patient care supplement will be specified along with information that such supplements are not subject to the across-the-board salary increases specified in Article VIII, Section I of the Agreement [J-1, J-2].

This letter grew out of negotiations for a successor to the 1986-1989 collective agreement, a number of faculty members wrote the AAUP Board to protest the practice of giving negotiated salary increments only on base salary and not on clinical components of salary (CP-2a and CP-2b). The AAUP raised this concern at its first negotiations session on March 20, 1989 and formulated a negotiations proposal that cost of living increases be applied to clinical salary components as well as base salary (CP-2c through CP-2e; 1T69-1T70). The AAUP dropped this proposal during negotiations because University Chief Negotiator Robert D'Augustine explained that some clinical components were given to faculty members for charity care which did not generate fees. Thus, because payment for these services did not change a lot, the University could not afford to pay increases on clinical

supplements. The side letter agreement clarified that across-the-board increases only applied to academic base not clinical supplements (J-1, J-3; 1T69-1T70, 1T73).

The other side letter of agreement, entitled "Faculty Practice/Patient Services Salary Components and Academic Base Salary", and executed in 2002 states:

The University agrees not to substitute either faculty practice or patient services salary components for any increase in academic base salary provided for in this Agreement. The University represents that, to the best of its knowledge, there are no other non-negotiated components of faculty salary [J-1, J-3].

This issue was raised in a grievance and resolved in 2002 by this agreement appended to the parties' 2000-2004 collective agreement (J-3; 1T187-1T188).

These are the only two references to clinical salary components in the parties' collective agreements. Other than these two letters incorporated into J-1 and J-3, no other article in the previous or current collective agreement addresses the establishment of or adjustment to clinical or faculty practice components of salary (J-1 and J-3).

5. UMDNJ owns and operates University Hospital in Newark which is the provider of last resort for charity care patients throughout the State (12T46). University Hospital relies solely on NJMS faculty to provide clinical services to charity care/uninsured patients (12T74). The State provides funds to

University Hospital to cover the expenses of caring for patients for whom there is otherwise no source of payment (5T10).^{5/}

University Hospital then allocates funds to NJMS for the provision of charity patient care. NJMS through the Chairs of each department pay their faculty a patient services salary component to provide patient care for these indigent patients, although this salary component is a broad category and is also utilized by Chairs during the hiring process to attract new hires to UMDNJ (6T92, 11T14).

6. At RWJMS, faculty treat patients at Robert Wood Johnson University Hospital (RWJUH) in New Brunswick (5T19). Unlike University Hospital, RWJUH is not owned by UMDNJ, but contracts its services as a health care entity, separate from RWJMS. There is an affiliation agreement whereby the hospital is a site for training RWJMS medical students and residents as well as providing a clinical practice staffed by the RJMS faculty, who bill for patient services (5T20). University Medical Group (UMG) administers the faculty practice plan for RWJMS faculty and is responsible for patient billing (6T13). The proceeds from

^{5/} University Hospital registers all charity care patients that are seen in hospital logs and files a report annually with the State. The State then decides how to allocate funds to various hospitals, partially based on volume indices, but does not allocate funds proportionately. University Hospital does not get fully funded for the number of patients it provides charity care to annually (13T32-13T33).

faculty clinical activity are returned to the various departments (2T95-2T96, 5T19).

For instance, the department of anesthesiology provides all anesthesiology services at Robert Wood Johnson University Hospital and is contracted by the University to the hospital (2T96). In order to provide patient services or perform clinical activities at the hospital, clinicians must have medical privileges at the hospital (2T96-2T98). RWJMS faculty also treat patients at other locations and their services are also billed and collected through the school's faculty practice plan and returned to the faculty as faculty practice income (5T20). Most of the money available to the department of anesthesiology comes from the provision of clinical services billed through UMG (6T13).

7. Similarly, Kennedy Hospital contracts with SOM for its faculty to provide clinical services (5T22). Kennedy is also not owned by SOM but has an affiliation agreement with the medical school (5T22). Like RWJMS faculty, SOM faculty provide clinical services both at the hospital but at other locations as well. The SOM faculty practice plan bills and collects for these activities and returns proceeds to faculty as faculty practice income.

8. At NJMS, the faculty participate in a separately incorporated faculty practice plan called University Physician

Associates (UPA) (5T14). UPA is an autonomous, not-for-profit practice plan that bills, collects and distributes revenue for all clinical activities of NJMS faculty. There is an agreement between UPA and NJMS whereby some of the net revenue from UPA collections is given to the Dean for use in educational and other programs at the medical school and some is given directly through the Department Chairs to the clinical faculty for services provided to insured patients (5T14-5T15).

Under the UPA plan, every 2 years, each department develops a formula to distribute the monies collected by UPA. The formula is subject to the approval of the Dean and the UPA Board (13T18). About 50% of the monies collected in most years go to pay mandatory taxes and operational fees, and the rest is distributed to the faculty in accordance with their distribution formulas (13T19-13T20, 13T32). There is no money from UPA that goes directly to University Hospital with the exception of faculty guarantee money that are negotiated by the Chairs upon hire with in-put from the Dean's office and University Hospital who fund the guarantee (13T27). UPA income is income over and above what is received by the faculty from academic base and patient services components and varies from year-to-year (13T23-13T24).

9. The Chair of each department in the three medical schools is responsible for the initial hiring of faculty members (5T8, 11T11). The Chairs negotiate with these individuals at the

time of hire a total compensation package, comprised of the academic base set by the parties' collective agreement as well as one or both of the non-negotiated clinical components of salary, namely faculty practice and/or patient services components, and possibly a faculty practice guarantee (1T49, 5T30-5T31, 10T5-10T6, 11T79-11T82).

The Chairs have a lot of flexibility in hiring-compensation decisions in order to attract talent to their staff - individuals who might otherwise decide not to come to UMDNJ (6T92, 8T16). Chairs generally consider many factors in the hiring process to establish compensation offers, such as what is deemed fair market value for physicians with comparable professional and academic credentials in the northeast, their expertise including number of years in practice, and any sub-specialties (6T19, 10T5-10T6, 11T79-11T80, 12T119, 12T162). Total compensation would be allocated between academic base, patient services and faculty practice components as well as the faculty guarantee after consultation between the Chair, the Dean and sometimes University Hospital. Clinical components of salary make up the majority of compensation and vary widely among faculty (14T6). In the case of NJMS, funding for the non-contractual clinical salary components comes from either NJMS or University Hospital depending on the activities to be provided to each entity and sometimes the availability of funds from each

source - e.g. who has more money (11T121). The AAUP is not involved in the hiring process (6T98, 11T146).

10. Offer letters must be approved by the Deans and are signed by the prospective hire, the Chair and/or Dean of the medical school (CP-1, CP-45, CP-46, CP-47, CP-85, CP-86, CP-87, CP-90; R-40, R-41, R-42; 6T91). The AAUP is not a signatory to either the offer letter or reappointment letters (CP-92; R-44, R-47). After the offer has been extended and accepted and administrative procedures within the medical school have been completed, all paperwork is submitted to the department of academic affairs for review by Vice President of Academic Affairs Dr. Karen Putterman or her staff to make sure the offer complies with all rules, policies and union agreements (5T32, 5T40). All faculty actions, including hiring and any subsequent changes in compensation or title, are memorialized in faculty transaction forms which require Putterman's approval before implementation (4T21, 6T99). For some actions, her signature alone is sufficient, but additional review at the University or Board level may be required (5T40-5T41).

11. The AAUP is also not involved when changes or modifications are made to the clinical components of salary. Changes to compensation are determined by the individual Chairs, with or without the agreement or of the faculty member (1T188-1T189, 2T26-2T27, 2T35, 3T48-3T39, 5T79, 6T98,

6T104-6T105, 8T37-8T38, 12T187). According to Putterman, the Chair has the discretion to sit down with any member of the department to discuss a change in their faculty practice or patient services salary components before making the change, but there is no policy requiring or precluding this; it is at the discretion of the Chair (6T102-6T103).

I do not credit the testimony of Mark Schorr that the practice of the parties' was that modifications to clinical salary components are always mutually agreed upon between the Chair and the individual faculty member after discussion or negotiation (8T61). The AAUP's own witnesses, Dr. Anthony Boccabella, AAUP Former Executive Director Debra Osofsky and Dr. Catherine Monteleone, who were on the negotiations team for the 2004-2009 (J-1) collective agreement, contradicted his testimony.

Specifically, Boccabella testified that the AAUP fashioned its proposals at the negotiations table to change the practice of the University of modifying, on occasion, clinical salary components without the approval of the faculty member (8T37-8T38). Osofsky confirmed that faculty communicated concerns to the AAUP that changes were made in their compensation that would just show up in their pay checks without prior notification (3T48-3T49). Monteleone was on the AAUP faculty advisory committee for the most recent negotiations and communicated to the AAUP negotiators (Schorr, Boccabella and

Osofsky) the concerns raised faculty that the University administration would unilaterally change clinical salary without negotiations and their desire to have individual written agreements to prevent such unilateral actions (2T26-2T27).

Another AAUP witness, Vasanti Tilak, a NJMS faculty member, testified that, at different points in her career, her patient services salary component was increased and/or reduced by her Chair without negotiation with either her or the AAUP (9T30, 9T37).

Beside this testimony, the AAUP is notified on a monthly basis by UMDNJ of modifications to all compensation, including clinical components of salary. Osofsky, the former AAUP executive director, as well as Alex Bernstein, the current director, testified that the AAUP does not scrutinize the monthly reports for whether, or if, changes are mutually agreed upon. Data from the reports are merely entered into a data base and only if a faculty member raises a question or complaint to the AAUP does it pursue a further inquiry (R-10; 3T51-3T52, 3T91, 4T8, 13T71-13T72). Therefore, the AAUP cannot conclude from the information it receives whether or not modifications are always mutually agreed. Based on the above testimony, I credit Putterman's testimony that modifications to clinical salary are not always mutual. Some chairs are inclined to discuss or

negotiate decisions to change clinical components with their faculty, and some Chairs are not.

12. For instance, when Monteleone was hired to work at RWJMS, she received an academic base salary and negotiated a clinical salary component with her Chair (2T24-2T25). Monteleone's clinical salary component, has remained constant throughout her career. It did not change despite the fact that she went from full-time to part-time status, because Monteleone negotiated with her Chair to maintain her full clinical salary. Specifically, Monteleone persuaded her Chair that she would perform more of her administrative paperwork at home (2T33-2T34). She acknowledges, however, that some Chairs are not inclined to negotiate with faculty. "Everything depends on the individual Chairs" (2T35).

13. Unlike Monteleone, when Professor of Neurology and Ophthalmology Dr. Frederick Lepore was hired twenty-six years ago to work at RWJMS, his salary was unilaterally set by his Chair. Like Monteleone, however, his clinical salary component has never been reduced (3T149-3T150). As Acting Chair from 1994 to 1996, Lepore never reduced the clinical salary components of his faculty, although he acknowledges there is a common perception among the Chairs and Deans that ". . . the clinical supplement is a malleable, a changeable figure that could be, for whatever reasons they would care, could be changed" (3T154, 3T159).

As current AAUP President, Lepore disagrees with this "common perception". He feels that clinical salary components are simply a bookkeeping tool and should not change, but he concedes that they do change. He, personally, cannot conceive of any legitimate reason for reducing a faculty member's clinical component, although Lepore admits that he never supervised a faculty member who lost their medical privileges at RWJUH and could not, therefore, treat patients at the hospital (3T148, 3T153-3T154, 3T156).

14. Dr. Robert Knuppel was employed by RWJMS from 1990 through 2002 as Chair and Professor of the Department of Obstetrics and Gynecology (4T27-4T28). At the time he was hired, his salary consisted of an academic base and a faculty practice component, although he was given a total income figure and was not aware of this breakdown in salary until later (4T28-4T29). As Department Chair, Knuppel hired close to fifty clinicians (4T31-4T32). He negotiated salary packages with each individual and explained the breakdown of salary into the various components and also explained that only the faculty practice component was tied to productivity and could vary from year to year (4T34). As far as Knuppel understood, another salary component, attributable to what he called clinical supplement, was fixed. In fact, Knuppel testified that he tried to change this component but was told by his Dean that he couldn't (4T34-4T35).

15. In any event, the AAUP is notified of all changes in components to faculty salary in monthly reports provided by Putterman's office. Information contained in the reports are gathered from faculty transaction forms (R-10; 3T49-3T50, 5T48, 5T54-5T55). Each report contains the name of the faculty member, title, academic department, school, the action taken, the effective date of the action and the impact of that action on compensation, if any (R-10; 5T52-5T53). The report does not advise the AAUP of the reason for the change or whether the change was by mutual agreement (3T49-3T50, 6T102).

Once the AAUP receives the monthly report, the information is reviewed by an assistant and entered into a data base. Osofsky only became involved if a faculty member telephoned her with a concern about a change or her assistant was confused about the change. Osofsky would then look into the issue. The AAUP did not seek to negotiate every time it observed a change in a clinical component of salary because there were numerous changes every month, and the AAUP assumed that the changes were appropriate unless a faculty member alerted her there was a problem (3T51-3T52, 3T91). According to Osofsky, ". . . without a reason to worry or to wonder, it would be ridiculously time-consuming to try to pursue every single one of [the changes], so we wait and see if somebody has an objection or a complaint or a question, then we use that as reference to respond

to questions that come from the membership or the leadership or one of the administrative people in the audience" (4T8).

Current AAUP Executive Director Alex Bernstein confirms that the AAUP does not know if a change in a clinical component is inconsistent with what the AAUP considers to be past practice unless the faculty member contacts him. The monthly reports do not always contain enough information to disclose the reason for the change in compensation (13T71-13T72).

16. R-10 are the monthly reports of changes in faculty employment status - including changes to patient services and faculty practice salary components - sent to the AAUP by Putterman's office covering the period from June 2002 through December 2004 (3T92-3T94). The changes contained in the monthly reports were approved by Putterman.

R-10 reflects approximately 1800 faculty actions taken in this time frame with approximately 1600 attributable to faculty actions at the three medical schools. Of the 1600 total faculty actions at the medical schools, there were approximately 127 changes to patient services components, including approximately 34 reductions and 93 increases. There were approximately 351 changes to faculty practice components with approximately 135 reductions and 216 increases.

Some of the reasons for changes to faculty practice and patient services components were apparent from the information

provided in the report, such as changes in FTE, appointment or reappointment, promotion, resignation, retirement, leave, merit increase, paid status change, correction or out-of-cycle increases. Most changes were effective July 1, the beginning of the fiscal year, and others were made at random times during the year. Some of the reasons for the changes were not readily apparent from the information provided in the reports.

However, in all instances, information explaining the basis for the modifications were provided in attachments to the faculty transaction forms requesting approval for the change and submitted to Putterman by the Department Chair for her review and approval. The faculty transaction forms were not routinely provided to the AAUP, although there is no evidence to support that the AAUP requested them from the University and/or that the University refused to provide the faculty transaction forms if requested. In any event, below is my summary of relevant information gleaned from my review of R-10.

17. Specifically, R-10 reflects that at NJMS, there were approximately 70 increases and 12 reductions to patient services components. Of the 12 reductions, eight were due to changes in FTE status, while three were reduced for no reason apparent from the information provided in the monthly report. During this time period, there were also approximately five increases and 35 reductions in faculty practice salary components at NJMS. Of the

35 reductions, approximately 30 were tied to like increases in the patient services component with no reduction to overall compensation, a couple of the reductions were attributable to changes in FTE, while one reduction in faculty practice was for no reason that could be inferred from the information provided in the report (R-10).

At RWJMS, there were approximately five increases and 13 reductions to patient services components; all of these increases and reductions were in the department of psychiatry and presumably attributable to charity care provided at the UBHC locations. Of the reductions in patient services components, 12 were due to changes in FTE and 1 was for no reason apparent from the information provided in the report. There were also a total of approximately 130 increases and 66 reductions in the faculty practice salary components. Of the reductions, approximately 17 were due to changes in FTE and 49 (including Dr. Sanford Klein's reduction discussed below and at issue in the matter before me) were attributable to no apparent reason based on the information contained in the monthly report (R-10).

Finally, at SOM, consistent with Putterman's testimony that patient services components are only given to faculty at NJMS and department of psychiatry faculty at RWJMS, there were no changes to patient services components. There were, however, approximately 67 increases and 44 reductions in the faculty

practice components of salary listed in the R-10 monthly reports. Of the reductions to faculty practice, 19 were attributable to FTE, while 13 were for no apparent reason based on the information contained in the report (R-10).

18. Some specific examples of reductions in components of clinical compensation listed in the R-10 monthly reports, where there were no stated reasons and none could be inferred from the information provided in the monthly report - e.g. change in FTE or title, but which were made for reasons that Putterman considered to be valid, are as follows:

a. In 2003, Dr. Helen Ratico was appointed as a clinical assistant professor in the RWJMS department of psychiatry at eighty percent of a full-time position (CP-1e; 1T58-1T60). Her salary consisted of a base (\$81,462) and a patient services component (\$39,738). In January 2004, Ratico began seeing patients at an out-patient site, and her Chair successfully recommended that her patient services component be increased to \$70,038 to reflect the increase in patient care activities (CP-1g through CP-1i).

In March 2004, Ratico's patient services component was decreased to \$39,738. The reduction was listed in R-10 with no apparent reason for the change. The AAUP never contacted Putterman to discuss or negotiate the change (5T70-5T71). Putterman approved the change for the reasons stated in the

letter from Ratico's Chair attached to the faculty transaction form submitted to her for approval, namely because Ratico would no longer be seeing patients at the out-patient site (CP-1j through CP-1m; R-10 at UMD 110; 5T70).

b. Dr. Rajeev Mehta in the department of pediatrics at RWJMS had an \$11,000 reduction in his faculty practice component effective October 1, 2002 for no reason that was apparent from the information contained in the R-10 monthly report (R-10 at UMD 18; 5T55-5T59). Attached to the faculty transaction form (R-15) submitted to Putterman for approval of the reduction was a letter of explanation from Mehta's Chair, Dr. Notterman, indicating that the reduction reflected a decrease in activities due to Mehta discontinuing coverage in the division of neonatology. Putterman approved the request as a valid reason for the reduction. The AAUP never requested to negotiate over this reduction nor does the record support that the AAUP requested a further explanation for the reduction, an explanation that it could not discern from R-10 alone (5T59).

c. Similarly, Dr. William Croff in the OBGYN department at SOM had a \$20,000 reduction in his faculty practice component effective July 1, 2002 for no reason that could be gleaned from the information contained in the monthly report (R-10 at UMD 23; 5T60). Putterman approved the reduction based on the explanation submitted by Croff's Chair and attached to the

faculty transaction form, namely the reduction was due to Croff's lower than anticipated productivity for FY 02 (R-16). Putterman considered this to be a valid reason for the reduction (5T62). There is no evidence in the record that the AAUP sought a further explanation for the reduction after receiving R-10 or that it sought to negotiate with the University.

d. Dr. Steven Schutzer in the department of medicine at NJMS had his patient services component eliminated effective August 1, 2003 for no apparent reason supported by information contained in the monthly report sent to the AAUP (R-10 at UMD 78). Attached to the faculty transaction form submitted to Putterman's office requesting approval was a letter from Schutzer's Chair, Dr. Jerrold Ellner, explaining that he was eliminating Schutzer's patient services component because patient services components are paid for patient care and Schutzer was not engaged in patient care activities that generated funds (R-17). In another letter attached to R-17, Dean Joffe indicated to Putterman that the department had attempted to contact Schutzer about his availability to see patients, but Schutzer was not responding to their calls. Even though the department had not been able to confer with Schutzer, Joffe wrote that they intended to eliminate his patient services component (R-17). Putterman considered the reason indicated by Notterman to be valid and approved the request (5T62). There is no evidence that

the AAUP contacted the University concerning the unilateral elimination of Schutzer's patient services salary component and/or requested negotiation on behalf of Schutzer.

e. Finally, Dr. Bernard Vasseur in the department of surgery at RWJMS had his \$70,788 faculty practice component eliminated effective January 1, 2005 for no reason apparent in the monthly report sent to the AAUP (R-10 at UMD 140). Attached to the faculty transaction form submitted to Putterman's office for approval of the action was a letter of explanation from his Chair, Dr. Stephen Lowry (R-18). Lowry listed several budgetary reasons to support his request, namely Vasseur's clinical practice had not grown, he had not cultivated referral sources, Vasseur's hospital case volume had diminished below minimum requirements, and his financial results sustained continuing deficits. Putterman approved the request because she considered the reasons offered by Lowry to be valid (5T67). The AAUP never attempted to contact Putterman about this elimination of the faculty practice component nor did it request to negotiate (5T67).

Based on these examples, I conclude that in addition to the reasons listed in R-10 - changes in FTE, appointment or reappointment, promotion, resignation, retirement, leave, merit increase, paid status change, correction or out-of-cycle increases - among the reasons also considered to be valid for

such faculty actions and approved by the University are decreased patient care activity and/or productivity generally in the care of patients and decreased production of revenue to the department.

19. With the exception of Dr. Sanford Klein in the department of anesthesiology at RWJMS, whose faculty practice component was eliminated effective December 1, 2004 due to Klein's inability to perform clinical activities as a result of the RWJUH Credentials Committee's actions (R-10 at UMD 139), the AAUP has never contacted Putterman with respect to any changes in patient services or faculty practice components during the period of time covered by the R-10 monthly reports or for any monthly reports her office sent to the AAUP (R-1; 5T71-5T73, 14T61). Schorr confirmed that the AAUP, with the exception of Klein, has never sought negotiations on any of the changes listed in the monthly reports sent to Osofsky (R-10; 1T181-1T182).

In her 20 years at UMDNJ, Putterman explained, it has never been the practice of the University to negotiate any change in patient services or faculty practice components with the AAUP, that was left to the Chairs to deal individually with the faculty member (5T73-5T74). If the individual faculty member felt that a change in their compensation was not based on a valid reason,

according to Putterman, they could appeal to their Chair and then to the Dean (6T102-6T103).^{6/}

Administrative Notice

20. I take administrative notice of the following^{7/}:

In UMDNJ, P.E.R.C. No. 2002-53, 28 NJPER 177 (¶33065 2002) (UMDNJ I), the Commission dismissed a Complaint alleging that UMDNJ decreased an associate professor's patient services component without negotiations with AAUP. The Commission affirmed a Hearing Examiner's determination, H.E. No. 2000-13, 26 NJPER 377 (¶31151 2000), that the University acted consistently with its past practice of at least fifteen years by unilaterally increasing, decreasing or eliminating faculty stipends (clinical components of salary), and had, therefore, no obligation to seek negotiations with the AAUP before it reduced the patient services component (clinical supplement) of Dr. Stanley Weiss's salary. The Commission determined that the AAUP could seek prospective

^{6/} The AAUP postulates that I should reject Putterman's testimony regarding the parties' past practice as hearsay unsupported by a residuum of evidence on the record. N.J.A.C. 19:14-6.6. Numerous exhibits, including faculty transaction forms, as well as testimony from various Department Chairs bolstered her testimony. I reject this argument.

^{7/} N.J.A.C. 19:14-6.6. See also, Downe Tp. Bd. of Ed., P.E.R.C. No. 87-154, 13 NJPER 576 (¶18211 1987) (hearing examiner properly noticed factual findings in prior unfair practice proceeding between the same parties).

negotiations over Weiss's salary and future reductions in patient services components.

The Commission did not reach the Hearing Examiner's determination that the AAUP knowingly waived its right to negotiate over the reduction in Weiss' salary by its long-time acquiescence to a system where patient care stipends were established and changed outside the sphere of collective negotiations, because that issue did not influence its ultimate determination to dismiss the Complaint on other grounds.

21. I also take administrative notice of UMDNJ, P.E.R.C. No. 2001-31, 27 NJPER 28 (¶32015 2000) (UMDNJ II), a scope of negotiations case, decided after the issuance of the Hearing Examiner's decision, but before the issuance of UMDNJ I. The Commission declined to restrain binding arbitration over an AAUP grievance contesting the University's decision to reduce the clinical salary component of 63 faculty members whose academic base salaries were below contractual ranges. UMDNJ reduced the non-contractual clinical components of salary (faculty practice and/or patient services components) to offset the increases in academic base set by the parties' collective agreement. The Commission determined that salary is a negotiable term and condition of employment and rejected UMDNJ's argument that its right to unilaterally set salaries upon hire to attract qualified

faculty, included a prerogative to reduce supplemental salaries unilaterally.

Although the Commission acknowledged UMDNJ's suggestion that Department Chairs may seek to withhold or reduce supplemental salaries based on a faculty members failure to fulfill expectations, it did not consider this argument because that was not the basis for the reductions in the matter before it - clinical salary components were reduced to offset negotiated increases to academic base. The Commission also did not consider UMDNJ's defense that the AAUP waived its right to negotiate and arbitrate any issues concerning clinical salaries since this defense did not address the question before the Commission, namely whether reductions in clinical salary components are mandatorily negotiable and legally arbitrable in the abstract. In scope determinations, the Commission only addresses the abstract issue as to whether the matter in dispute is within the scope of collective negotiations.^{8/}

Negotiations for 2004-2009 Agreement

22. The AAUP has been represented by Attorney Mark Schorr for over twenty-five years. He has also occasionally represented individual unit members and has participated in collective negotiations on behalf of the AAUP since the early 1980's

^{8/} Ridgefield Park Ed. Ass'n v. Ridgefield Park Bd. of Ed., 78 N.J. 144 (1978).

(1T42-1T43). Schorr was lead negotiator for the current collective negotiations agreement effective from July 1, 2004 through June 30, 2009 (J-1). Also on the AAUP negotiations team with Schorr were unit member Dr. Anthony Boccabella and then AAUP Executive Director Debra Osofsky ^{9/}. Others occasionally participated (1T43, 1T61-1T62, 3T11, 8T7-8T8).

23. Dr. Karen Putterman is Vice-President for Academic Affairs at UMDNJ. She negotiated the 2004-2009 collective agreement on behalf of UMDNJ together with Director of Labor Relations Abdel Kanan and Executive Director of University Faculty Affairs Sheila Eder. Others also occasionally participated (1T63, 11T154-11T155).

24. In late 2003, in preparation for negotiations, the AAUP established a faculty advisory committee made up of representatives selected from the various institutions represented by the AAUP to set policy and define issues for the AAUP negotiations team (1T63, 3T11, 8T8). Some members were on the committee because of experience they had with specific topics of concern. For instance, Dr. Sanford Klein from RWJMS and Dr. Leonard Bielory from NJMS joined the advisory committee to provide information regarding faculty practice at their schools (1T64, 2T92, 3T16). Specifically, there was a concern, particularly at RWJMS, about transparency, because some faculty

^{9/} Osofsky left her position with the AAUP in February 2007.

members did not have sufficient information to understand changes to this component of their compensation. The AAUP negotiations team was looking for advise concerning formulating a negotiations demand regarding notification provisions pertaining to faculty practice income (1T64-1T65).

25. Boccabella met with the committee^{10/} to discuss issues and concerns and to formulate a questionnaire for distribution to faculty seeking their in-put as to what should be on the negotiations table. From their responses to the questionnaire, the committee selected those issues that were determined to be the most important to bring to the negotiations table (3T12, 3T15, 8T8-8T9). There were several issues of concern to the AAUP going into negotiations and identified by the advisory committee (3T17).

26. One issue related to merit increases and bonuses that were determined by the Chairs (3T18, 8T15-8T16). The faculty wanted some portion of their compensation not tied to subjective determinations by the Chairs (3T18). Another issue of concern, also related to compensation, was the method for determining how extramural incentive awards were paid (3T19). These are bonuses that are awarded to faculty for getting self-funded grants from outside entities (3T19, 3T22).

^{10/} Since Osofsky was hired in January 2004, she did not participate with the committee in 2003 or join in negotiations until 2004.

27. The AAUP advisory committee also identified clinical salary components - both faculty practice and patient services components - as issues of concern to the membership (1T65). In particular, faculty at RWJMS were concerned about Department Chairs who were threatening to eliminate or reduce clinical supplements if faculty did not do what they wanted (1T74, 8T15-8T16). In other words, faculty were fearful that clinical supplements would be arbitrarily reduced or eliminated for no good reason as a punitive measure (CP-3; 1T77-1T78, 1T87, 3T20, 3T123, 8T15-8T16, 8T20).

Dr. Catherine Monteleone who was on the negotiations advisory committee described that there were discussions among the committee members that there could be changes to clinical salary components without negotiations or without a reason and that there should be something in the collective agreement to prevent this occurrence (2T26). Monteleone understood that such a proposal was not in previous collective agreements (J-3; 2T27).

Boccabella understood that the faculty was concerned - a concern expressed to Putterman and Kanan in negotiations - that changes to clinical salary components could be made at the whim of the Chair or "willy-nilly" or for any frivolous purpose (8T35). Boccabella felt that there was no uniformity in how the University modified clinical components of faculty compensation. The AAUP's biggest concern was that there were no rules or

regulations to guide the decision-making process when changes were made. Boccabella saw it as a quagmire. Faculty were treated differently versus each other and differently by medical school and by department within the medical (8T38-8T43).

Osofsky was also concerned with arbitrary changes to clinical salary components. She described that the AAUP was concerned that any change was not made because the Chair didn't "like faculty who have glasses. . ." (3T123-3T124).

The AAUP wanted limits and criteria similar to academic base salary incorporated into the successor collective negotiations agreement and to prevent the University from continuing the practice on occasion, at least, of making changes in clinical salary components without the faculty member's approval. In other words, according to Boccabella, the AAUP's proposal on the subject of patient services components of salary was to guarantee that this portion of salary would be a permanent and fixed part of compensation as long as there was continued agreement that the initial reason for giving that money was still present (8T35, 8T37-8T38, 8T42-8T43).

28. Another issue of concern to the AAUP related solely to faculty practice. Faculty were concerned that there was no transparency regarding changes to this salary component; in other words, they did not have enough information from their departments as to revenue collections to determine how their

practices were doing and the reasons for changes to this component of their salaries (3T103).

Eventually, all of these issues were addressed by the AAUP when it formulated its negotiations proposals submitted to the University in April 2004.

29. Two negotiations sessions however, were held prior to April 2004 - October 28 and November 6, 2003 (R-19, R-31). At the first session on October 28, 2003, there were seven topics introduced by the AAUP for discussion - merit-based increases, the appeals process for unsatisfactory evaluations, performance evaluations, overwork of faculty, support systems for clinical faculty, parking fees, and patient services salary components (R-19, R-31; 5T77, 5T79, 6T125, 6T128).

As to this last topic, the AAUP wanted the patient services salary component to be guaranteed for the full period of the faculty appointment and to be changed only upon negotiation between the Chair and the individual faculty member (R-19, R-31; 5T77-5T79, 6T130).

To Putterman, the AAUP proposal of a guaranteed patient services component and negotiation over any change in this component of salary represented a major change in past practice. During Putterman's 20 years with the University, the practice had never been to negotiate with the AAUP over any changes in clinical components of salary represented by either patient

services or faculty practice salary components (5T73).

Putterman's experience was that the Chair could make changes to patient services components based on valid reasons and without a requirement to negotiate or obtain the permission of the faculty member (5T79, 6T104-6T105). If the faculty member disagreed with the Chair, he/she had recourse to the Dean (6T111). Once the Chair and the Dean were in agreement about the proposed change, Putterman checked that there was a valid reason for the change - that it was not arbitrary - by reviewing the information given to her by the Chair, and by relying on her 20 years of experience, her sense of fair play and her knowledge of the purpose of both patient services and faculty practice salary components before she approved the modification to compensation (6T111, 14T35).

No agreement was reached between the parties at the first negotiations sessions on any of the issues raised by the AAUP (6T132).

30. At the second meeting on November 6, 2003, four topics were discussed - (1) A salary package, including merit raises, was discussed. The AAUP wanted more information about the distribution of raises by school and department. The AAUP again raised the issue that the Chairs had too much discretion in granting merit raises and wanted across-the-board increases; (2) The appeals process for performance evaluations was discussed. The AAUP wanted a committee not the Dean as the final

decision-maker; (3) The AAUP again raised the issue of negotiating the process of changing clinical components of salary. According to Putterman, the AAUP raised concerns that Chairs, in particular Chairs at RWJMS, threatened to reduce patient services components as punishment. This made no sense to Putterman at the time, because the only faculty at RWJMS who get a patient services component are faculty in the department of psychiatry who see charity patients at UBHC locations, so she assumed that the AAUP negotiators were referring to Chairs threatening to reduce faculty practice components; and (4) The University wanted to modify the system regarding multi-year contracts for clinical faculty (R-20, R-32; 5T82-5T83, 6T84-6T85, 6T134-6T136).

No agreement was reached at this session on any of the topics (6T137).

31. On April 23, 2004, Boccabella sent the first set of AAUP proposals to Putterman (CP-3). The AAUP proposed generally as follows:

- (1) six percent across-the-board salary adjustments in each year with no merit-based increases
- (2) a dedicated pool for merit bonuses, and various other changes to the merit bonus system
- (3) an administrative change regarding when salary is reflected in faculty paychecks

(4) a more elaborate appeals process for unsatisfactory evaluations, including an appeals panel with a neutral person as a tie-breaker

(5) reimbursement for travel expenses

(6) "Components of Compensation" proposal was as follows:

a. Annually, but by no later than November 30, the University shall advise each unit member of his/her total compensation, exclusive of faculty practice, and the amount of each component. All letters of appointment shall also advise unit members of the amount of each component of his/her compensation.

b. The **University shall not reduce remuneration for the patient services component**, patient care clinical supplement, or equivalent clinical component, of unit members, **except by written agreement between the unit member and his/her Chair** or other authorized representative of the University [CP-3]. [emphasis added]

(7) annual reporting of performance information relating to individual faculty by department.

In addition to the above, the AAUP proposed two revisions to the parties' collective negotiations agreement involving reduction in force of tenured faculty and renewals for clinical faculty. The AAUP also proposed two new articles, including one entitled "Faculty Practice". It stated:

A. "Faculty Practice" means activities of unit members that generate income related to patient care. Faculty practice, for purposes of this Article, does not include activities under the auspices of University Physician Associates at the New Jersey Medical School.

B. Annually, the University shall provide each unit member who participates in Faculty Practice with a written contract ("Individual Contract") specifying the terms and conditions of the unit member's rights and responsibilities in connection with his/her Faculty Practice, including the compensation each unit member shall receive and any conditions connected with such compensation.

C. The University shall provide to each unit member who participates in Faculty Practice the budget for that unit member's department. Such information shall be provided after the budget is finalized in July.

D. A breach, misinterpretation or improper application of the provisions of this Article or the Individual contracts of unit members shall be grievable pursuant to Article V, Section B(1). However, unit members retain their right to pursue actions on their Individual contracts in any other for a [sic] I lieu of utilizing the grievance process. In instances in which a grievance is filed, the University shall produce documents which relate to the action complained of, including financial documents [CP-3].

32. As to the proposal for across-the-board increases, in the previous collective agreement (J-3), only the first year of the agreement required across-the-board increases. In the last three years of the agreement, increases were merit based (6T139-6T140). This was something that had been achieved by the University in the last negotiations for the 2000-2004 agreement (J-3), and it was something that they did not want to agree to give up (6T140). The University's position on this proposal, therefore, was that it was not going to agree to eliminate the

merit-based program in exchange for an across-the-board increase (6T140).

As to both proposals concerning patient services and faculty practice salary components, the University negotiations team felt that they represented a departure from the policies and practices that existed before (5T90, 6T141). No previous collective agreement required a written agreement between the faculty member and his/her Chair before a reduction in a clinical component of salary nor was a breach of an individual's employment contract grievable under the parties' grievance procedure. There had also never been a requirement for an annual written contract with RWJMS and SOM faculty who participate in faculty practice plans or that the departments provide each unit member in the plan with a departmental budget (5T90, 6T142).

33. After receiving CP-3, Kanan and Putterman met with then-University President John Petillo to discuss the proposals (CP-3; 6T143). Shortly after this meeting, Kanan met with Schorr and Boccabella. Kanan told them that this was his (Kanan's) first negotiation with the AAUP and explained his legacy was not going to be that he was the first one to put anything in the collective agreement about clinical components (6T147). Kanan recalls that Schorr put his hands on his chin and responded that he totally understood Kanan's position (6T147).

34. The next day, on May 13, 2004, the parties conducted the first negotiations session since receiving the AAUP's proposals (CP-3; R-21). The parties discussed four topics, including the AAUP demand for across-the-board versus merit-based increases, the more elaborate appeals process for unsatisfactory evaluations which the University was resisting, the University's position opposing any requirements about patient services components in the collective agreement, and Putterman's request for clarification regarding the faculty practice proposal (R-21).

As to this last topic (faculty practice), the AAUP explained that it wanted individual written contracts to memorialize what were previously oral agreements with faculty members concerning the amount of faculty practice income and any requirements for receiving the income, such as productivity (5T93). Boccabella also testified that the AAUP's proposals for a written agreement with faculty members before changes could be made was to prevent the University from continuing the practice on occasion, at least, of making changes in clinical salary components without the faculty member's approval (8T37-8T38).

Regarding clinical components, Schorr explained to the University's team the AAUP's understanding regarding past practice as it related to the setting and changing of clinical supplements. Namely, he explained that the clinical components of salary were offered at the time of hire to attract faculty to

the University and "that [clinical components] often . . . weren't dependent upon the extent or even the existence of clinical practice, and that [the AAUP] thought that it was important to have contractual recognition because of the threats by these chairpersons at [RWJMS]" (1T82).

Schorr's understanding of the past practice was that clinical salary components were reduced, for example, when a faculty member ". . . went from full-time to part-time or when a faculty member was being paid a patient services component or [faculty practice component] for a particular clinical activity and no longer did that activity or [the activity] was reduced" (8T72). Schorr felt, however, that the reduction or elimination was generally done through mutual agreement between the clinician and his/her Department Chair (1T42, 1T50-1T52, 1T76-1T77).

Schorr recognized that these were not the sole valid reasons for reducing or eliminating clinical salary components, but these are the only two examples he gave at the negotiations table. Neither he nor Putterman discussed other possible reasons for a change in a clinical salary component during negotiations (8T75). Nevertheless, Schorr felt that Putterman, as the University's spokesperson, agreed with his description of the past practice (CP-33; 1T83, 8T71, 8T75).

In any event, at this May 2004 meeting, the University objected to the AAUP's proposals on the subject of patient services and faculty practice salary components (6T92).

35. Beside the formal negotiation session with the AAUP, there were on-going discussions being conducted by University President Petillo, Kanan, Putterman, the Deans of the medical schools and other administrators concerning the AAUP negotiations demands (5T95, 6T143-6T145). On May 20, 2004, Putterman sent Petillo her analysis of the impact of the AAUP proposals as well as the positions of the Deans on the various proposals (CP-33; R-22). Putterman explained that the Deans felt strongly about three key issues in the AAUP proposals - across-the-board increases, patient services salary components and faculty practice salary components (R-22).

As to the proposal regarding patient services salary components, Putterman explained that a requirement, that the faculty member agree before a salary reduction was implemented, was untenable because the faculty member was unlikely to agree unless the reduction was based on a decrease in hours or the elimination of clinical activities. NJMS Dean Joffe, in particular, was adamantly opposed to this proposal because the patient services salary components represented millions of dollars coming from University Hospital to pay for the services of NJMS faculty in providing charity care. Joffe told Putterman

that the University Hospital's funding came from the State as charity care funds, and this revenue stream was not constant or reliable and, in any event, did not cover all expenses for the provision of such care (5T100). Therefore, locking him into specific amounts of payment to faculty from this uncertain source of income was extremely problematic to Joffe (5T100). The AAUP's proposal, Joffe felt, would severely impact NJMS and University Hospital operations (CP-33; R-22).

Putterman wrote, in pertinent part, to Petillo that:

In addition, the union's belief that patient services are arbitrarily reduced by Chairs for inappropriate reasons is not borne out by the data. In the past eleven months, only eleven faculty had decreases in patient services salary, in each case for bona fide reasons such as transfer of clinical activities to the VA, reduction of clinical activities or hours, moving patient services money into another salary component with no overall decrease in salary, or prior contractual agreement with the faculty member. On the other hand, there have been 29 increases in patient services component in this period of time.

* * * *

It is possible however, that, **outside of any union contract and following the conclusion of union negotiations**, Dean Joffe would be willing to give his faculty annual written statements about their patient services salary and written notification of any changes in this salary . . . [CP-33; R-22]

As to the AAUP proposal regarding faculty practice salary components, Putterman wrote to Petillo that the issue had never

appeared in any contract because the University had been successful in keeping it out. She explained that both RWJMS Dean Paz and SOM Dean Gallagher would be seriously impacted by the requirement of individual written contracts containing the terms and conditions of faculty practice income and felt that such a requirement would tie their hands in running their departments. Putterman wrote that "[t]here is also the fear of the camel's nose under the tent" by allowing anything regarding faculty practice to appear in the contract (CP-33; R-22). She explained to Petillo that, as with patient services, the Deans might be willing, outside of the contract and following conclusion of negotiations, to put into writing each faculty member's faculty practice income and notify them about changes (CP-33; R-22).

Finally, Putterman reiterated that the University and Deans felt strongly that merit-based salary increases as opposed to across-the-board increases should be preserved (having just been achieved in the prior collective agreement) and that the AAUP's proposal regarding merit bonuses was not acceptable. She also rejected the idea of changing the effective date of salary increases from September 1 to July 1 as an administrative headache, and described the union's proposal for appealing unsatisfactory performance evaluations as overly complicated and time-consuming (CP-33; R-22).

36. The University's response to the AAUP's proposals regarding clinical components of compensation came during a series of negotiations sessions in the spring and summer of 2004. Basically, the University through Kanan and Putterman rejected the AAUP's proposals and explained that they were unable to include any provision about patient services or faculty practice salary components in the successor agreement because the Chairs did not want to lose their flexibility in setting these amounts (6T107, 6T147). The AAUP understood from these discussions, that the University would not sign a collective agreement that contained a provision dealing with faculty practice/patient services salary components (1T155, 6T107). According to Schorr, although this was not the highest priority for the AAUP in terms of its proposals, he understood this was an important issue for the University (1T81-1T82, 1T153-1T154).

37. Nevertheless, Putterman theorized that there was a way to address everyone's concerns, in particular, the concern expressed by Boccabella that one of the reasons for the proposals regarding clinical components was that the faculty were not given the courtesy by their Chairs of being informed officially about changes and the reasons for the changes (5T101). Putterman concluded it was reasonable for the AAUP to request written notification of any proposed changes in clinical salary components and the reason for the changes, as long as it did not

prevent the Chairs from making the changes for valid reasons as they had done in the past (5T101-5T102).

Putterman also assured the AAUP negotiators that she personally approved all changes in compensation, meaning she reviewed the requested change and either approved it or requested additional information before approving (6T100). Putterman considered many reasons for change in compensation to be valid including, but not limited to, changes related to patient care activities or a faculty plan that did better or worse than anticipated (6T101). For instance, according to Putterman, the most typical reasons for a change in a clinical component of salary is that there was an increase or decrease in the amount of patient care activities by the faculty member or that the faculty practice plan did better or worse than expected and the payout to faculty has to be adjusted. But these are just a couple of many reasons she considered to be valid (6T101).

Executive Director of Faculty Affairs Sheila Eder, who works with Putterman and has been employed in her position since 1993, confirmed Putterman's testimony in this regard. Eder stated that clinical salary components in general are paid for clinical activities and can be increased or decreased if the level of that activity increases or decreases, revenues change or FTE (full-time equivalent) goes up or down (11T59). In any event, Putterman was never asked by the AAUP during these negotiations

to provide a list of valid reasons for such changes, so she did not do so, although she eventually prepared such a list as guidance to the Deans and Chairs as to valid reasons for changing clinical salary components as part of the new notification procedures that the parties agreed to during negotiations (R-29; 6T108-6T109).

38. In return for the AAUP taking the proposals regarding patient services and faculty practice salary components off the negotiations table, the University gave the AAUP new notification procedures regarding changes to faculty practice and patient services salary components as well as the assurance of Putterman that she would review all requests for changes in these salary components to confirm that the reason for the change was valid (1T156). This understanding was reached after a series of meetings in the spring and summer of 2004 as described below.

On June 17, 2004, at a negotiations session, Putterman and Kanan explained to the AAUP team that the Deans were absolutely opposed to having anything related to patient services components in the collective agreement but Putterman assured the AAUP negotiators that she would personally approve every alteration to patient services components (CP-25; 1T82, 1T84-1T85, 1T87, 6T100).

At the end of July or early August negotiations session, the parties again addressed the issues of faculty practice and

patient services salary components. According to Schorr's meeting notes, Putterman proposed to establish the operating procedures for these salary components outside the collective agreement (CP-4). As to faculty practice, she proposed that the initial terms and conditions of faculty practice be addressed in every appointment letter and, whenever there was a change in this component, another letter would be generated with an attached budget. As to patient services components, according to Schorr, Putterman suggested that "patient services components would only change if there were some accompanying alteration in a term of employment - for example, a reduction or increase in patient care activities or a corresponding decrease or increases in faculty practice income. As to modifications, the AAUP should be notified of the amount of the change and the reason for the change" (CP-4).

According to Putterman's notes of the meeting (R-23), the University made a counter-proposal to notify faculty members in writing of the reasons for a change to either patient services or faculty practice salary components. She described the AAUP negotiators as responding favorably to the proposal, but requesting something in writing to show to the members (5T107).

39. On August 5, 2004, the University submitted its financial proposal to the AAUP (R-11). It proposed, among other items, no across-the-board increases, only merit-based increases

in all years of the collective agreement. The AAUP was adamantly opposed to this proposal (5T111).

40. At off-the-record and official negotiations sessions in August 2004, the AAUP approved the University's proposal in regards to faculty practice and the issue of transparency, namely that financial statements be made available in the departments of each medical school (R-24, R-26; 5T113, 5T120-5T121, 6T148-6T149). The AAUP also accepted Putterman's proposal regarding a new notification procedure for changes to clinical components of salary (R-23, R-24, R-25). The new procedures were not to be included in the collective agreement, despite the AAUP's request to include them in the MOA, and would be distributed to the Deans and Department Chairs as soon as the new collective agreement was ratified (5T114, 6T151). It was agreed that Putterman would prepare draft memos to be sent to the Deans of the three medical schools for distribution to the Chairs with the new procedures, because the AAUP wanted proof it could show its membership to support that there was a new practice at the University in regard to changes to clinical salary components (5T114).

Eventually, at the end of August 2004, Putterman gave the AAUP CP-27, draft memos she prepared with notification to the Deans about the new procedures, for their review and in-put (R-25). In the memo to the Deans about the new procedures,

Putterman informed the Deans that as a result of the discussions with the AAUP, all changes to a faculty member's faculty practice or patient services salary components must be accompanied by a memo to the faculty member and attached to the faculty transaction form, with information regarding the amount of the change (either increase or decrease), the effective date and the reason for the change (CP-27). Putterman also got approval from the Deans at RWJMS and SOM to provide faculty with annual financial statements regarding departmental faculty practice income (R-26).

41. Putterman felt that these concessions made by the University - new written notification procedures regarding changes to clinical salary components and departmental financial statements about faculty practice income - were made in exchange for the AAUP withdrawing its proposals concerning faculty practice and patient services components (R-26; 5T120-5T122). Putterman believed that there would be no further negotiations on these issues in the context of the successor agreement (5T126-5T127).

Although Schorr felt that these procedures did not address the AAUP's concerns that clinical salary components could be arbitrarily reduced or eliminated, the AAUP ultimately accepted the notification procedures and withdrew its proposals regarding the clinical salary components (CP-3e and CP-3f) because "Karen

Putterman and Abdel Kanan had told us that politically they were unable to agree to anything in the contract about patient services components. And we took them at their word that we understood that that would be an impediment of entering into an agreement" (1T87-1T88, 6T148).

Putterman's representations and discussions at the negotiations table, Schorr felt, confirmed the AAUP's understanding of the past practice in regard to reducing or eliminating patient services/faculty practice salary components, namely, that changes to clinical salary components could only be made for valid reasons, such as a change in hours or clinical activities, although, Schorr concedes, that these were not the only valid reasons for modifying clinical salary components (8T61). In addition, Putterman had assured the AAUP negotiators, according to Schorr, that she would review every one of the proposed changes in clinical supplements to determine whether they were valid (8T61, 8T71).^{11/}

^{11/} Schorr also testified that Putterman confirmed his understanding of the parties' past practice that there were no changes in clinical salary components without negotiation or discussion with the faculty member - e.g. the change was the result of mutually agreement. For the reasons stated earlier in these facts, I do not credit that Putterman agreed that the past practice was that change was only by mutual agreement. Other witness testimony - Boccabella, Osofsky and Monteleone - does not support Schorr's description of the past practice and the AAUP's understanding of that practice.

42. Like Schorr, Osofsky understood that insisting on putting the new procedure into the collective agreement would be an impediment to getting the contract done (3T59-3T60). According to Osofsky, the AAUP, through Schorr, made clear to the University that by accepting the notification procedures, they were not waiving their right to enforce the past practice regarding changes to these components of salary - e.g. to enforce the status quo. Osofsky understood the past practice was that there had to be a valid reason for making the change tied to a change in circumstance and also accepted Putterman's assurances that all changes in clinical components would come across her desk so that she could make sure that the changes were not arbitrary but only changed in appropriate circumstances for a legitimate or valid reason (3T58-3T59, 3T121-3T122, 3T140-3T142, 3T144).

43. Finally, Boccabella also supported withdrawing the AAUP's proposals regarding clinical salary components based on Putterman's assurances that the past practice regarding changes to this salary component would be maintained. Boccabella understood the past practice was that there would be no change to clinical salary components unless the status of the faculty member changed or there was a change in their activities (8T22-8T23, 8T33).

44. By the end of August, the parties were still discussing their respective financial proposals. The AAUP rejected the concept of merit-based raises and insisted on across-the-board increases (R-25). Although there was some movement on the part of the University towards a hybrid of some across-the-board and some merit-based increases as well as merit bonuses, the AAUP rejected the University's alternative proposals (R-35; 6T153).

As to the appeals process for unsatisfactory evaluations, the AAUP broached some new ideas for the University to consider and discussed who would be the tie-breaker in the event the evaluation committee deadlocked (CP-26; R-25; 5T117, 6T151-6T152). No agreement was reached on this issue either (5T117, 6T153). The AAUP also proposed five float holidays, but the University communicated that this would be a major cost and it needed to prepare a financial cost-out to evaluate the impact of such a proposal (R-34; 6T152).

45. On September 14, 2004, Kanan confirmed by e-mail to Putterman that the parties had reached a tentative agreement and requested her to review it with her supervisor, Senior Vice-President of Academic Affairs Dr. Saporito (R-27; 6T160). As far as Putterman was concerned, the agreement represented several concessions on the part of the University, including 2 additional float holidays for all unit members, a new and more formalistic appeals process for unsatisfactory evaluations with a

neutral third-party tie-breaker and a salary package that included an across-the-board increase as well as a merit increase in each year of the agreement (R-27; 5T123, 5T125-5T126). The salary package, in her view, represented a real roll-back from gains in the previous collective agreement (5T123, 5T125-5T126).

46. Putterman disagreed, however, with Kanan's characterization of what the University got in return for these concessions. Kanan listed four items that he considered to be of benefit to the University - (1) reduction in the percentage of clinical faculty on multi-year contracts, (2) merit-bonus pool calculations based on total academic base payroll for unit members eligible for merit increases, (3) employees eligible for salary increases must be employed at time increases are distributed, and (4) notification procedures about changes to clinical components of salary (R-27).

The only real benefit Putterman recognized in the tentative agreement was the reduction in the percentage of clinical faculty on multi-year contracts. She did not view the new notification procedures as a benefit except to the extent that there would no longer be negotiations about faculty practice and patient services salary components in the current collective agreement. These were the two most important issues to the Deans in the negotiations (5T126-5T127). Indeed, when Putterman recommended the tentative agreement to her boss, Saporito, she explained to

him that it was worthwhile for the University to institute the new practice in order to keep the issue of clinical salary components out of the successor agreement. Saporito agreed and approved the tentative agreement (5T128).

47. On September 15, 2004, the AAUP and University executed a Memorandum of Agreement (MOA) (J-2). At the meeting before the execution of the MOA, Kanan brought a draft which was revised at the meeting after discussions with the AAUP (R-12; 6T164, 7T27). Specifically, there was a change in the ranges for the merit salary increases (R-12; J-2; 6T161-6T162). Also, language was added to the final paragraph and the words "unless mutually agreed upon were added, to address that the parties understood the there was an agreement on new notification procedures that were not included in the MOA (4T9-4T10, 7T28).

48. The final MOA (J-2) executed by the parties renewed the terms of the 2000-2004 collective agreement for a five-year term (2004-2009) except as modified by the MOA and was subject to ratification. To summarize, the MOA provided:

In each year of the successor agreement, salaries were subject to both across-the-board and merit increases. The minimum and maximum salary ranges for unit titles were increased.

An appeals process structured with an agreed upon neutral third party for less than satisfactory performance evaluations was added.

Unit members were given two additional float holidays.

Article XXVI, entitled "Multi-year Contracts for Clinical Educators", was amended to provide that the University could employ up to seventy-five percent of such educators on one-year contracts.

The parties amended Appendix A and C-1 to reflect changes to various salary ranges.

The parties agreed to reimburse travel expenses as per a particular University Policy.

The parties agreed to include notices of non-renewal consistent with University by-laws in the contract.

The parties agreed to continue to meet and discuss issues related to the School of Nursing, the Librarians, Extra-Mural Support Incentive Awards, Reports to the Union and timely payment of increases.

The MOA then states:

This Memorandum of Agreement represents the entire agreement of the parties in connection with their negotiations under the Provisions of Article XIX ["The Negotiation Procedure for Future Agreements"]. Any and all proposals and counter-proposals not contained herein are deemed withdrawn, void and without further effect. No other agreement, whether written or oral, between the parties shall be enforceable unless mutually agreed upon (J-2).

49. The following colloquy represents Schorr's understanding as to the execution of the MOA and any further negotiations on the AAUP's proposals regarding faculty practice and patient services components of salary:

Q. On September 15th, when the parties executed the memorandum of agreement, did you consider that to be the conclusion of negotiations on the subject of demands that had been made by the union with regard to faculty practice and patient services components?

A. The conclusion of negotiations? There were no further negotiations on the issue, no.

Q. Did you feel at that point that the issue had been resolved as a matter of this contract, the current contract?

A. Yes.

Q. And there were no outstanding demands by the union at that point on those two topics?

A. No. (8T72-8T73)

When signing off on the MOA, the AAUP did not reserve for future discussion anything having to do with patient services or faculty practice components, but Schorr advised that signing the MOA did not constitute a modification of past practice (1T129, 1T148, 8T61). Schorr was comfortable that the past practice the parties had discussed at the negotiations table would continue and that “. . . Putterman had assured us that she would review every one of the proposed changes in clinical supplements to determine whether they were valid” (8T61).

50. Putterman signed the MOA based on her understanding that there would be no additional negotiations regarding clinical salary components for the term of the successor agreement -

2004-2009 (J-1). If the AAUP had either verbally or in writing indicated to her that they were reserving the right to continue to negotiate these topics, she would not have signed it (5T131-5T132).

51. After the MOA was signed, Osofsky and Boccabella prepared a preliminary report to the members of the Council, Negotiating Committee, Board of Governors and Executive Committee about the parties' negotiations and tentative agreement (R-13). The report noted significant progress in contract negotiations including a tentative agreement on the "items of greatest interest to our membership" (R-13). These items of "greatest interests" were the salary adjustment comprised of both across-the-board and merit increases totaling a 24% increase over five years; a new appeals procedures for unsatisfactory evaluations including a neutral third party as a member of the appeals panel; and two additional float holidays (R-13). Boccabella and Osofsky conceded that as a concession to the University, the AAUP had to reduce the percentage of multi-year contracts for clinical educators. The report generally noted that there were other areas in which small improvements were achieved and concluded their preliminary report with the opinion that the AAUP had achieved substantial success (R-13).

52. After the execution of the MOA, the parties continued discussions on the topics listed in the MOA, namely, issues related to the School of Nursing, the Librarians, Extra-Mural

Support Incentive Awards, Reports to the Union and timely payment of increases (1T180, 3T72). Kanan concluded further negotiations as the University's point person. Putterman stopped going to the subsequent negotiations sessions, but learned from Kanan that President Petillo was pressuring him to conclude the negotiations so that he (Petillo) could announce that the University had a new collective agreement with the AAUP, who he considered to be the most important union (6T116, 6T118, 14T58).

53. On September 21, 2004, Schorr wrote to Kanan about the understanding reached between the parties concerning the faculty practice and patient services component procedures. He stated in pertinent part:

On behalf of the AAUP, I stated, and you agreed on behalf of the University, that our discussions about the foregoing [new University notification procedures] and the University's adopting the procedures did not constitute a waiver by the AAUP of its right to negotiate these topics (CP-5).

According to Schorr, the AAUP was not reserving its right to continue to negotiate the issue of clinical salary components in the 2004-2009 agreement or to reopen negotiations these issues unless the University changed the status quo as represented by the parties' past practice. The AAUP would seek to enforce any unilateral change in the status quo represented by the past practice (1T92-1T93, 1T120, 1T146-1T147, 1T179, 8T61-8T62).

In addition to the September 21 letter (CP-5) to Kanan, Schorr recalled having at least one discussion with Kanan about

the waiver/non-waiver issue sometime before signing the MOA on September 15 (1T202, 8T61). Kanan confirmed at least one discussion. Namely, before executing the MOA, Kanan spoke to Schorr about and rejected his (Schorr's) request to include the notification procedures in the MOA. According to Kanan, at that time, Schorr mentioned something to Kanan about not waiving the AAUP's rights to negotiate the issue of clinical salary components in the future (8T61). Kanan recalled that he told Schorr that was fine for future collective negotiations; the AAUP could bring up whatever it wanted to then (6T166-6T167).

Kanan testified that he would not have signed the MOA if Schorr told him that the AAUP intended to continue negotiations on the subject of patient services/faculty practice salary components in the successor agreement because he felt that the University had made concessions in order to keep what was most important to the University out of the collective agreement, namely proposals concerning clinical components of salary (6T166-6T167).

54. When Kanan received CP-5 from Schorr, based on his prior discussions with Schorr, he interpreted Schorr's statement on waiver to mean that the AAUP was not waiving its right to negotiate on the subject of the clinical components of salary in future contracts and, therefore, did not respond when he received Schorr's letter (6T166-6T167). Putterman, however, contacted Kanan when she received CP-5, because Schorr had not previously

raised the waiver issue to Putterman. Kanan explained to her that he believed the waiver referred to future contract negotiations (5T133). Putterman had no problems with that explanation (5T133).

Schorr admits he had not previously raised the issue with Kanan or Putterman in writing before sending CP-5, even though on September 2 (13 days before the MOA was signed), he sent Osofsky an e-mail recommending that he send Putterman a letter raising the waiver issue (CP-15; 1T201, 2T9, 2T11-2T12, 5T133).

Based on the foregoing, I cannot find that Schorr told Kanan or Putterman that he was reserving the AAUP's right to continue to negotiate the issues of faculty practice or patient services salary components before the execution of the MOA.

55. Subsequently, by letter dated November 2, 2004 (R-37), Schorr wrote to Kanan confirming the parties agreement on the new notification procedures regarding patient services and faculty practice salary components "subject to the reservation of rights in my letter to you of September 16, 2004." Kanan had not received a letter dated September 16, 2004 from Kanan (6T168-6T169). I infer that Schorr's letter (R-37) mistakenly referenced September 16 and that the letter Schorr was referring to was the September 21 letter (CP-5).

56. It was during this period of time, after the signing of the MOA on September 15, 2004 and before the execution of the collective agreement in February 2005, that an issue regarding

the elimination of the faculty practice clinical salary component of Dr. Sanford Klein, an anesthesiologist at RWJMS, arose.

Dr. Sanford Klein

57. Dr. Sanford Klein is currently employed by UMDNJ as a professor of anesthesiology at RWJMS (2T37). He holds dual degrees in dentistry and medicine with a sub-specialty in surgical anesthesiology (2T38).

58. In 1983, Klein was recruited and hired by Dean Richard Reynolds to be the first chairman of the department of anesthesiology at what was then Rutgers Medical School and later became RWJMS. He also held the titles of full professor with tenure and clinical chief at what was then Middlesex General Hospital which subsequently became Robert Wood Johnson University Hospital (2T39-2T40, 2T46, 2T100-2T101). As a Department Chair, Klein's title was not represented by the AAUP, but he paid dues to be a member (2T43, 2T73). The AAUP, however, did not assist him in negotiating his letter of appointment (2T110).

59. During his initial hiring discussions with Reynolds, Klein requested a salary of \$150,000, but agreed to accept a lower salary of \$110,000 (2T42, 2T103-2T104). His salary at the time of hire was composed of a base salary which represented approximately fifty percent of the salary received by academic anesthesiology Department Chairs in the northeast. Klein also received a faculty practice service component to bring him up to his negotiated salary of \$110,000 (CP-16; 2T40, 2T42-2T43). At

the time Klein was hired, the University could not find and/or hire a Chair of the Department of Anesthesiology for the base salary alone (2T44). Klein's understanding, therefore, was that the faculty practice component was a fixed amount to bring his salary to an acceptable level (2T44).

Specifically, Klein's base salary was \$77,952 and a faculty practice component of \$32,048 (CP-16). Klein's appointment letter also required that he get a N.J. Medical License before he could receive his salary. Klein understood that in order to do the job of Chief of Service he would need medical privileges at the hospital, and he had those privileges when was hired (CP-16; 2T106-2T107).

60. On July 29, 1983, Klein received notification from Dean Reynolds that the University's Board of Trustees approved his appointment as tenured Professor and Chair of the Department of Anesthesiology effective August 15, 1983. The letter set forth the terms of Klein's employment as follows:

Your salary rate for the 1983-1984 fiscal year will be \$110,000. This will be composed of \$77,952 in base salary and \$32,048 in professional service income. This professional service income will be guaranteed by the Department of Anesthesiology for a one year period (R-2).

Klein and Reynolds signed the letter to verify their agreement on the terms set forth (R-2). Subsequently, when Klein's salary was set annually, he received a professional service income as part of that salary but the word "guarantee"

was not used (2T102). Over the years, while Klein was Chair, the University made unilateral changes to the professional income by increasing it, but the AAUP was not involved because, as Chair, Klein was not in the bargaining unit (1T169-1T170). Once Klein was no longer Chair in 1999, this component of salary remained constant (1T190).

61. When he was hired, Klein was instructed to limit his time in the operating room, because Dean Reynolds insisted that he spend as much time as necessary performing administrative duties in order to create the department of anesthesiology (2T44-2T45). According to Klein, his salary was thereby divorced from his clinical output (2T45).

62. In the next sixteen years as Chair, Klein negotiated an annual compensation with his Dean and received a faculty transaction form with a breakdown of the salary components and the funding source for each component (R-5; 2T112). His base salary never exceeded the 64% of the salaries of the 33 Academic Anesthesiology Chairs in the northeast (2T46). The rest of his salary was made up by the clinical component of the total negotiated salary (2T45-2T47). He received this clinical salary component as part of his salary continuously until it was eliminated effective December 1, 2004 (CP-23; 2T47).

In addition to base salary and clinical component, as Department Chair, for seven or eight years he received an executive bonus which was generated out of the Dean's fund, not

departmental monies (2T122-2T124). In his last year as Chair, the bonus was \$96,000. The bonus was terminated in 1999 when he stepped down as Chair (CP-21; 2T47, 2T122).

63. As Department Chair, Klein was responsible for hiring all members of the department, including clinicians (2T47-2T48). In the case of the clinicians, Klein negotiated a total annual salary which did not breakdown into separate base and clinical components (2T48, 2T67). After negotiating the salary, Klein instructed the department business manager to allocate the maximum base salary allowed under the AAUP collective agreement and to allocate the remainder to clinical dollars in order to reach the total negotiated salary (CP-17; 2T49, 2T68). The amount allocated to clinical service did not necessarily represent the percentage of clinical work performed because each clinician was a medical educator as well as a provider of clinical service (2T51).

64. Also, as Chair, Klein evaluated the physicians in the department annually (2T116). The physicians were responsible for teaching, research and clinical activities (2T116). The teaching responsibilities consisted of lecturing, course presentation and supervision of residents in the operating room (2T116). Of the three categories of responsibility, Klein required that the physicians he supervised perform at least two out of the three activities (2T116).

In the beginning, Klein did not factor in the amount of clinical activity when evaluating individual physicians. But in the late 1990's, he set up a bonus system based on clinical output (2T116-2T117). He also set up a system called "Chairman's Choice" to award a one-time cash bonus to the individual who made the biggest contribution to the department in a particular year, including individuals who generated a significant amount of faculty practice income (2T117).

65. Every 2 years Klein evaluated his faculty to determine what staff privileges were being renewed, added or reduced based on their activities (2T18). The evaluations were sent to the Credentials Committee for action on credentials (2T118). Klein never recommended against credentialing of his faculty, because anyone he did not want in his department he fired (2T118-2T119). For instance, he fired physicians for abusing the on-call system, fraudulent billing practices, clinical errors and substance abuse (2T120).

66. During his tenure as Chair from 1983 to 1999, Klein reduced or eliminated the clinical salary component only a handful of times and, then, only where there was a drastic change in the individual's circumstances either due to change in research activities or due to personal health (2T52). Also, in these circumstances, Klein would first speak to the clinician about the cut in their clinical salary component and negotiate

the change with them (2T52, 2T125). The AAUP was never involved in these discussions/negotiations (2T58).

Klein was always successful in the negotiations, because he felt that if he wanted the faculty member to stay in the department, something could be worked out (2T125-2T126). Klein, however, never had occasion to reduce a clinical supplement over the objection of the faculty member (2T126).

For instance, in 1995 Klein reduced the base salary and eliminated the clinical salary component of Dr. David Amory, because Amory was no longer doing clinical work. He was doing more research (CP-18; 2T124-2T125). Amory requested the change in his work load. Klein wanted to keep Amory on despite the reduction in his clinical activities, because he was one of the senior cardiac anesthesiologists in the United States (2T53). Klein discussed the change in salary with him, and Amory agreed to it (2T54).

67. Other examples of Klein's reducing the clinical salary component of faculty in his department are as follows:

a. In 1996, Klein reduced the clinical supplement of Dr. Raymond Roginski from \$162,200 to \$120,000 (CP-19). Roginski wanted to lighten his clinical load so that he could do more research (2T55). Klein and Roginski reached an understanding which allowed Roginski to do what he wanted - more research, while also accommodating the concerns raised by the rest of the

department concerning the amount of Roginski's clinical activity (2T55).

b. In 1998, Klein decreased the clinical salary component of Dr. Niashat Zedie by \$5,000 (CP-20). Zedie was head of the pediatric anesthesiology unit but no longer wanted to take night calls. Klein and Zedie agreed to the reduction in her clinical salary component (2T57).

68. In 1999 Klein lost his position as Department Chair, and as a faculty member in the department was represented by the AAUP and covered by the terms and conditions of the parties' collective agreement (CP-21; 1T137, 2T64, 2T73).

Before he lost his chairmanship, Klein's annual salary was \$394,000 composed of a base salary of \$179,843, a faculty practice income of \$117,412 and an executive bonus of \$96,000 (2T64-2T65, 2T71). Klein's executive bonus was eliminated by the action removing him as Chair (CP-21; 2T65). His base salary was also reduced by five percent (R-5). Thereafter, as a full professor, he received \$277,255 (CP-21; 2T127).

69. Dr. Lawrence Kushins succeeded Klein as Chair (2T65-2T66). Kushins was Chair for approximately three years and was then succeeded by Dr. Christine Hunter, the current Chair (2T68-2T69). Shortly after Klein lost his chairmanship he took a medical leave for eighteen (18) months and, thereafter, was immediately granted a sabbatical for one year (1T138, 2T73-2T74; 2T129). The sabbatical was approved by Kushins and Academic Dean

Dr. Saporito (2T130). During the time that he was on medical leave and sabbatical, as was the custom, Klein received his annual salary, consisting of the base and clinical salary component (1T138, 2T131).

70. Klein returned from sabbatical in March 2001 (2T132). For the next seven months, he resumed his full clinical activities, working 5 days a week in the general day rotation as an anesthesiologist in the operating room (1T139-1T140, 2T74-2T75, 2T132, 2T135-2T136). Klein worked from 7:00 a.m. until all elective procedures were completed around 2:00 or 3:00 p.m. Sometimes, on a busy day, he worked until 9:00 p.m. (2T135). During this time period, he billed over \$700,000 for his services (1T140, 2T215). The money that was collected was paid, presumably through the faculty practice plan, and eventually to the department of anesthesiology (2T216).

71. At this time, Klein was not taking on-call night duty because he was not yet comfortable working alone. Taking rotation in the operating room means that the on-call anesthesiologist performs emergency procedures. The first-call schedule covers from noon to 8:00 a.m. the next morning and that person carries a beeper because they are the first responder in emergencies. There is also a second-call and third-call schedule. All anesthesiologists do two or three on-calls per month (2T133-2T135).

Dr. Kushins, however, was pushing Klein to take night-call assignments. He wanted Klein to work five days a week and take a full on-call schedule (2T136-2T137). Klein resisted, because he was not comfortable taking that assignment (2T136). Also, Klein had set up a rule when he was Chair that on-call schedule changed when a physician reached 55 years old (2T137).

In response to Klein's position, Kushins threatened to take away Klein's clinical salary component, if he refused to take a full clinical assignment (2T137). On May 3, 2001, Kushins sent Klein a letter to clarify issues raised by Klein (R-6). He wrote in pertinent part:

Finally, I must reiterate the only two options that I can responsibly offer you. Should you accept full clinical assignment (five days per week) with second and third calls and nonclinical [sic] time for teaching and administrative activities upon which we mutually agree you will receive base and full supplement. Should you not accept full clinical assignment (i.e. five days a week) then you will have no clinical assignment and receive only base pay (R-6).

Klein viewed Kushins' letter as a negotiations ploy. Klein could see nothing wrong with working a full-time or part-time on-call schedule and thought Kushins position was "stupid". Nevertheless, he returned to a full clinical assignment, but did still not take on-call duty (2T139-2T141).

72. In June 2002, Klein's medical privileges at RWJUH were up for renewal, but Dr. Kushins refused to renew them because of a dispute with Klein over his refusal to take a particular

radiology assignment (2T74-2T75, 2T132, 2T142-2T146). There was a hearing before the Fair Hearing Committee which recommended non-renewal of Klein's privileges (2T77, 2T146). The recommendations of the Fair Hearing Committee were reviewed by the Credentials Committee which issued its findings on October 8, 2004 (R-3, 2T79-2T80).

The Credentials Committee conditioned Klein's retention of medical staff membership and clinical privileges on his undergoing "an acceptable retraining program, satisfactory to the Anesthesiology Service" (R-3). The Committee also required Klein's physical, mental and emotional condition to be evaluated and that his clinical activities remain under supervision (R-3).

The Committee then explained:

The requirement for retraining is a reduction of your right to exercise clinical privileges at the Hospital, as is the requirement for supervision. Both are considered to be adverse professional review recommendations under Section 1.2 of the Fair Hearing Plan. Therefore you have the right to an appellate review by the Hospital's Board of Directors. . .

* * *

As long as you continue to voluntarily refrain from performing any clinical activities at the Hospital, no further action will be taken to suspend your privileges or to place you under observation while the appellate review process is in progress (R-3).

73. After issuance of the Credential Committee report, Klein filed for appellate review by the Hospital's Board of Directors. He also filed for a review by the Board of Medical Examiners and instituted several, eventually, unsuccessful lawsuits against the University and Dr. Kushins (2T152, 2T219). During this appeal process from June 2002 until October 2004, Klein continued to receive his annual salary, including base and clinical supplement (2T77).

74. On October 15, 2004, he met with Dr. Christine Hunter, Chair of his department and Dr. Alann Solina, Vice-Chairman of the Department (CP-22; R-4; 2T80, 2T152, 2T192). The meeting was part of an annual review that all faculty members undergo with their supervisor to discuss their performance and what the Chair expects from them for the up-coming year (2T81-2T82).

Several topics were discussed at the meeting, including Klein's recent contributions to the department. Klein explained to Hunter that he gave lectures to residents and second year pharmacology seminars, and that he did work for the State that earned an annual \$1,000 fee (CP-22; 2T194-2T195). As part of the evaluation process, Klein had submitted to Hunter his faculty data form, a self-evaluation form sent by the University to all faculty members (2T170-2T171).

Klein's form, covering the evaluation period from July 1, 2003 to June 30, 2004, reflected Klein's accomplishments and activities for the year as 10 hours of teaching anesthesiology

residents and 16 hours teaching second year pharmacology students. The amount of time reflected in R-7 spent on these non-clinical activities is less than the average faculty member spends on similar activities who is also carrying a full clinical case load (6T33-6T34). Under the heading of University committees, Klein listed his participation on the AAUP negotiations committee (R-7; 2T172-2T173, 2T178). During the 2003/2004 period covered by the form, Klein performed no supervision of residents in clinical rotations nor did he direct students, residents or laboratory personnel in research projects or participate in curriculum development all of which are activities performed by other clinicians in the department of anesthesiology (2T176-2T177, 2T179, 2T181).

75. Minutes of notes taken at the October 15, 2004 meeting reveal the following dialog between Solina and Klein regarding Klein's activities for that year on behalf of the department:

Dr. Solina: What role in the department do you see yourself doing? What would you like to do to make a meaningful contribution? What hopes do [you] have clinically?

Dr. Klein: I can only make limited responses due to circumstances and you are aware of absurd charges.

Dr. Solina: What would you like to do?

Dr. Klein: I would like to retire, "If cleared, I will retire."

Dr. Solina: What plans do you have? We have manpower needs and we would like to prepare for your return to clinical work if

that is what you plan to do. I know that everything is litigious; but we need to make plans and determine what you can do that will be beneficial to the department and yourself. We could use your expertise and you would get job satisfaction. What are your expectations and goals? For the next 1-5 years?

Dr. Solina: Do you think you will return clinically?

Dr. Klein: I have no objections; but will wait until the final settlement. That is not expected to happen soon.

Dr. Solina: What meaningful way can you contribute now?

Dr. Klein: I will pace work output based on the non-clinical output of the rest of the department.

Dr. Solina: Non-clinical times are based on the clinical load. Are there things you want to do to make a meaningful contribution to the department?

Dr. Klein: If you want me to do something, write it down and I will consider it.

Dr. Solina: Would you want to update the sections report; is this what you want to do?

Dr. Klein: To the extent that anyone else works non-clinical.

Dr. Hunter: We have discussed this information regarding the review.

Dr. Klein: I want the minutes typed and signed by all of us.

All parties present at the meeting signed the minutes (CP-22). At no time during the meeting did the participants discuss the possibility that Klein's clinical salary component would be

eliminated, if Klein did not resume his clinical activities (2T83).

76. Klein decided that he was not going to fulfill any of the conditions necessary to regain his medical privileges at RWJUH pending his appeals (2T156, 2T168). Since the meeting, Klein has also not indicated to Dr. Hunter or anyone else at the University that he was willing to resume his clinical practice at other locations for which he had medical privileges (2T155).

77. Based on Klein's responses at the meeting and his apparent unwillingness to contribute to the department by increasing his activities in non-clinical areas, Dr. Hunter determined to eliminate Klein's clinical salary component. In evaluating faculty and setting compensation, Hunter has always considered the relationship between the amount of the clinical component paid and the amount of time spent by faculty in clinical activities, namely for faculty who reduce their clinical time, their clinical salary components are reduced (6T20, 6T22). In Hunter's department, the faculty spend 75 to 100% of their time engaged in clinical activities; teaching and supervision of residents is part of the clinical activities. Those who spend less than 100% of their time in clinical activities are engaged in administrative duties or research (6T16).

Klein's inability to participate in clinical activities at RWJUH represented a loss of faculty practice revenue to Hunter's department, revenue needed to hire and retain clinical faculty at

RWJUH who in turn provided services to all 28 clinical sites within the hospital that the anesthesiology department is required to staff (6T12-6T15, 6T23, 6T37, 6T41). In October 2004, the anesthesiology department was not providing clinical services at any location other than at RWJUH (6T30).

On October 19, 2004 she wrote to Klein:

I am writing to inform you that your current clinical supplement of \$117,412.00 shall be eliminated effective December 1, 2004. Receipt of the clinical supplement is based upon providing clinical services. Based upon the actions taken by the Robert Wood Johnson University Hospital Credentials Committee and Fair Hearing Committee requiring you to undergo retraining, supervision and be evaluated by the Physician Health Program and to refrain from performing any clinical activities, you are unable to perform any clinical activities. Robert Wood Johnson Medical School cannot continue to pay the clinical supplement when you are not performing any clinical services or generating any clinical income for the faculty practice (CP-23).

Although Hunter refers to Klein's receiving a clinical supplement, Klein's Faculty Transaction Form dated October 25, 2004 reflects the \$117,412 as faculty practice salary component (R-1).

78. When Klein received CP-23, he called Osofsky to protest the elimination of his faculty practice salary component. He felt that this component of his salary was unrelated to his clinical activities and, therefore, whether or not he was participating in clinical activities should not form a basis for

the elimination (3T74). Accepting Klein's reasoning, Osofsky concluded that the elimination violated the parties' past practice, because it was not done for a valid reason. On October 21, 2004, Osofsky faxed Putterman with her concerns (CP-30).^{12/} Putterman responded by e-mail (CP-31) on October 25, 2004 that she (Putterman) did not understand the AAUP's concern since Hunter's letter to Klein was self-explanatory. I infer that Putterman concluded, after reviewing Hunter's explanation to Klein, that the reason for the elimination was valid.

79. After receiving Putterman's response, Osofsky contacted Schorr who reached the same conclusion that Osofsky had, namely that Hunter's reason for the elimination - the loss of medical privileges at RWJUH and ability to provide patient care - was not a valid reason and, therefore, violated the parties' past practice in regard to changes in clinical components of salary (3T78, 3T128). Schorr claimed that it was the University's past practice to continue to pay Klein's clinical salary component,

^{12/} Boccabella reasoned that Klein had been receiving a patient services salary component for years without seeing patients so Putterman's approval of Klein's elimination was not for a valid reason. Boccabella testified generally that he knew of at least one faculty member who had not seen patients for a long time, was not permitted to practice and to this day is receiving a patient services salary component (8T44, 8T46-8T47). I do not credit this anecdotal account as evidence that faculty received patient services salary component without performing any clinical activity. Several witnesses, including Hunter, testified that receipt of a clinical salary component implied that some level of clinical activity was required.

even though he could provide no clinical patient care. Schorr drew this conclusion even though he was not aware of any other instance where a faculty member lost medical privileges and could not presumably participate in clinical activities at a hospital (1T145-1T146, 8T63-8T64, 8T75).

80. On November 2, 2004, Klein responded in writing to Hunter's letter (CP-23; 2T85, 2T209). He contended that his clinical salary component had never been based on clinical services or clinical output. He felt he was being paid as a clinical educator not as a clinician. As Chair of the department of anesthesiology, his salary, Klein asserted, was deliberately not based on providing patient services so that there would never be an incentive to skim the lucrative cases for himself. Also, Klein contended that when he was Chair total annual compensation was negotiated, and only divided into base and clinical supplement for bookkeeping purposes (CP-23).

As to the actions of the Credentials Committee, Klein explained that he had a full and unrestricted license to practice medicine in New Jersey despite the Committee's findings. Klein also argued that he had full privileges at RWJUH that he voluntarily chose not to exercise pending completion of the hearing process - e.g. Klein chose not to go through retraining or take physical/psychological exams which were prerequisites to resuming his clinical activities at the hospital (CP-23).

Finally, Klein questioned the precipitous actions of Hunter when, he understood, that the parties had agreed to maintain the status quo pending "final results" of the appeals process. He particularly questioned the timing in light of his appearance four days earlier at a forum conducted by Dr. Petillo, then President of UMDNJ, at which Klein criticized Petillo and the current Hospital Administration, and in light of his filing various retaliation and harassment charges against Dr. Hunter and Dr. Kushins (CP-23; 2T83-2T84, 3T72-3T73).

81. A series of letters were then exchanged between Schorr and the administration about the AAUP's position regarding Klein, while the AAUP continued to meet with Kanan to finalize the 2004-2009 collective agreement (CP-7 through CP-15, CP-32; R-14; 3T78-3T79, 4T12, 7T37, 8T64). Specifically, in November and December 2004, the AAUP and Schorr discussed the Klein issue with Kanan and Putterman. Schorr and the AAUP did not consider these discussions to be part of the negotiations for the 2004-2009 agreement (8T64).

For instance, on November 5, 2004, Schorr wrote Putterman concerning the AAUP's position on the Klein matter (CP-7). He reiterated that the parties negotiated over clinical salary components during negotiations for the 2004-2009 collective agreement. Schorr reminded Putterman that in exchange for a modification of University notification procedures and Putterman's assurance that the University would follow the

parties' past practice - not modify clinical salary components unless there was a valid basis to do so - the AAUP withdrew its proposals and agreed that no provision regarding either patient services or faculty practice components would be included in the successor collective agreement (CP-7).

Schorr reiterated that, in his opinion, Klein's clinical salary component was never conditioned on his clinical activities and, therefore, the elimination of that component of Klein's salary based on his loss of medical privileges and inability to provide clinical services was not a "valid basis" for the action taken. Schorr distinguished Hunter's reason from a reduction based on a diminution of a clinical commitment or a change from part-time to full-time status (CP-7). Schorr characterized the University's actions in regard to Klein as being inconsistent with past practice (1T97-1T98). Finally, Schorr reminded Putterman that in a September 1, 2004 letter to Kanan (CP-5), the AAUP approved the new notification procedures and stressed that this approval did not constitute a waiver of the AAUP's right to negotiate the subject (CP-7).

82. In a November 12, 2004 letter (CP-8), Putterman responded to Schorr. She defended Dr. Hunter's decision to eliminate Klein's clinical salary component. It was clear, she felt, that due to Dr. Klein's intent to appeal the outcome of the Credentials Committee and due to the recommendation that he undergo retraining before resuming clinical practice, Klein would

not be able to resume clinical activities for an extended period of time, if ever.

Additionally, Putterman clarified statements she made during recent collective negotiations regarding clinical salary components of AAUP bargaining-unit members. She explained that she "stated that all bargaining-unit members who receive clinical salary components perform clinical activities with the exception of some New Jersey Dental School faculty" (CP-8). Finally, Putterman added that Hunter's letter to Dr. Klein (CP-6), explaining the basis for her decision to eliminate Klein's clinical supplement, conformed to the new notification procedures agreed upon in negotiations, even though those procedures would not be in effect until after contract ratification (CP-8).

83. On November 22, 2004, Schorr responded to Hunter's letter (CP-8, CP-9). He disagreed with her that Hunter's actions in eliminating Klein's supplement and felt that Hunter's actions did not conform to assurances Putterman made at the negotiations table, particularly regarding the reduction or elimination of a clinical salary component without a change in clinical responsibility or a change from full-time to part-time work. He repeated that for twenty years, Klein's clinical salary component had no relation to his clinical activities (CP-9). In other words, the AAUP concluded that there was no change in Klein's circumstances to justify the elimination of this salary component and, thus, the University's actions were inconsistent with past

practice and, in its view, constituted an unfair labor practice (1T105-1T106, 1T111, 1T162-1T64).

84. At the time of these written exchanges concerning Klein, the parties were finalizing contract language (1T107). On November 22, 2004, Schorr wrote Kanan about various issues which arose from the AAUP's review of the draft Agreement (CP-10). In conclusion, Schorr wrote about a new issue of concern:

The new matter involves the question of clinical supplements. You have received copies of the recent correspondence on this issue, and I will shortly be responding to Karen's [Putterman's] most recent letter. As you will recall, we specifically advised you that we were not waiving the right to negotiate on the issue. We are deeply concerned now because, in our view, recent actions by the University are a departure from its representations at the table. (CP-10).

The recent actions referred to were the elimination of Klein's clinical supplement (1T109). According to Schorr, the AAUP was not seeking to reopen negotiations; negotiations on the issue of clinical salary components had been concluded as far as the AAUP was concerned (8T61-8T62). Schorr was reminding Kanan of the AAUP's right to negotiate if there was a unilateral change in the parties' past practice regarding these components of salary (8T62).

85. In a December 9, 2004 letter, which Schorr later revised, Schorr proposed that the University agree to proceed with ratification and execution of the 2004-2009 agreement, and

suggested that if litigation arose from the Klein issue, the University would not raise waiver as a defense (CP-34; 8T66-8T67).

Kanan did not agree to the suggestion in the original letter or revised letter that the University agree not to raise waiver as a defense (7T40, 7T44). He discussed it with Putterman and Deputy Attorney General Michael Gonnella who told him that he (Gonnella) was "vehemently" opposed to the University agreeing to waive the defense (CP-35; 7T46, 7T49, 8T67).

86. The University, through Kanan, rejected all other AAUP attempts to resolve the Klein matter. It did not want to reopen negotiations on clinical salary components (8T65). Kanan told Schorr that Klein should be handling the matter through his private attorney, and the AAUP should not be involved (1T111-1T112, 8T65). In a December 15, 2004 correspondence responding to Schorr's November 22 letter (CP-10), Kanan first addressed specific changes to contract language proposed by the AAUP and then wrote, in pertinent part:

Finally, with regard to the item of clinical supplements and Dr. Sanford Klein, you are aware that an understanding on the issue of faculty practice and patient services components was reached back in September 2004. As a result, the major items agreed too [sic] in the MOAs [sic] were based on that understanding, and it is inappropriate for the AAUP to now hold up ratification or the signing of this contract because of Dr. Klein's situation. In addition, it is my understanding that Dr. Klein has several lawsuits pending against

the University. Therefore, the issues you raise on behalf of Dr. Klein should be handled by his private counsel and our Office of Legal Management (CP-11).

In Kanan's opinion, with the contract-language changes agreed upon, the negotiations were concluded (CP-11).

87. On December 21, 2004, Schorr wrote Kanan concerning the 2005[sic]-2009 contract negotiations and clinical salary components. The AAUP approved the various revisions to the collective agreement. As to Klein, Schorr wrote:

We take exception to your assertions about what you characterize as "Dr. Klein's situation." Our concern has been the issue of clinical supplements in general and the University's unilateral alteration of this condition of employment during these negotiations in particular. There is nothing "inappropriate" about our position on the issue, and we believe that the University's refusal to include a provision covering this subject matter in the Agreement and now to decline to negotiate further on the matter is actionable.

* * *

. . . As you will recall, in my letter to you of September 21, 2004, I reiterated that the AAUP did not waive its right to negotiate on the issue of clinical supplements. You have also been advised that the AAUP reserves its rights, in lights of the University's actions and position, to enforce past practices as to clinical supplements in an appropriate forum (CP-12).

87. In a letter dated December 21, 2004, Kanan replied to Schorr. Kanan wrote that the parties reached an agreement on the issue of clinical salary components when the proposals were withdrawn in exchange for other proposals which were included in

the MOA (CP-13; 7T52). Kanan asserted to Schorr that once the AAUP executed the 2004-2009 agreement, the AAUP would be deemed to have waived its right to negotiate on the issue of clinical supplements during the term of the 2004-2009 agreement (CP-13).

89. According to Schorr, this was the first time, either in this letter or in a telephone conversation shortly before the letter was received, that Kanan expressed that he felt the AAUP was waiving negotiations on clinical salary components during the term of the 2004-2009 agreement (8T68). Boccabella read the letter from Kanan (CP-13) and concluded that Kanan's statement about waiver was not true. In any event, Boccabella felt that by executing the collective agreement the AAUP did not waive its rights to enforce the past practice regarding modifications to clinical components of salary (8T31). Basically, neither party agreed on their respective positions at this point in time (8T56-8T57).

90. Boccabella had been contacted during this time period by University President Petillo to find out what the problem was with the finalization of the collective agreement, since he (Petillo) was anxious to conclude negotiations (8T29). Boccabella suggested to Petillo, that the parties execute the agreement and let the Klein matter resolve itself (8T30). Petillo told Boccabella that his suggestion sounded reasonable, and he would speak to Kanan (8T54-8T55).

91. Kanan was aware that the AAUP threatened that the Klein issue presented an obstacle to closing the collective agreement (7T36). Kanan communicated to Boccabella previously that the University wanted the Klein matter to go away, but Boccabella refused to stop Klein or the AAUP from pursuing the matter (8T28). Kanan admits that he was told by Petillo that he (Petillo) wanted the collective agreement finalized because of its importance to the faculty, but Petillo also told Kanan that he wanted a fair agreement and was not willing to "give up the shop" (7T36-7T37).

92. Schorr responded in writing to Kanan's December 21 letter on January 5, 2005 (CP-13, CP-14). He wrote, in pertinent part:

The University's failure to even acknowledge that the elimination of Dr. Klein's supplement represented a change in an existing employment condition without negotiation gave us no choice but to move forward with the contract and reserve our right to litigate the issue (CP-14).

Kanan did not respond to this letter (1T123).

93. By letter dated February 2, 2005 (R-38), the AAUP confirmed ratification of the 2004-2009 collective agreement (J-1). The parties executed the collective agreement on February 8, 2005 (J-1). The AAUP decided it had done all it could for Dr. Klein at that time and, therefore, it was appropriate to execute the agreement and pursue its unfair practice charge at a later date (1T123, 1T126).

94. Since the execution of J-1, the University has implemented the parties' agreements involving new notification procedures as to modifications to clinical salary components and the provision to faculty of annual financial statements about departmental budgets (5T134-5T136).

95. Meanwhile, since the execution of J-1, on April 1, 2005, the Board of Directors Appellate Review Committee Report on Klein's appeal was issued (R-8; 2T167). Among its conclusions and recommendations, the Appellate Review Committee concurred with the previous findings of both the Fair Hearing Committee and the Credentials Committee that in order to retain his membership on the Hospital's medical staff, Klein would need to undergo retraining before resuming clinical activities. The Committee recommended that pending retraining, Klein's privileges be renewed on condition that he participate in and successfully complete a retraining program before resuming clinical practice at the Hospital. Additionally, the Committee affirmed the decision to require a physical and psychological examination before Klein be allowed to resume activities at the Hospital. On April 13, 2005, the full Board of Directors adopted the recommendations of the Appellate Review Committee (R-8).

96. At no time following receipt of Hunter's letter eliminating his faculty practice supplement, has Klein informed Hunter that he would meet the conditions set by the Credentials Committee nor did he offer to increase his non-clinical

activities, apply for research grants on behalf of the department, or expand his teaching role (6T36, 6T38-6T39). Dr. Klein has not, to date, participated in the retraining necessary to resume his clinical activities at RWJUH nor has he submitted to a physical or psychological examination as required by the Board of Directors. He has continued to appeal the findings of all Committees. He is also involved in an appeal involving the University before the Appellate Division (2T93). It is unclear from the record whether the appeal involves the matter before the Credentials Committee.

2007 Budget Reductions

97. Dr. Bruce Vladeck was hired as interim president of UMDNJ in the winter of 2006 and remained in that position for approximately 16 months (9T38). Upon his hire, Vladeck determined that there were significant budget deficits throughout the University, but, in particular, at University Hospital in Newark (9T51).

98. Because of the university-wide financial disarray, it took Vladeck some time to get a reasonable estimate of the magnitude of the deficit (9T52). However, by the middle of March 2006, it was clear to him that he could not eliminate the financial deficit by the start of the new budget cycle on July 1 (9T52). Nevertheless, Vladeck began to establish a more realistic budget for fiscal year 2006/2007 and sought immediate

control over University Hospital finances (9T52). Despite these actions, the budget for that year still produced a deficit in excess of \$20 million (9T52).

99. During the summer of 2006 University Hospital CFO Ed Burke alerted Vladeck about the high levels of payments University Hospital was making to NJMS for clinical services provided by its faculty (9T40). Burke suggested that the level of payment was out of line with comparable institutions and would have to be reduced if University Hospital was to return to a break-even operation (9T40). Burke provided Vladeck with data on actual faculty clinical productivity and advised him that he (Burke) was going to propose to NJMS a reduction in payments for clinical activities to a more realistic figure that would match the norm in comparable institutions - e.g. an amount related to actual services being provided by faculty members to University Hospital (9T41).

100. For instance, Burke provided Vladeck with productivity data - RVUs (Relative Value Units)^{13/} - per department and per full-time equivalent (FTE) faculty member by department at NJMS

13/ RVUs were originally developed for the Medicare physician fee schedule as a means of incorporating into a single measure the amount of time, effort, skill and experience that were necessary for a physician to provide a particular service to a patient in order to set a schedule of (9T42-9T43). RVUs are now the industry standard measure of physician productivity (9T45). The system is not affected by whether a physician has a low or high percentage of Medicare or insured patients (9T44).

for clinical activities at University Hospital and compared this data to standard national benchmarks of productivity (9T45). The standard benchmarks were derived from Medical Group Management Association (MGMA) and University Hospital Consortium (UHC), national data services that collect data on a wide range of physician practices by specialty (9T46). MGMA is comprised primarily of data from larger independent physician group practices around the country, while UHC is an association of major teaching hospitals of which University Hospital is a member as well as approximately 90 other relatively similar hospitals in the database (9T46-9T47).

The three comparative methodologies - University Hospital RVUs, MGMA RVU data, and UHC RVU data - demonstrated that University Hospital productivity per faculty member was roughly half as high as the productivity in the MGMA and UHC databases, confirming Burke's and Vladeck's suspicion that University Hospital was paying NJMS excessively for the value of physician services (9T47). Some departments at NJMS, however, were more productive compared to others (9T48).

101. A series of extensive budget discussions ensued between University Hospital representatives, the NJMS Dean's office, central administration and the NJMS Department Chairs and their staff (9T41, 9T49). Among those attending the meetings were Putterman, Interim NJMS Dean Robert Johnson, then NJMS Associate Dean Deborah Johnson, and NJMS Vice Dean Dr. Maria

Soto-Greene as well as the NJMS Chairs. Vladeck learned in particular from Putterman and Dr. Soto-Greene, that the clinical components of an individual faculty member's salary was not a matter negotiated with the AAUP, but was determined between the Chair and the faculty member at the time of hire and subject to annual review and change at the department level by the Chair and the faculty member. These salary components, Vladeck learned, changed up and down for all sorts of reasons (9T61).

102. During these budget discussions, Vladeck communicated that he would not accept simply shifting the University Hospital deficit to NJMS by reducing the Hospital's payments to the medical school without NJMS either reducing expenses or applying other revenue sources (9T53). Vladeck believed that NJMS had other resources it could tap to make up some, if not all, of the difference in reduced subsidies from University Hospital (9T53). How this would be accomplished, as far as Vladeck was concerned, was a determination to be made by the NJMS Dean in consultation with the Department Chairs (9T53). In other words, the Chairs were responsible for meeting reduced departmental budget projections and for decisions related to salary reductions, if any, for their clinicians (9T56).

At this time, there was no consensus within NJMS or the broader University community on an appropriate formula for tying productivity to compensation (9T56). There was no formal institutional template, although it was the publically-stated

University goal to move towards one (9T56). Therefore, any formula devised by the Chairs to reduce compensation, if necessary, to meet their budgets, and which formed the basis of their decision-making in this regard, was an individual effort (9T56-9T57).

103. As a result of Vladeck's budget discussions at NJMS, there were on-going discussions about a new contractual relationship between the medical school and the hospital growing out of Vladeck's budget review and decision that the reporting relationship between these institutions had to change (9T54). Vladeck decided to make the University Hospital CEO a direct report to the UMDNJ President; previously, the University Hospital CEO reported to the NJMS Dean. This change in reporting, Vladeck concluded, necessitated a more formal contractual agreement between the two entities (9T54).

These discussions involved the development of a system whereby funds flowed from University Hospital to NJMS based on a contract between the two entities (9T102, 9T105). The goal was to have University Hospital outline its needs for clinical services and to create benchmarks that the departments could use to determine that they had reached the goals (9T104). University Hospital was also to create a budget for delivery of clinical services, and the departments had the responsibility to deliver clinical services within that budget (9T104). An outline of a new contractual arrangement was prepared, but given the intensity

of the '08 budget negotiations, was eventually put on hold until the completion of the budget process (9T54).

104. NJMS Interim Dean Robert Johnson was Chair of the department of pediatrics at NJMS before assuming the role of Interim Dean (9T92-9T93). As a result of Vladeck's budget review, Johnson sent a memo dated February 16, 2007 to the approximately 14 NJMS Department Chairs, entitled "New Contractual Relationship with University Hospital" (CP-40). Johnson informed the Chairs, for the first time, that a change in the relationship between University Hospital and NJMS was contemplated. He also informed them that University Hospital's budget was in deficit, resulting in a \$7 million reduction to NJMS and, therefore, reductions to each department's budget (CP-40; 9T127, 12T25). Johnson explained that in addition to the non-renewal of faculty, "UMDNJ Central Administration [Putterman's office] has assured us that you can decrease patient services component payments on any clinician, including tenured faculty" (CP-40; 9T114).

Finally, in CP-40, Johnson explained to his Chairs that a consultant, the Bard Group, had outlined its vision for the new partnership model between University Hospital and NJMS. Johnson summarized what he considered to be several salient point from the Bard report including:

Negotiated departmental budgets based on WRVUs^{14/} and other variables (e.g. administration, teaching), sized to anticipated UH clinical service needs, with reductions where appropriate.

Department budgets rolled up into a clinical practice budget for NJMS Faculty Practice as a whole and managed by NJMS through Clinical Department Chairs.

Opportunity for Faculty Practice to earn additional incentive payments at year end by meeting or exceeding agreed upon performance measures (e.g. WRVUs, quality measures, etc.)

Address uneven distribution of clinical revenue impacting faculty incomes, morale, and ability to participate in the academic mission [CP-40].

Johnson's memo also referred to a recent analysis conducted by an accounting firm, J.H. Cohen, as a result of compliance issues and the Federal Monitor's concerns (CP-40; 9T109). The Cohen analysis concluded that compensation for some clinicians was too high (9T109). At that time, Dean Johnson only had a draft analysis report, and has not, to date, received a final report (9T111). Except for reporting the findings of the draft report, as far as Dean Johnson knows, the analysis was not given to the Chairs nor were reductions to compensation taken in reliance on the Cohen analysis (9T112, 12T35-12T36).

105. After the Johnson's memo (CP-40) was distributed, Vice Dean Dr. Maria Soto-Greene generated a memo, dated February 26, 2007, to the NJMS Chairs emphasizing Dean Johnson's message that

^{14/} WRVUs are Work Relative Value Units.

they had to meet their budget reductions which could include non-renewals, although clinical services had to be maintained. She also reminded them that in reviewing their department budgets and determining how to address the decrease in funding from University Hospital, their decisions should be made in a fair and equitable manner (CP-43; 11T73). However, unless Soto-Greene was specifically consulted by a Chair, it was basically up to the Chairs to ensure that their decisions were fair and equitable (CP-43; 11T75)

106. The month of February begins the budget process for the next fiscal year, and the Chairs meet, usually through June, to discuss and finalize their budgets beginning in July (10T7). Budgets consist of money from both NJMS and University Hospital (10T8).

Dean Johnson attended meetings with the Chairs regarding their departmental budget reduction (9T131-9T132). In regard to the issue of possibly reducing patient services components of salary to meet budget reductions, Dean Johnson told the Chairs to consider the impact of any decision on the provision of clinical services, because Johnson wanted no reduction in the availability of services to patients (9T132, 9T147). Johnson, however, did not give the Chairs any specific standards to apply if they decided to reduce faculty compensation, but reduction in compensation was the last thing he wanted them to do. Therefore, his office worked with every department to determine whether or

not there was some alternative to salary reductions to meet budget goals (9T133-9T135).

107. Although the Chairs were provided no specific compensation formula, the Chairs looked to earnings as measured against the MGMA 75% of clinicians in the same specialty in the northeast and to productivity as measured by RVUs (11T57-11T58). RVUs measure patient care activity and, thus, productivity (12T122-12T124). There is a correlation between the bill generated by the physician for patient services either in their private practices or at University Hospital and the number of RVUs. RVUs increase by the numbers of procedures (12T151-12T152).

108. Having been notified that their departmental budgets would be substantially reduced, the NJMS Chairs studied their reduced budgets to determine how to meet their overall budget goals, while providing the same level of clinical services (9T113). In deciding whether to reduce patient services components of individual clinicians as one of the possible methods to close budget gaps, Dean Johnson's office provided each Chair with productivity information for the clinicians in their respective departments, namely the number of patients treated by the clinician, the procedure performed and clinical earnings billed by the NJMS faculty plan (UPA) (9T118-9T124). Associate Dean Deborah Johnson, compiled this productivity information. She gave each Chair RVU data for the department's faculty as well

as other general information about department activities, such as utilization of space (9T125). Specifically, she provided the Chairs with a copy of the Bard consultant report for their departments (12T28, 12T35-12T36).

109. Each Chair had been given a deadline of July 1, 2007 to address their budget deficits (9T154-9T155). Putterman told Deborah Johnson that if it was necessary, the patient services component of salary could be reduced provided that the faculty member was given notification of the reduction and reason for the reduction in accordance with the new notification procedures agreed to with the AAUP as part of the recent contract negotiations (12T16).

110. Putterman also provided Deborah Johnson with R-29, a list of reasons for changes to clinical components of salary that Putterman had prepared in conjunction with the new notification procedures as a guide for the Deans and Chairs regarding what she considered to be valid reasons for changes to clinical components of salary (R-29). Putterman began preparing R-29 in December 2004, but only distributed it in February 2005, when she sent R-29 together with a memo regarding the new notification procedures to the Deans with instructions to distribute it to the Chairs (11T165-1T166).^{15/} Putterman intended the reasons

^{15/} It does not appear that all of the Chairs received R-29, listing the various reasons to modify clinical salary components prepared by Putterman in conjunction with the new (continued...)

contained in R-29 to be guides for Department Chairs, in the event that a Chair decided to reduce the clinical salary components, so that the Chairs could comply with the notification of the reduction of the change and the reason for the change.

111. The reasons Putterman listed as valid reasons for decreases/termination of patient services or faculty practice salary components were:

- expiration or decrease of faculty practice guarantee as set forth in offer letter
 - decreased clinical or administrative duties or responsibilities (specify)
 - decreased activity (or time or call or billings or clinical earnings) in the practice plan or in UH or UBHC
 - decreased productivity or failure to meet pre-established productivity or activity goals in the practice plan, or in clinical activities at UH or UBHC, or in clinical research
 - termination of all faculty practice or patient services activities (or of clinical activity at a specific site)
 - decreased (or insufficient) departmental faculty practice revenue collections available for distribution to participating faculty
 - decreased clinical teaching of students and/or house staff
 - faculty renewal leave, military leave or other unpaid leave
 - prescribed in settlement agreement or other legal document
- [R-29]

112. When NJMS Chair eventually determined to reduce the patient services components of seven faculty in various departments at NJMS as a result of the 2007 budget deficit, each

15/ (...continued)
notification procedures. Some chairs testified that they were aware of the list, while others had never seen the list.

notification of reduction to NJMS faculty was accompanied by a letter from the Chair explaining that the reason for the reduction was "decreased departmental funding from University Hospital for patient care service activities of NJMS faculty" (CP-77). This was not a reason that Deborah Johnson saw specifically listed in R-29, so she called and e-mailed Putterman and Sheila Eder, who worked with Putterman in the Office of Academic Affairs, for approval of the language (CP-77; 12T19). Putterman had not listed this as a specific reason when she prepared R-29, because she had not previously experienced a situation where University Hospital reduced payments to the NJMS for faculty clinical activities at the hospital. The R-29 reasons were based on reasons that in the past Putterman had experienced and considered to be valid (14T36-14T37).

Putterman felt, however, that another reason listed in R-29 - "decreased (or insufficient) departmental faculty practice revenue collection available for distribution to participating faculty" - was completely analogous and, therefore, was a valid reason to reduce the patient services salary component in this instance. Putterman reasoned that a reduction in clinical income to a department either from University Hospital or from faculty practice plan activities has a tremendous impact on the budget of a department (13T39). Therefore, a reduction in clinical components of salary in order to maintain the financial solvency

of that department, in her opinion, was a valid reason for making a reduction (13T39).

113. Putterman would not approve a reduction in patient services component of salary based solely on a Chair's decision that compensation was too high, but the requested reductions at NJMS were similar to ones she had authorized in the past, where faculty in faculty practice plans depend on funding generated by those plans to support the faculty practice components of their salaries that can be and are increased or reduced accordingly (R-29; 13T23, 13T93-13T94, 13T99, 14T17). For instance, at RWJMS and SOM, where the source of funding for patient care activities is the school's faculty practice plan, Putterman has approved a reduction in faculty practice income as a result of decreased funding to a particular department from this source of revenue (R-10, R-96 through R-98; 13T91). As an example, in January 2006, Dr. Daniel Abesh at SOM had his faculty practice income reduced due to decreased departmental faculty practice revenue collections available for distribution to participating faculty (R-97). Putterman approved this reason as valid and the AAUP never objected.

Also, in January 2006, Putterman approved the reduction in the faculty practice salary component of Dr. Michael Voyack at SOM due to decreased departmental faculty practice revenue collection available for distribution to participating faculty. The AAUP never protested or asked to negotiate over that change

(14T44-14T45). Then again, in August 2006, Dr. John Parsons, a Ph.D faculty member at NJMS was notified that his patient services component of salary was being reduced due to decreased University Hospital revenue collections available for distribution to participating faculty (R-99). Putterman approved this change for the stated reason and the AAUP never objected (14T46-14T47). Putterman sent these changes together with the monthly reports she continues to send to the AAUP and has sent since the filing of the charges in the instant matter (14T41).

114. Putterman concluded, therefore, that since University Hospital was the source of funding for patient care activities of NJMS faculty, when the hospital reduced its payments to the department of the school for those services it is a valid reason that those faculty might have their clinical salary component reduced (13T91).^{16/} After consulting with Sheila Eder who worked with Putterman in the Office of Academic Affairs, she approved the reason for the reductions as being due to decreased departmental funding from University Hospital for patient care

^{16/} According to Interim Dean Robert Johnson, in the past, when he was Chair, he reduced faculty practice and patient services components of faculty because of decreased funding from University Hospital (9T116). To him, a budget deficit is the same as decreased faculty revenues (one of the reasons listed by Putterman in R-29 as valid to make a change) because NJMS faculty receive income from clinical services performed at University Hospital. When University Hospital reduces its payment, then that decreases the money available for patient services salary components (9T116-9T117).

service activities and communicated this wording to the Chairs who were required, as per her agreement with the AAUP, to notify faculty of any modification to clinical compensation and the reason for the change (CP-77, CP-80; 13T88-13T89).

Having approved the proposed reductions in patient services components for the reason of decreased funding from University Hospital for patient care services activities, Putterman did not notify the AAUP of the University's contemplated actions because, she concluded, there was nothing to be gained by consulting the AAUP (CP-80; 12T22).

115. Eventually, the patient services salary component of seven NJMS faculty members in three departments were reduced based on the determination of their department Chairs that the action was necessary to address their budget deficits and, specifically, due to decreased funding from University Hospital for patient care service activities, the valid reason approved by Putterman (9T136). The reductions were to take effect on July 1, 2007, although, apparently, not all reductions have yet taken effect. The affected faculty were: Dr. Michael Cho in the OBGYN department; Dr. Thomas Schieble, Dr. Vasanti Tilak and Dr. Melissa Davidson^{17/} in the department of anesthesiology; and Dr. Leonard Meggs, Dr. Mark Levin and Dr. Edo Kaluski in the department of medicine (CP-109; R51 through R-58).

^{17/} As an assistant dean, Davidson is not covered by the AAUP collective agreement (J-1, J-3; R-57, R-58).

116. Putterman also approved reductions to faculty practice salary components at RWJMS - 26 in all. She approved one reduction in faculty practice income of Dr. Lewis Reisman in the RWJMS pediatric department "in conjunction with alignment of faculty practice supplement with faculty practice activity" (R-96). Additionally, Putterman approved 25 reductions to faculty practice income in the RWJMS OBGYN department for the reason of "decreased, insufficient departmental faculty practice revenue collections available for distribution to participating faculty" (R-59 through R-83).

117. Putterman also approved 12 reductions to faculty practice income in the SOM OBGYN department due to budget constraints, after requesting and receiving additional information from the Chair that faculty members were reduced if they were below their individual productivity targets set by their faculty practice plans (R-84 through R-95; 13T130). This reason comported with Putterman's previous experience of reductions based on poor performance in the faculty practice plan (13T26).

118. Alex Bernstein was hired as executive director to succeed Debra Osofsky in February 2007 (13T36-13T37). Bernstein learned after he was hired that, in negotiations for the 2004-2009 collective agreement, the parties agreed that changes in clinical components of salary - patient services component and faculty practice income - were not made arbitrarily but that the

past practice was that changes were only made for legitimate reasons (13T73).

Bernstein understood that the parties agreed during negotiations that the past practice would be maintained and that any legitimate reason for a reduction had to be consistent with what had been done in the past. As far as Bernstein was told, presumably by Schorr, Osofsky and/or Boccabella, reductions to clinical components had never been based on budgetary deficits or for reasons of productivity (13T75, 13T79). Bernstein concluded that if clinical salary components were changed for reasons of productivity, they would be going up and down all the time and faculty members would be calling the AAUP office complaining. As far as he knew that had not been the case previously (13T76-13T77).

Bernstein admits that if there were changes to clinical components of salary that were consistent with past practice, the AAUP would not know unless the faculty member contacted the AAUP, because the monthly faculty transaction reports do not always contain sufficient information to disclose the reason for the change in compensation (13T61, 13T64, 13T71-13T72). Unless the information is provided separately upon request or the AAUP is contacted by a faculty member, the AAUP would not know the reason for the change (13T71-13T72). Also, patient services salary components have increased in the past, and the AAUP was not involved nor did they demand to negotiate, because the increases

were, Bernstein assumes, with the consent of the faculty member (13T77-13T78).

119. Bernstein was first alerted to the reduction in patient services salary components at NJMS, when a faculty member contacted him and sent him a copy of the February memo from Dean Johnson to the Chairs (CP-40) about the budget deficit and decreased funding from University Hospital (13T39-13T340). Bernstein prepared a letter dated February 22, 2007 for Boccabella and AAUP President Dr. Hugh Evans to send to University Senior Vice President Dr. Denise Rodgers (CP-101).

The letter demanded negotiations over the University's intention to cut the clinical components of salary. The letter reminded Rodgers that during recent negotiations for J-1, Putterman assured the AAUP that the University would not change clinical salary components unless there was a valid basis to do so, such as a diminution of a clinical commitment or a change from a part-time to a full-time status. Putterman, Bernstein wrote, denied that patient services salary components were reduced by Chairs for arbitrary reasons (CP-101).

120. When the AAUP received no response to CP-101, Bernstein wrote a follow-up letter to Rodgers (CP-102) reiterating the AAUP's negotiations demand and also suggesting that the faculty be included in the decision-making process regarding responses to the budget deficit (CP-102; 13T45). At

this time, Bernstein also had an off-the-record conversation with Kanan (13T74).

Bernstein reminded Kanan that the contemplated reductions were terms and conditions of employment and that there were notification requirements required when any changes were made (13T74). Kanan wrote Bernstein on March 14, 2007 confirming the substance of their conversation and explaining that no reductions had yet been implemented. Kanan confirmed that it was the University's intention to meet with the AAUP when appropriate to discuss any pertinent issues that might impact the membership (CP-103).

121. Despite Kanan's assurances that no faculty salary actions had been implemented, Bernstein started receiving calls from NJMS faculty members that their Chairs were speaking to them about specific reductions to their patient services salary components (13T49-13T50). As a result, Bernstein wrote Kanan and again demanded negotiations over the reductions (CP-104).

122. In April 2007, Bernstein wrote Kanan that the reasons given to faculty for the reductions, namely that they were due to a budget shortfall, was not consistent with past practice and, therefore, must be negotiated (CP-105). Bernstein also requests specific information necessary for enforcement of the parties' collective agreement, including information on individual faculty members impacted by the reduction, a copy of the complete Bard Group report, documents related to budget reductions for each

department in each school where faculty were being impacted and all faculty compensation analyses that were referenced by Dean Johnson in CP-40.

Bernstein never received the requested information (13T56).

123. On May 4, 2007, Dean Johnson, Soto-Greene, Puttermsn, Acting Vice President of Human Resources Jerry Garcia and Kanan met with Bernstein, Boccabella, AAUP President Dr. Evans and several NJMS surgical faculty members (13T56). Bernstein reiterated the need for providing the requested information in order to understand the basis for the proposed reductions. He also put the University on notice that it had a legal obligation to negotiate because the changes were being made for budgetary reasons - a reason that, as far as the AAUP knew, had not in the past supported such actions (13T56-13T57).

The faculty who attended the meeting expressed concern that faculty had already left the University or were contemplating leaving which would impact patient care. The faculty explained that these departures affected the primary mission of the University which was providing patient care to the indigent community in Newark (13T59-13T60).

Ultimately, as a result of the meeting, Dean Johnson sent a memo advising faculty of the status of the budget talks and committed to meet with the AAUP and other concerned faculty on a monthly basis (13T59-13T60).

124. On June 22, 2007, Bernstein sent a memo entitled "Request for Explanation for Modifications to Clinical Components" to University Senior Vice President Dr. Denise Rodgers, Putterman and Eder, because he determined that there were many reductions in compensation that were not explained by the information in the monthly faculty action reports sent to the AAUP (CP-108; 13T66). He reminded them that on February 22, 2007 and again on August 9, 2007 the AAUP demanded to negotiate over all modifications to unit member compensation and that the AAUP requested information in April 2007 as to the reasons for any modifications to clinical components. Bernstein asserted that, to date, he had not received the requested information, but that he wanted it included in each monthly faculty action report "[t]o ensure compliance with the AAUP contract and past practices in regard to any modifications to clinical components" (CP-108). Finally, in the absence of the requested information, the AAUP was objecting and reserving its right to challenge any past and future modifications to clinical components.

125. In preparation for the hearing in this matter, Bernstein compiled CP-109 (NJMS Clinical Reductions) and CP-110 (RWJMS Clinical Reductions) to summarize the reductions to clinical salary components since February 20, 2007 taken at NJMS and RWJMS respectively and due to departmental budget deficits. These faculty actions are summarized below.

Reductions in Patient Services Salary Components. at NJMS

126. Only three out of 14 Chairs at NJMS reduced the patient services salary components of their faculty in order to meet their reduced department budget projections - OBGYN Department Chair Dr. Gerson Weiss, Department of Medicine Chair Dr. Bunyad Haider, and Department of Anesthesiology Chair Dr. Ellise Delphin. Two other Chairs - Department of Surgery Chair Dr. Edwin Deitch and Department of Physical Medicine and Rehabilitation Chair Dr. Joel DeLisa - planned for reducing the patient services salary components of specific faculty members in their departments but were able to avoid these actions through last minute budget deals with the approval of the Deans office.

127. In December 2006, Dr. DeLisa was informed that University Hospital withdrew all funding support for his department (11T89). This was the first time in his experience - DeLisa has been Chair since 1987 - that University Hospital reduced funding to his department (11T115-11T116). In order to avoid immediate layoffs, NJMS made up the difference for the rest of that budget year through June 30, 2007 (11T89). But in putting together his budget for the budget year beginning July 1, DeLisa was still facing a \$700,000 deficit, a sum representing a loss of 50% of the funding from University Hospital (11T90).

Nevertheless, by the end of February 2007, in meetings with Vladeck as well as representatives from both the Dean's office

and University Hospital, DeLisa was informed that the Bard consultants determined his department would be key to the future financial success of University Hospital in regard to discharging patients and that, therefore, his budget would only be reduced by 20%, not the 50% anticipated (11T93-11T94). It was made clear, however, that his faculty was to be more involved in seeing clinic patients and less involved in private practice. There was particular concern about three faculty members - Drs. Todd Stilak, Patrick Foye and Peter Yonglas - who were spending no time in the University Hospital clinics and were engaged primarily in private practice (11T94-11T96, 11T113). These three faculty, it was felt, were the logical candidates for a reduction in their patient services salary components (11T97, 11T114).

DeLisa knew that patient services salary components were used to attract and recruit individuals to the University, but as private practices grew and earnings increased, it made sense to him that patient services salary components would change (11T100-11T101). In the case of the three physicians (Stilak, Foye and Yonglas), DeLisa told them on numerous occasions during faculty meetings that the federal monitor was looking into faculty compensation and what the faculty was doing to earn it (11T98). In particular, DeLisa observed that Foye and Stilak provided almost no patient care at University Hospital and were reluctant to participate in charity care clinics (11T113). It seemed logical to DeLisa that since University Hospital was

paying his department to provide patient care, the three physicians who were spending little or no time at University Hospital should have their patient services salary components reduced to make up the department's budget deficit (CP-82; 11T114).

On April 10, 2007, DeLisa received a memo from his faculty objecting to the proposed salary reductions and a request to negotiate with the AAUP (CP-83). However, the reductions were never implemented because University Hospital decided to restore full funding to his department (11T103). For fiscal year 2007/2008, however, the responsibilities of his faculty have changed to provide more patient care in the University Hospital clinics in order to safeguard the funding from this source (11T111-11T112).

128. Department of Surgery Chair Dr. Edwin Deitch, like DeLisa, planned, as part of the severe cuts to the department of surgery, to decrease the patient services component of a faculty member, Dr. Paul Bolanowski, but was able to avoid the action by finding other ways to meet his budget shortfall (CP-41). Initially, however, at a February 2007 meeting with the administrations of both the University and University Hospital, Deitch was told that University Hospital was reducing his budget in the department of surgery by \$650,000, a significant portion of his total \$2.3 million department budget (CP-41; 10T8).

Deitch was informed that he had several options to address his department's budget reduction, including among other items, reducing the patient services salary components of faculty compensation (10T23). Deitch was not told which faculty salary, if any, to reduce (10T11). The only standard he was given was to be fair and equitable in meeting budget reductions (CP-43; 10T17-10T18). Basically, he was instructed to come back with a plan to reduce costs and increase revenues (10T18). Deitch also learned that the Federal Monitor evaluated the operations at University Hospital and concluded that the hospital was overpaying its faculty. The Monitor had recommended a faculty salary reduction initiative in every department (10T18-10T19).

Patient services salary components in Deitch's department are paid primarily by University Hospital (10T25). Although faculty practice income of his faculty has varied from year to year, until this point in time, the patient services salary components of his faculty have not varied (10T6).

After the February meeting, Deitch and his department personnel administrator worked together to gather raw data on faculty productivity. Deitch based proposed reductions to faculty compensation mainly on RVU productivity, giving the biggest cuts to those who were below the MGMA national 75%, as a mean benchmark (10T13, 10T19-10T20, 10T24). Deitch also evaluated intangibles like commitment to doing additional service

and how many hours they were working compared to their peers (10T24).

Deitch and his division chiefs then met with each faculty member (approximately 70 faculty) to explain that they were at risk of a reduction in the patient services component of their salaries. Deitch also informed them that he hoped to avoid any reductions by making up the budget deficit in other ways (10T11-10T12, 10T16). Deitch has been a Chair since 1994, but this was the first time he proposed reducing patient services compensation because of decreased funding from University Hospital (10T20).

Of all the faculty he met with, only Dr Paul Bolanowski asked that Deitch confirm their conversation in writing which he did by memo dated February 28, 2007, informing Bolanowski that his salary would be decreased by 20% from \$198,697 to \$158,697 beginning July 1, 2007 due to a decrease in his patient services salary component (CP-42, CP-96, CP-97; 10T12, 10T16). According to Deitch, he told Bolanowski at the meeting that his patient services salary component was being cut because of his low productivity - Bolanowski's RVUs were in the 25% or 30% of the MGMA national average (10T13).^{18/}

18/ Bolanowski denied that Deitch told him the reason that his compensation was being reduced (12T98). I do not find this a material dispute of fact and need not resolve the discrepancy in their testimonies. Whether Deitch told Bolanowski the exact reason at the meeting or not, the
(continued...)

Bolanowski signed and sent a memo to Deitch from the surgery department faculty protesting any reduction in the patient services compensation and demanding that negotiations be done through the AAUP on a group-wide basis (CP-98). However, before the reductions were to take place, Deitch got Dean Johnson's approval in June 2007 for a budget allocation plan that met the department's projections, while avoiding any reductions to faculty patient services components (CP-41). No compensation reductions were implemented.

129. In the OBGYN department, however, one faculty member, Dr. Michael Cho, was informed by his Chair, Dr. Gerson Weiss, that the patient services salary component of his compensation would be reduced due to decreased departmental funding from University Hospital for patient care service activities effective July 1, 2007 (CP-84). Weiss had been informed after the February budget meetings that his department budget was reduced, and that he would have to cut at least one physician's salary. Weiss was not told whose salary to cut nor was he given a formula to do so (11T25-11T27).

Weiss reviewed RVU data that he had been receiving for seven or eight years from UPA to assess the productivity of his faculty

18/ (...continued)

record supports that Deitch based his decision on the productivity numbers for his faculty. There is no evidence to refute that Bolanowski's productivity was low compared to the national numbers and compared to others in his department.

(11T29-11T30). Weiss determined that Cho performed only 10% of what the other faculty performed in services for University Hospital (11T128).^{19/} At the same time, Cho's income was significantly higher than the rest of the department, because he performed clinical work at University Reproductive Associates in Hasbrouck Heights which provides high-technology fertility care and treatment to insured patients who are billed at commercial rates (11T128, 11T144). Although Cho would have liked to set up a fertility program at University Hospital, there was not enough clinical space for him to do so (11T145).

Weiss concluded that it did not make sense to pay Cho for working at University Hospital, when Cho was providing 10% of the patient care others in the department were but was receiving the same patient services salary component as the rest (11T139). Weiss decreased Cho's patient services component by approximately \$34,000 and notified him by memo dated June 25, 2007 that the reduction was due to decreased funding from University Hospital for patient care service activities (CP-84). The reduction was effective July 1, 2007 (R-51).

^{19/} In Cho's original appointment letter (CP-85) setting a total compensation of \$120,000 composed of a \$79,628 academic base and \$40,372 patient services component, Cho was informed that his patient services component was dependent on providing patient care as assigned by his Chair and would be subject to annual review. Weiss did not annually review this salary component (11T142-11T143).

Cho and then NJMS Dean Joffe signed a reappointment letter (R-44) for a two-year period from July 1, 2004 through June 30, 2006. In the reappointment letter, Cho was informed that his patient services component was dependent on providing patient care as assigned by his Chair. He was also informed that his patient services component was contingent upon satisfactory performance and subject to change (R-44). Weiss interpreted this language as giving the Chair the discretion to change this component of salary for a valid reason (11T147).

Weiss considered the fact that Cho was spending 10% of his time at University Hospital together with the decreased funding from University Hospital as a valid reason for the reduction in this instance (11T147). This was also in line with Weiss' past experience regarding funding sources. For instance, prior to 2007, although overall salaries might not change, there were changes to patient services components based on lower activity levels at University Hospital. In that case, although total compensation remained the same, salary would be reallocated from University Hospital for patient services to NJMS budget lines (11T131).

Weiss took other steps to reduce his departmental budget besides reducing Cho's salary, including not filling empty positions, decreasing the salary of some non-clinical staff, and moving a faculty member from a State budget line to a line for grant money as well as other small belt-tightening measures

(11T146). Weiss was able to avoid terminating any faculty (11T146).

130. In the department of medicine, the Chair, Dr. Bunyad Haider, was also informed in February 2007 of a budget reduction to his department, namely 20% of his total nine million budget was being cut as the result of reduced funding from University Hospital (12T111, 12T155). University Hospital funds accounted for approximately half of his total departmental budget (12T155). Haider was also told that there were several options to manage his budget cuts, including non-renewal of faculty, shifting some dollars to NJMS or reducing the patient services salary component of faculty (12T116, 12T121). It was left to Haider to decide what options were feasible to meet the new budget projection, but he was instructed by Soto-Greene that any plan to meet budget reductions must be done in a fair and equitable manner (CP-43; 12T114).

Haider together with his financial director, Matt Chisholm, reviewed the overall compensation of all 94 faculty members in his department, including their RVUs (12T119, 12T122, 12T158). Haider felt that University Hospital was providing funds to faculty for patient care which was reflected in the patient services component of their salary and, therefore, low productivity in this regard was not acceptable and justified reductions to this salary component to bring it into "sync" with contributions connected to clinical activities (12T143-12T145).

Haider did not consider performance reviews in determining how to meet his budget or whose compensation, if any, to reduce (12T124).

Ultimately, Haider reduced the patient services component of Dr. Edo Kaluski, Dr. Mark Levin and Dr. Leonard Meggs effective July 1, 2007 due to decreased departmental funding from University Hospital for patient care service activities (CP-38, CP-39; R-54, R-55, R-56). Levin was also reduced due to the elimination of his administrative duties as acting division director (CP-91). Additionally Kaluski's was first notified that his salary component would be reduced by \$90,000 (CP-38), but shortly thereafter, when Haider got additional funding, Kaluski was notified that the reduction would only be for \$55,000 (CP-39). A fourth physician, Dr. Marc Klapholz, voluntarily took a reduction to his own salary by \$90,000 (12T155-12T159).

131. As to Kaluski, Haider determined that he was the second highest paid member of the department after Klapholz and his compensation was excessive compared to the rest of the faculty particularly in regard to the level of his clinical patient care activities (12T131-12T133). Klapholz and then Chair Dr. Jerrold Ellner hired Kaluski for a three-year term beginning April 1, 2006 and ending June 30, 2009 (R-40).

Klapholz and Kaluski negotiated a total compensation package of \$475,000 composed of the AAUP-negotiated academic base, a patient services component of \$250,000 which was contingent upon

satisfactory performance and subject to change, and a faculty practice annual guarantee of \$75,000 (R-40). The AAUP had no involvement in these negotiations (9T84). The appointment letter was signed by Ellner, Dean Johnson, University Hospital CEO Darlene Cos and Kaluski, not Klapholz.

When Kaluski received his appointment letter, including compensation breakdown (R-40), he was concerned about the phrase "subject to change" and expressed reservations to Klapholz who told him that this was standard terminology in all department contracts and that Kaluski should not be concerned because his patient services component was not likely to change (9T76, 9T84). Kaluski decided the phrase meant that this component of salary was tied to good performance, but Kaluski never raised his reservations about the "subject to change" issue with the signers of his offer letter - Klapholz was not a signatory to the letter (9T84, 9T89).

When Klapholz learned that Haider was intending to reduce Kaluski's salary by \$90,000 (CP-38), Klapholz, who did not agree with Haider's decision, negotiated with Haider and/or Chisholm to trim the reduction to \$55,000 (CP-39). Kaluski was notified of the reduction due to decreased departmental funding from University Hospital for patient care service activities (CP-39; R-56).

132. As to Meggs, Haider determined that his RVUs were well below expectation, namely his patient care activity did not match

his patient services component (12T125, 12T133-12T134, 12T136, 12T138). According to his initial offer letter (R-47), Meggs was hired for a five-year term effective July 1, 2003 through June 30, 2008. As in other appointment letters, Megg's was informed that his faculty practice and patient services components of salary were contingent upon satisfactory performance and were subject to change (R-47; 12T151). Based on Meggs' low productivity figures related to patient care, Haider notified Meggs that effective July 1, 2007, his patient services salary component would be reduced by \$50,000 due to decreased departmental funding from University Hospital for patient care service activities (CP-99; R-54).

133. Finally, Haider also determined that Levin had low productivity figures for patient care activities. He reasoned that low productivity together with the removal of his administrative duties as acting division director justified the reduction in Levin's patient services salary component by \$30,000, although it was primarily the low productivity figure that persuaded Haider to reduce the salary (12T140-12T141). He notified Levin that effective July 1, 2007 his patient services component would be reduced by \$30,000 due to the elimination of his administrative duties as well as due to decreased funding from University Hospital for patient care service activities (CP-91; R-55).

Levin was hired initially by Dr. Lawrence Harrison and Dr. Howard Ozer, who at the time were associated with the cancer center in Newark. The Center was later transferred and became a part of the NJMS department of medicine. Like Kaluski, Levin was also confused by his initial offer letter, specifically the breakdown of his total compensation of \$230,000 into an academic base (\$115,000), a patient services component (\$85,000) and a faculty practice guarantee (\$30,000). He telephoned Harrison who explained the components and, in particular, told Levin that the patient services component was used to reach a total salary figure (12T56-12T57). As to the language in the offer letter that his patient services component was contingent upon satisfactory performance and subject to change, Levin understood that phrase to mean that this component could change, if his performance was not satisfactory, although no one at the University confirmed Levin's understanding (12T67).

Since the reduction, Levin's administrative duties have decreased, while his clinical activities have increased from 20 to 32 hours per week. His consultation services and on-call duties are unchanged (12T62-12T63).

134. Although there was no reduction in the clinical responsibilities of the physicians whose patient services salary components were reduced, Haider felt that the reduction in compensation for Levin, Meggs and Kaluski bought their compensation more in line with their clinical responsibilities

(12T144). Their hours of work have not increased, because they are full-time employees, but they are expected to increase their patient care activity within their hours of work (12T144-12T145). Kaluski testified that his responsibilities and workload have increased dramatically (9T77-9T78).

In addition to the salary reductions of Klapholz, Kaluski, Meggs and Levin, in order to meet budget projections, Haider also instituted staff layoffs, non-renewed some faculty, did not replace vacant positions, relocated other faculty and shifted some funds to the NJMS budget line (12T156).

135. Dr. Ellise Delphin, NJMS Chair of the department of anesthesiology, was also informed at the February 2007 with administration representatives and the Bard consultants, that her department's budget was being reduced. Specifically, she was informed that her budget was reduced by \$900,000 (12T171). Eighty percent of her department's funding derives from University Hospital (12T203). Delphin was instructed that it was up to her how to make up the budget deficit, but that she would have to come up with a plan by the end of February (12T171).

At this meeting, Delphin was also given figures by the Bard consultants that broke down the salary structure of her department. She learned that several members of her department were making significantly more money than the average for other

anesthesiologists in the northeast (12T172).^{20/} In this regard, seven physicians were specifically identified - Dr. Thomas Schieble, Dr. Anuradha Patel, Dr. Melissa Davidson, Dr. Vasanti Tilak, Dr. Kaufman, Dr. Jackson and Dr. Gubenko (12T172-12T173).

136. Delphin understood that she had the authority to increase and decrease patient services salary components where necessary, and that this salary component is subject to annual review (12T187-12T188). Delphin has from time to time increased the patient services salary components of her faculty, and the AAUP has not been involved in this process (12T206-12T207). For instance, Delphin increased Tilak's clinical component by \$160,000 from \$17,214 to \$176,532 in 2002 before reducing it by \$38,000 from \$176,532 to \$138,532 in 2007 to address the reduced revenue from University Hospital for patient care activities (R-39; 12T186-12T188). Also, Delphin increased Dr. Davidson's patient services component by \$130,000 before it was reduced by Delphin from \$47,485 to \$180,964 when University Hospital reduced her department's budget in 2007 (12T180, 12T206). Prior to February 2007, however, Delphin had not reduced the patient services salary component of her faculty. During her four-year tenure as Chair, University Hospital also had not reduced funding to her department (12T207).

^{20/} Presumably, the standard used by Delphin was the MGMA 75% standard used by other Chairs at NJMS and who attended the same February 2007 meeting as Delphin.

137. Delphin spoke to Associate Dean Deborah Johnson about faculty guarantees and patient services salary components because she knew that she would have to decrease them to meet her budget target (12T175). Johnson assured her that the legal department confirmed that these two components of the salary package could be decreased because both were dependent on funding from University Hospital and with the large reduction in that funding source, these salaries could no longer be supported (CP-40; 12T171, 12T175-12T176).

In Johnson's experience, if a faculty member provided clinical services at University Hospital, his/her salary was funded by University Hospital, so if the faculty member spent 100% of his/her time at University Hospital, his/her salary would be funded 100% by University Hospital. However, there is no correlation between what University Hospital gives to NJMS for faculty compensation and the allocation of a faculty member's salary between academic base and the clinical component of salary, because the allocation depends on what activity is given to NJMS and what activity is given to University Hospital (12T11-12T14). For instance, activities related to direct patient care or supervision of residents is allocated to University Hospital, whereas teaching medical students and research are activities allocated to NJMS (12T11-12T12). Each entity would contribute accordingly toward the non-academic base component of salary (12T11-12T14).

138. In the end, Delphin notified four of the seven physicians identified by Bard as having compensation above the 75% MGMA standard - Schieble, Tilak, Patel and Davidson - that their patient services salary components would be reduced effective July 1, 2007 due to decreased funding from University Hospital for patient care service activities which was language given to her by the University administration (CP-93, CP-100; R-52, R-53; 12T180-12T181). Although Delphin was pleased with their performances and all were providing patient care at University Hospital, Delphin decided to reduce their salaries because all 4 were making at least \$100,000 more than other faculty members in the department, and she wanted to bring them more in line with other faculty salaries (12T177, 12T183-12T184, 12T198, 12T203). There was no reduction in their clinical responsibilities tied to the announced reduction to their patient services salary component (12T183-12T184).

Delphin did not reduce the salaries of the other three physicians identified by Bard for various reasons. In the case of Dr. Jackson, Delphin had already reduced his compensation by \$400,000 the previous June during negotiations for his reappointment (12T177-12T178, 12T182-12T183). Dr. Kaufman was not reduced, because he was the only faculty member providing interventional pain service. Delphin concluded that she could not afford to lose him (12T178). Similarly, Delphin determined

not to reduce Dr. Gubenko, because she felt he would leave and was too valuable to lose (12T178).

After notifying the four physicians of the reductions, Delphin received a memo entitled "Objection to Proposed Salary Reductions and Demand to Negotiate" dated June 26, 2007 from the anesthesiology department faculty (CP-94). The letter requested that the administration desist from unilaterally modifying terms and conditions of employment - salary and workload - until negotiated with the AAUP.

Below are the specific employment histories of Schieble, Tilak, Patel and Davidson - the faculty members Delphin selected for reductions in compensation.

139. Delphin recruited and hired Dr. Thomas Schieble and negotiated the terms of his offer letter dated March 21, 2003 directly with Schieble (CP-45). Schieble began the hiring process with Delphin's predecessor, Dr. Melissa Davidson. Schieble was not happy with Davidson's initial compensation offer (\$450,000 composed of an academic base of \$120,000, a faculty guarantee of \$72,000 and a patient services component of \$235,000) (CP-44) and, subsequently, negotiated a total compensation \$35,000 higher with Delphin (CP-45). Delphin's offer was also for a two-year contract, but set a total compensation of \$485,000 consisting of an academic base of \$85,330, a patient services component of \$34,670 and a two-year faculty guarantee of \$365,000. Schieble's appointment letter

explained that his patient services component was dependent upon providing patient care as assigned by the Chair. The AAUP had no role in negotiating Schieble's initial offer with the exception of the academic base salary covered by the collective agreement between the AAUP and the University (J-1, J-2).

On March 23, 2005, Schieble received an offer from NJMS Dean Joffe to renew his appointment for two years effective July 1, 2005 through June 30, 2007 under the same compensation terms as his initial appointment letter (CP-45). The renewal letter also stated that the patient services component of his salary was "dependent upon [his] providing patient care as assigned by the Chair of [his] Department. It is contingent upon satisfactory performance and is subject to change. If you receive a Faculty Practice Guarantee, the guarantee may be revised or terminated at the expiration of the guarantee period" (CP-46). The letter confirmed that even if Schieble did not sign the letter, by accepting the appointment he agreed to be bound by the terms and conditions set forth in the offer (CP-46).

After receiving CP-46, Schieble spoke to both his brother who is an attorney and to Delphin, because he was concerned about the language regarding his compensation which seemed to him to be non-committal generally and, specifically, he was concerned about the language regarding the faculty guarantee. Schieble asked Delphin if there was any reason for him to think that anything regarding his guaranteed salary would change. According to

Schieble, Delphin assured him that nothing would change (10T54). Schieble, however, did not sign the letter because the letter indicated that he would be bound by its terms (10T35). However, even though Schieble did not sign the letter, Schieble accepted the appointment. The letter indicated that by accepting the appointment, he was bound by the terms of the offer (CP-46).

In February 2007, Schieble had a discussion with Delphin, after hearing that there could be a reduction in salaries, to make sure that he was performing satisfactorily, because he wanted to make certain that whatever the proposed salary cut would be, it would not be performance-based. Delphin assured him that given the way things had been with renewal terms in the past nothing was expected to change (10T57). However, at a department faculty meeting in March, Delphin announced the \$900,000 cut to the department budget, and that she would have to reduce salaries of selected faculty (10T40).

Schieble again confronted Delphin about his salary and was told that it would probably be cut, because he was one of the highest paid members in the department and that his salary would be reduced to meet the MGMA 75% standard (10T42). Schieble felt that the standard was not a fair one in light of his superior academic training - e.g. he considered himself above the 75%. Schieble also decided that if his salary was cut, he would probably leave (10T42-10T43).

On June 25, 2007, he received notification from Delphin that effective July 1, 2007 his faculty practice salary component would be reduced from \$365,000 to \$244,807 due to decreased departmental funding from University Hospital (CP-48; R-52). Since Schieble's appointment letter (CP-45) listed a faculty practice guarantee of \$365,000 and does not list a faculty practice salary component, it is unclear whether the reduction was to a faculty practice component or to a faculty practice guarantee. Schieble's reappointment letters (CP-46 and CP-47) are for a specified two-year term but do not set out his specific compensation, although the letters refer in generic terms to participation in the UPA faculty practice plan.

At about this same time, Schieble received an offer from Dean Johnson to renew his appointment for two years containing similar language to CP-46. The offer did not specify compensation amounts (CP-47). Schieble did not sign or return the letter because of the uncertainty throughout the University about the salary reductions (10T37-10T38). Also, by this time, he received an e-mail from the AAUP instructing its members not to sign the letters until they discussed it with them (10T60).

In July 2007, Schieble was relieved of his title as Director of Pediatric Anesthesiology due to missed opportunities within his division (10T44). Schieble did not understand this explanation and, even after meeting with Delphin, was given no further clarification (10T45). As of August 2007, the date

Schieble testified in this matter, his salary had not been reduced (10T46).

140. Dr. Anuradha Patel was hired in 1998. The AAUP was not involved in her initial salary negotiations (12T87). In 2002, Patel was going to leave NJMS for private practice, but instead was promoted to director of anesthesiology by then interim Chair Melissa Davidson (Delphin's predecessor) and negotiated a new employment agreement with Davidson, including a salary of \$400,000 (CP-92; 12T71, 12T73-12T75). Patel's salary was guaranteed for 5 years effective November 15, 2002 (CP-92). Patel's salary consisted of an increase in the patient services salary component from \$17,372 to \$242,044, an academic base of \$85,956 and a faculty practice guarantee of \$72,000. The AAUP was also not involved in these negotiations (12T87).

Subsequently, Patel received a reappointment letter dated December 31, 2002, from Dean Joffe approving the new salary terms negotiated with Davidson (R-46). The reappointment letter stated that the appointment was effective from November 15, 2002 through June 30, 2008 (R-46)^{21/}. As to the patient services component of her salary, Joffe confirmed that it was dependent upon providing

21/ It is unclear why CP-92 covers a five-year period from November 15, 2002, while Joffe's letter (R-46) appears to cover a different period of time from November 15, 2002 through June 30, 2008 (R-46). For purposes of my decision, this fact is not material.

patient care as assigned by the Chair and was subject to annual review.

Patel learned at the general faculty meeting in March 2007 that there was a deficit and that there would be salary reductions (12T77). Delphin called Patel into her office to explain that based on recommendations of the Bard group, certain faculty, including Patel, had been identified for salary reductions and that Patel would have her salary reduced by \$50,000 (12T78). Patel was notified formally of the reduction to her patient services component on June 25, 2007, when she was given a memo that this component of her salary would be reduced from \$242,044 to \$174,044 due to decreased departmental funding from University Hospital for patient care service activities (CP-93; 12T79).

According to Patel, Delphin indicated that although she was very pleased with Patel's performance and felt badly about the reduction, her hands were tied (12T80). Patel told Delphin that she hoped that the decrease was going to be effective for all faculty members who were making as much or more than Patel (12T80). Delphin assured her that was the case (12T80). Subsequently, however, Patel learned that certain members of the faculty, making much more than her, were not having their salaries reduced (12T81). When Patel confronted Delphin, she was told that their salaries would be reduced effective December 2007 (12T81).

Both in March 2007 when Patel first learned of the salary reduction and then again after receiving CP-93 in June, Patel notified AAUP Executive Director Alex Bernstein. Bernstein met with the department faculty about sending a memo to Delphin protesting the reductions as well as decreased funding for on-call payments (CP-94). With the exception of this meeting, Patel has never had AAUP representation when, in the past, she has raised concerns about changes to her salary with her Chairs (12T91-12T92).

Patel also sent Delphin a memo from herself dated June 27, 2007 entitled "Notice of Reservation of Rights" (CP-45) in which Patel protested the salary reduction and reminded Delphin that she had a five-year commitment based on CP-92 guaranteeing her salary at least until November 15, 2007 (CP-95; 12T84). Patel received no reply from Delphin to CP-95, but since the notification of the reduction, Patel's workload has increased because three faculty members left the department and have not been replaced. Also, four more faculty members have handed in their resignations (12T85).

In August 2007, during Patel's annual performance review, Delphin indicated that she was very pleased with Patel's performance and was attempting to avoid implementing Patel's salary reduction (12T86).

141. Delphin also reduced the patient services salary component of Dr. Vasanti Tilak (CP-36) from \$176,532 to \$138,532

effective July 1, 2007 due to decreased funding from University Hospital for patient care service activities (CP-36; R-39; 9T15). When Tilak was hired in 1985 (R-39 at UMD 1534)^{22/}, her then Chair, Dr. Wu, unilaterally set her compensation. There was no negotiation (9T21). The AAUP was not involved in the hiring process (9T23). Indeed, in all of her letters of appointment, Tilak has never negotiated how her compensation is set or allocated (9T8-9T9, 9T22).

At different points in her career, Tilak's patient services salary component was increased and/or reduced by her Chair without negotiation with either her Chair or the AAUP (9T30, 9T37). For instance, Tilak was promoted in 1986 and her academic base was increased while her patient services component was reduced by her Chair and without AAUP involvement (R-39 at UMD 1533). At another point in her career from January 1989 to June 2002, Tilak's patient services component was reduced when she went from full-time to part-time employment status (9T10).

In October 2004, Tilak was made division chief of general anesthesiology. Delphin increased Tilak's salary. The amount of the raise was set unilaterally, not negotiated by Tilak, nor did the AAUP participate in the salary change (R-39 at UMD 1497, 9T23-9T24). Like other physicians' appointment and reappointment letters, the receipt of her patient services salary component was

^{22/} UMD refers to a page in the multi-page exhibit.

dependent on patient care, contingent on satisfactory performance and subject to change (R-39 at UMD 1497). Also, like Schieble and Patel who also accepted appointment/reappointment letters containing this language, Tilak interpreted the phrase "subject to change" to mean that any change was tied to her performance, but she never confirmed that understanding with the administration or Dean's office (9T33).

Tilak learned in March 2007 at a departmental meeting that there were University-wide budget cuts and that, specifically, her department was losing \$900,000 in funding from University Hospital (9T11-9T12). Delphin explained that she was going to deal with the cuts in two ways: (1) reduce salaries of some faculty who were making significantly more money than the rest of the department and (2) reduce on-call pay (9T12-9T13). The on-call pay was never changed after the faculty signed a petition protesting the decision (9T14). Delphin, however, told Tilak at a meeting with her in April 2007 that her salary would be reduced by \$38,000 because of the budget cuts (9T14). Tilak's duties would not change nor was Delphin unhappy with her performance (9T15). Tilak knew that her salary was one of the highest in the department (9T20). In late June 2007, Tilak received formal notification (CP-36; R-35) that as of July 1, 2007, her patient services salary component was being reduced due to decreased funding from University Hospital for patient care activities.

After receiving notice of the reduction, Tilak sent Delphin a memo (CP-37), entitled "Notice of Reservation of Rights", protesting the decrease because of her current appointment letter effective from July 1, 2006 through June 30, 2008, and because the reduction might be inconsistent with the AAUP collective agreement and past practices.

Tilak had never been told that her salary could be reduced for budgetary reasons. She always understood that a reduction was possible based on performance or if she reduced her hours of work, but her performance reviews were always satisfactory (9T34-9T36). Despite the notice of reduction, to date, her salary has not been reduced (9T19).

142. Finally, Delphin reduced the patient services component of Melissa Davidson who was Delphin's predecessor and held the title of interim Chair until her return to her faculty title in March 2003 (R-50; 12T204). In March 2003, Davidson was promoted to Assistant Dean for Graduate Medical Education, a title not covered by the AAUP collective agreement (J-1, J-3; R-58). Sometime after Davidson's promotion, Delphin increased Davidson's patient services salary component from \$47,485 to \$180,964 to reflect her new administrative and leadership functions within the department (CP-100; R-50; 12T208-12T209). In June 2007, Davidson was notified that her patient services salary component would be reduced by \$45,000 due to decreased

funding from University Hospital for patient care service activities (CP-100).

Reductions in Faculty Practice Salary Components at RWJMS

143. On March 29, 2007, Dr. Lewis Reisman in the department of pediatrics at RWJMS was notified by his then Chair, Dr. Dan Notterman, that the clinical component of his salary would be decreased by \$30,000 effective May 1, 2007 "in conjunction with alignment of faculty practice supplement with faculty practice activity" (CP-88; R-96). This was the first time that his faculty practice salary component had changed since he was hired (11T187).

Notterman hired Reisman in April 2003 at a salary of \$200,000 composed of an academic base of \$140,000 and a faculty practice component of \$60,000. Reisman's principal responsibilities, as set out in his offer letter, were to provide clinical care to pediatric nephrology patients, to teach and to participate in clinical research (CP-86, CP-87). Reisman negotiated these terms with Notterman and without AAUP involvement (111T78-111T79, 11T196).

When Reisman received his offer letter and saw the breakdown in his salary - academic base and faculty practice income - he spoke to Notterman and asked him if his salary was contingent on patient billing income. According to Reisman, at that time, Notterman said it was not dependent (11T187). In discussions

over the years, however, Notterman told Reisman that he expected him to see a lot of patients. Notterman also expressed concern that when the department hired a third physician, there was not sufficient income to cover that person (11T188).

Notterman met with Reisman on March 29, 2007 when he gave him the memo (CP-88) informing Reisman of the reduction to his salary. Notterman explained to Reisman that the department was experiencing a budget deficit, and that Reisman individually and the department in general was not seeing enough patients or generating enough billing to cover salary and expenses. Notterman suggested that the department could only support two positions, not the three positions it had (11T189-11T190, 11T201-11T202).

Reisman contacted the AAUP and sent a letter on April 10, 2007 to Notterman objecting to the proposed salary reduction and asserting that his faculty practice income was protected by the AAUP collective agreement, his individual contract and/or New Jersey labor law (CP-89). Reisman also retained a private attorney and filed a Notice of Claim against the University alleging a breach of his individual employment contract (R-45).

Since the reduction in his salary, Reisman's responsibilities have not decreased (11T193). His employment contract that expires in June 2008 has not been renewed (11T194).

144. Dr. Anthony Vintzileos has been Chair of the OBGYN department at RWJMS since December 2002, although he has been

employed by the University since 1993 (10T63-10T64). As Chair, Vintzileos is responsible for hiring faculty and negotiating their compensation. When he was appointed as Chair, the Dean explained to Vintzileos that when hiring faculty, he had to explain to the individual that there are two and sometimes three components of his/her compensation - (1) an academic base fixed by the AAUP collective agreement, (2) a faculty practice income derived from the billing and collection activities of the faculty member in treating patients and (3) incentives such as night call, productivity bonuses or faculty guarantees (10T84-10T85). In the OBGYN department, most faculty have the first two components of compensation and a few have the third component (10T85).

Faculty practice income is very important to the department. It is the major source of income for the department. Vintzileos explains this to prospective hires (10T102-10T103). In their letters of appointment, faculty are informed that faculty practice income is contingent upon satisfactory performance and subject to change, meaning that it is subject to change depending upon how much money the department makes in the faculty practice (10T104-10T105). Vintzileos has increased faculty practice income depending on market forces such as an increase in specialists in the area or if the faculty member brings something unique to the department (10T67). Prior to February 2007, Vintzileos had never decreased faculty practice income (10T81).

In February 2007, RWJMS Interim Dean Dr. Peter Amenta told Vintzileos that there was not sufficient revenue to fund his department and requested him to present three different budget plans reflecting cuts of five, ten and twenty percent to the OBGYN departmental budget (10T70, 10T81). Amenta was very concerned with the substantial amount of money being lost by the OBGYN department which had been running a deficit for four and a half years (9T61-9T62, 10T109). The reductions were to take place by March 1, 2007 (10T70).

After giving Amenta the three different plans, Amenta selected the plan reflecting a five percent or \$370,000 cut to the department budget (10T69). The faculty were told that a departmental review of faculty compensation would be conducted due to a lower than anticipated volume of clinical services being provided by the department (9T62).

Vintzileos needed to determine how to implement a \$370,000 budget cut and initially decided, for many reasons, not to implement a 5% across-the-board salary reduction (10T76). The department owed \$20,000 from the previous year to Dr. Patel for on-call night duty, so Vintzileos paid this amount first (10T75-10T76). Vintzeleos then reviewed faculty offer letters that were less than three years old, because he did not want to go below the initial compensation offer even though Vintzeleos considered that the offer letters clearly alerted the faculty to

expect a change in the faculty practice component of their salaries, if it became necessary (10T74-10T77).

Vintzeleos also did not want to reduce faculty members who took on-call night duty, because he felt that such an action would compromise patient care coverage by reducing hourly rates below fair market value (thus making it difficult to get coverage) and by taking away the only source of income from some of these physicians (10T69-10T70, 10T109). Finally, Vintzileos did not want to reduce the salaries of several faculty members for specific reasons - e.g. (1) Dr. Yinka Oyelese had just entered into a one-year contract, (2) Dr. Carrabello was engaged in practicing an extremely rare specialty that Vintzileos did not want to lose, and (3) Drs. Martin Cervez and Wendy Kinzler also practiced rare specialties in maternal fetal medicine and ran informational network imaging and pregnancy loss services (10T73-10T74).

After accounting for these considerations, Vintzileos reduced the salaries of 25 faculty members in varying amounts (CP-49 through CP-73; 10T67-10T68, 10T71, 10T80-10T95). ^{23/} He

23/ The faculty practice salary components of the following RWJMS faculty in the OBGYN department were reduced (CP-110): Adrian Balica, Steven Berkman, Pamela Brug, Joseph Canterino, Ru-Fong Chen, Joseph Cioffi, Francis Cioffi, Eumena Divino, Gary Ebert, Steven Feld, Carlos Fernandez, Gregg Giannina, Steven Goldberg, Glenn Hernan, Marianna Herrighty, Susan Janeczek, Maria Martins, Paul Matta, Myriam Mondestin-Sorrentino, Michael Muench, Archana Pradhan, Marlene Schwebel, William Scorza, Owobamishola Shonowo, Lami
(continued...)

reduced his own salary by the greatest amount (10T74). This was the first time that Vintzileos was involved in decreasing salaries (10T81).

Letters dated February 26, 2007 were sent to the faculty members informing each of the amount of the faculty practice salary component reductions and attributing the decreases to Amenta's instruction to reduce the department's 2007 budget (CP-49 through CP-73).^{24/} Putterman requested that Vintzileos provide her with a further explanation of the decreases. Vintzileos reviewed R-29, Putterman's reasons for changes in faculty clinical salary components.

On April 12, 2007, Vintzileos and Amenta sent Putterman a memo explaining that the reductions were "due to extremely decreased departmental faculty practice revenue collections

23/ (...continued)

Yeo. The AAUP submits in its brief that the reductions were for the limited period of March 1, 2007 through December 31, 2007, at which time they were restored. This was not a fact that was introduced at the hearing in this matter and, therefore, I do not consider it in my decision.

24/ Two of the 25 faculty members, Dr. Pamela Brug and Dr. Ru-Fong Cheng, received a letter from Amenta that they were being promoted effective July 1, 2007 (CP-74, CP-75). Vintzileos was not aware of Amenta's letters at the time that he made his decision to decrease their faculty practice salary components, but it would not have mattered to him (10T96-10T97). When he hired Brug and Cheng, her appointment letter explained that their faculty practice salary components were contingent upon satisfactory performance and subject to change (R-41, R-42; 10T103-10T104). Also, as far as Vintzileos was concerned, his proposed decreases took place before the effective date of the promotions (10T97-10T98).

available for distribution to participating faculty" (R-43).

Vintzileos then sent a second letter on April 23, 2007 to the 25 faculty members containing the explanation that he had sent to Putterman (CP-110; 10T82).

In addition to the 25 faculty members and himself, three administrators who were not represented by the AAUP had their salaries reduced by at least five percent (10T108-10T109). The salary reductions took effect March 1, 2007, but were only reflected in the June 1, 2007 paychecks as retroactive adjustments of salary (CP-76, CP-110; 10T99-10T100). There have been no reduction in clinical responsibilities as a result of the decreases in salary (10T101).

ANALYSIS

CO-2005-220 and CO-2007-271

N.J.S.A. 34:13A-5.3 authorizes the majority representative to negotiate terms and conditions of employment on behalf of unit employees. Patient services and faculty practice components are part of a faculty member's compensation at the University's three medical schools; compensation is a negotiable term and condition of employment. Hunterdon Cty. Freeholder Bd. and CWA, 116 N.J. 332, 338 (1989); UMDNJ, P.E.R.C. No. 2001-31, 27 NJPER 28 (¶32015 2000) (UMDNJ II).

Section 5.3 also defines when an employer has a duty to negotiate before changing working conditions:

Proposed new rules or modifications of existing rules governing working conditions shall be negotiated with the majority representative before they are established.

The Commission has held that changes in negotiable terms and conditions of employment, therefore, must be addressed through the collective negotiations process, because unilateral action is destabilizing to the employment relationship and contrary to the principles of our Act. Middletown Tp., P.E.R.C. No. 98-77, 24 NJPER 28, 29-30 (¶29016 1997), aff'd 334 N.J. Super. 512 (App. Div. 1999), certif. granted, 166 N.J. 112 (2000). The Act, however, requires negotiations, not necessarily agreement. Hunterdon Cty.

Employment conditions arise not only through the parties' collective agreement, but also through established practice. An established practice arises "from the mutual consent of the parties, implied from their conduct". Caldwell-West Caldwell Bd. of Ed., P.E.R.C. No. 80-64, 5 NJPER 536, 537 (¶10276 1979), aff'd in pt., rev'd in pt. 180 N.J. Super. 440 (App. Div. 1981). An employer violates its duty to negotiate when it changes an existing practice, unless the majority representative has waived its right to negotiate. Red Bank Reg. Ed. Assn. v. Red Bank Reg. H.S. Bd. of Ed., 78 N.J. 122, 140 (1978); Middletown Tp. For instance, if the employee representative has expressly agreed to a contractual provision authorizing the change or if it impliedly accepted an established past practice permitting similar actions

without prior negotiations, no violation will be found.

Middletown Tp. See also, South River Bd. of Ed., P.E.R.C. No. 86-132, 12 NJPER 447 (¶17167 1986), aff'd NJPER Supp. 2d 170 (¶149 App. Div. 1987) (employer not obligated to negotiate teacher salary reduction where Board acted pursuant to parties' prior conduct); State of New Jersey (Stockton State College), P.E.R.C. No. 90-91, 16 NJPER 260 (¶21109 1990) (no 5.4a(5) violation where employer unilaterally restored stipend in absence of past negotiation demands, although 5.4a(3) violation found where stipend withdrawn in retaliation for negotiation demand).

In the latter instance, the employer had every reason to believe, based on the representative's response to past actions of which it was notified, that it would not object to similar actions. Monmouth Cty. Sheriff, P.E.R.C. No. 93-16, 18 NJPER 447, 449 (¶23201 1992). If the employer has proven that the representative, by its actions, has waived the right to negotiate, the employer has the right to make the change unilaterally. Middletown Tp. The employer in that instance has maintained the status quo, and no negotiations obligation is triggered.

Even where the status quo is maintained, there may be an obligation to negotiate prospectively over the term and condition of employment that is the subject of the practice. Negotiations obligations arising from such a demand, however, are waived where the parties have fully discussed and consciously explored the

subject during collective negotiations - e.g. proposals are exchanged and withdrawn. In such instances, zipper clauses and fully-bargained clauses may act as express waivers of the right to negotiate for the term of a current agreement. Deptford Bd. of Ed., P.E.R.C. No. 81-78, 7 NJPER 35 (¶12015 1980), aff'd NJPER Supp. 2d 118 (¶98 App. Div. 1982); Tp. of Verona, P.E.R.C. No. 84-41, 9 NJPER 655 (¶14283 1983); City of Newark, H.E. No. 88-10, 13 NJPER 698 (¶18261 1987).

The parties do not dispute these legal principles. They disagree as to what the parties' past practice is regarding modifications to faculty practice and/or patient services salary components, also known as clinical components of salary, whether the status quo was changed, and whether the AAUP waived its right to demand mid-contract negotiations regarding these salary components absent a change in the past practice.

The University maintains that for the past 23 years, Department Chairs have unilaterally increased, decreased or eliminated clinical components of salary for many reasons that it alone determined were valid, with or without the agreement of the affected faculty member, and always without the participation of the AAUP, even though it has routinely notified the AAUP of such changes in monthly reports sent to the AAUP. The University specifically argues that its actions, in eliminating Dr. Sanford Klein's faculty practice component in 2004 and in reducing the clinical components of faculty at NJMS and RWJMS in 2007, conform

to the parties' past practice. Therefore, no negotiations were required because it has maintained the status quo.

Additionally, even though the University recognizes the right of the AAUP to negotiate prospectively on the subject of clinical salary components, it contends that, in this instance, the AAUP waived mid-contract negotiations rights by its implied and express conduct, namely by permitting similar actions in the past without prior negotiations and by its conduct during negotiations for the parties' current collective agreement. The University concedes that the AAUP can propose modifications to the existing practice in negotiations for a successor agreement.

The AAUP contends, however, that by past practice clinical components are set upon hire and are fixed components of compensation that are reduced or eliminated under limited individualized circumstances for valid reasons, such as a change in work hours from full-time to part-time, reduced commitment to a clinical activity where the activity is a basis for the compensation, and a realignment of compensation between components with no overall change in compensation. The AAUP contends that negotiations are required immediately because the University changed the parties' past practice, when it modified the clinical components of Dr. Sanford Klein's salary in 2004 and of faculty at both NJMS and RWJMS in 2007, without individualized changes in their circumstances.

Specifically, it asserts that the University has never before unilaterally eliminated the clinical salary component of a faculty member, such as Dr. Sanford Klein, when that component of compensation had been treated as part of his overall, pensionable compensation for over 20 years without regard to the level, if any, of his clinical activities. The AAUP also contends that, as to the reductions in 2007, the University has never before targeted clinicians for reductions in clinical salary components based on budget shortfalls.

Finally, the AAUP argues that it has not waived its right to negotiate either by its implied or express conduct. It contends that prior to the elimination of Klein's clinical salary component, the University made modifications to clinical components that the AAUP accepts were valid reasons consistent with past practice. Therefore, its silence does not support that it waived its right to demand negotiations prospectively, if the University changed the existing practice as the AAUP understood it to be. Also, during recent collective negotiations, it agreed to maintain the status quo as represented by the past practice in exchange for new notification procedures regarding modifications to clinical salary components and the University's assurance that Dr. Karen Putterman would review and approve changes to clinical salary components made for valid reasons consistent with past practice. The AAUP asserts, however, that it never waived its right to challenge a change to the status quo as represented by

the parties' past practice or to demand negotiations if there was such a change.

Based on the parties' respective positions, the central issues in these charges are: (1) what is the parties' past practice regarding the setting of and modification to faculty practice and patient services components of salary; (2) did the University change the parties' past practice, thus altering the status quo, when it unilaterally eliminated and/or reduced the faculty practice and patient services salary components of Dr. Klein in 2004 and faculty members at NJMS and RWJMS in 2007; and (3) has the AAUP impliedly or expressly waived its right to negotiate mid-contract over modifications to these components of salary by its acceptance of such unilateral changes in the past without a demand to negotiate and/or by its actions during recent collective negotiations in accepting the University's offer of a notification procedure and withdrawing its proposals on clinical salary components.

Having considered witness testimony and documentary evidence presented in this hearing, I conclude that the parties' practice has been and is that the University modifies (increases, decreases and/or eliminates) faculty clinical salary components (both patient services and faculty practice components) for many reasons, reasons that the University solely determines are valid, including, but not limited to, changes in individual circumstances such as going from full-time to part-time status,

as well as for budgetary reasons such as decreased revenues from funding sources such as faculty practice income; and the elimination and reductions in clinical salary components at issue here were consistent with the parties' past practice - the status quo was not changed by the University's actions. Further, the AAUP expressly and impliedly waived its right to negotiate mid-contract over patient services or faculty practice salary components by its actions both in the past - e.g. acquiescing to the University's conduct - and during negotiations for the 2004-2009 collective agreement wherein it withdrew its proposals regarding clinical salary components in exchange for a new notification procedure and concessions in the collective agreement.

The Parties' Past Practice

Although the parties' collective agreement sets the academic base salary of faculty at the three medical schools, it is silent on the subject of setting or modifying faculty practice and patient services salary components.^{25/} Thus, the parties' past

^{25/} Two side letters of agreement incorporated into the parties' collective agreement pertain to clinical salary components but are not germane to this decision, because the agreements do not touch on the setting or modifying of clinical components at issue here. One side letter exempts clinical components from across-the-board increase to academic base, and the other prohibits substituting clinical components, referred to as non-negotiated components of faculty salary) for increases to academic base (J-1; J-3).

practice controls and sets the employment condition in regard to this form of compensation. Middletown Tp.

In UMDNJ, P.E.R.C. No. 2002-53, 28 NJPER 177 (¶33065 2002) (UMDNJ I), the parties litigated almost the identical issues before me in this matter with some notable distinctions, mostly related to the issue of express waiver, in particular regarding the parties' conduct during negotiations for the current 2004-2009 collective agreement. In UMDNJ I, the Hearing Examiner determined, and the Commission concurred, that the University acted consistently with its 15-year practice of increasing, decreasing and eliminating clinical salary components unilaterally without negotiations with the AAUP, when it reduced the patient services salary component of Dr. Stanley Weiss, an associate professor in the NJMS department of preventative medicine and public health.

When Weiss was hired, his salary comprised an academic base and a "dean's faculty practice component" of \$15,000. The faculty practice component was not funded by the department, but came from an outside source presumably arranged for by the Dean's office. Weiss learned at some point that his faculty practice component would expire and his salary would be reduced unless an alternate funding source was found. His Department Chair committed to picking up the \$15,000, but urged Weiss to apply for grants to cover the expense.

In 1993, when Weiss was granted tenure, his appointment letter gave him an academic base salary and for the first time referred to a patient services component of \$15,000. Unlike previous appointment letters, the component had no expiration date, so Weiss assumed that it was permanent. This component was funded out of department "soft money" (money generated from grants); there was, however, no permanent source of funding. For a couple of years, Weiss' Chair, Dr. Louria, continued to pay the \$15,000 despite the fact that Weiss did not offset the money with grants. In November 1996, Louria advised Weiss that the department could no longer afford to offset the monies and that his patient services component would be reduced by half.

The AAUP filed its charge alleging that the University unilaterally changed the parties' past practice when it reduced Weiss' patient services component, because as a matter of practice, it asserted, unit members' patient service components had not been reduced absent a change in contractual status. The AAUP also asserted that the change was coercive because the reduction came during negotiations for a successor agreement.

The Hearing Examiner concluded that since the AAUP had never requested negotiations over non-contractual faculty stipend modifications, the University had a reasonable expectation that it did not have to negotiate before reducing Weiss' salary. The Hearing Examiner recognized the University's 15-year practice of unilaterally increasing, decreasing or eliminating faculty

stipends. She also found that the AAUP waived its right to negotiate changes to clinical salary components through its inaction when notified of the unilateral changes in the past. The Commission agreed with the Hearing Examiner and determined that the employer acted consistently with its past practice. Having found no violation based on unilateral change in past practice, the Commission did not reach the waiver issue.

Here, the evidence supports that the past practice as described in UMDNJ I had not changed. The existing practice is that Department Chairs negotiate with individuals, upon hire, their total compensation package, composed of an academic base salary as well as a faculty practice and/or patient services components of salary (clinical salary components). Faculty practice and patient services components are allocated, at least in part, for patient care activity, although there is no specific formula tied to how many patients are treated versus the amount of the component received. Sometimes the faculty member is also given what is known as a faculty practice guarantee that ensures a level of income for a finite period of time. The clinical salary components are often used to bring salary offers to a competitive rate to entice faculty to accept employment with the University. These components of salary, therefore, vary widely among faculty.

The AAUP is not involved in the hiring process or the initial setting of a faculty member's compensation, with the

exception of the negotiated academic base salary. The terms of the faculty member's employment are set out in appointment letters and, subsequently, in reappointment letters signed by the faculty member and the Administration. The AAUP is also not a party to negotiations regarding reappointment letters except to the extent that the collective agreement sets the academic base and other terms and conditions of employment.

The evidence supports that after hire, clinical salary components are frequently modified - mostly increased, but occasionally reduced or eliminated - by the Chairs with or without the agreement of the affected faculty member for a variety of reasons and without the involvement of the AAUP, although the AAUP is notified in monthly reports of the modifications. These reports contain information about the modifications, but occasionally it is not possible to ascertain, from the information provided, the reason for the modification. For instance, if the report indicates that a change in FTE (full-time equivalent) is connected to the modification of the clinical component, then the reason is attributable to a change in hours worked. Whereas, a modification to a clinical salary component attributable to discontinuation or participation in a particular clinical activity would not be reflected in the information provided to the AAUP.

The University's Academic Affairs Office prepares the monthly reports from information it gleans from the faculty

transaction forms authorizing the changes. It transmits the reports to the AAUP Executive Director who gives the monthly report to his/her assistant for in-putting into a data base. Unless the assistant has a question or a faculty member calls to inquire about a change in his/her salary, the AAUP does not seek additional information regarding the reason for the change or request negotiation of the modification to the clinical salary component. The AAUP had not changed its method of monitoring changes to faculty clinical salary components after the issuance of UMDNJ I.^{26/} Its procedures in this regard were not modified.

Specifically, the AAUP did not heighten its oversight or increase its monitoring of the changes to clinical salary components, by seeking explanations for the changes or additional information where the reasons for the changes could not be gleaned from the information provided in the monthly reports. Indeed, other than the change in Dr. Stanley Weiss' salary considered by the Commission eight years ago in UMDNJ I, the AAUP had not raised an objection to or requested negotiations for any

^{26/} In UMDNJ I, former AAUP Executive Director Joyce Orenstein testified that she received personnel summary sheets detailing personnel actions including faculty salary changes and specifically changes to patient services components. Upon receipt of the summary sheets, Orenstein gave the sheets to her assistant to review to determine who was added to the unit and to ascertain their academic base salary. Orenstein herself did not routinely review the summary sheets unless her assistant noticed a problem with a change in salary or had a question nor did she track changes in clinical components because it was her understanding that the components did not change.

changes implemented by the University to faculty clinical salary components until the elimination of Dr. Sanford Klein's faculty practice salary component in 2004 and until the 2007 reductions to the clinical salary components of seven faculty members at NJMS and 26 faculty members at RWJMS.

R-10 in evidence are the monthly reports submitted to the AAUP from June 2002 to December 2004. R-10 supports that during this time frame there were over 100 changes to patients services salary components and over 300 changes to faculty practice salary components. The changes encompassed increases, decreases and elimination of the components. At least 50 faculty members during this time experienced a reduction or elimination of their clinical salary component, including Dr. Sanford Klein. With the exception of Dr. Klein, the AAUP neither objected nor sought to negotiate over these changes.

Additionally, a review of these reports illustrates that changes were made for a variety of reasons, including but not limited to, changes in FTE, appointment, promotion, resignation, non-reappointment, retirement, leaves, merit increases, paid status change, out of cycle increases, and corrections. Sometimes, salary was simply moved from one funding source to another as where the faculty practice salary component of a faculty member was reduced while his/her patient services salary component was increased so that overall compensation remained the same. The University specifically cited several instances where

reductions to clinical salary components were made as a result of lower than expected productivity levels related to clinical activities, - e.g. Drs. Mehta, Croff, Schutzer, and Vasseur.^{27/} All of the reasons for the modifications to clinical salary components, however, were determined by the Department Chairs with or without the approval of the faculty member, but always with the approval of Dr. Karen Putterman or her representatives from the office of academic affairs.

The AAUP now seeks to frame the issue before me by characterizing the past practice differently from what the facts and evidence support. The AAUP contends that once set, clinical components are an essential part of compensation that remain unchanged throughout a clinician's career. It further asserts that unit members understand that clinical components can be reduced under only certain limited circumstances, such as: (1) a unit member's transfer from full-time to part-time status, (2) a reduction in clinical activities where clinical activities are the basis for receiving the clinical component, and (3) where monies are transferred from one salary component to another without a change in total compensation. The AAUP characterizes these acceptable instances as individualized changes in

^{27/} The AAUP asserts that these changes to clinical salary appear to be consistent with its understanding of the parties' past practice, namely the reductions were made for valid reasons related to unique individualized circumstances of the particular faculty member.

circumstance. This description of the past practice regarding changes to clinical components is not supported by the record.

First, the evidence supports that clinical components were frequently changed. Mostly the changes involved increases but a significant number of changes involved reductions to those salary components. R-10 in evidence suggests that the clinical salary components did not remain unchanged throughout a clinician's career.

Next, Karen Putterman, who, as Vice President of Academic Affairs, has approved all changes in faculty salary since 1999, credibly testified that in her 20 years with the University, the practice has never been to negotiate with the AAUP over any changes in clinical components of salary, particularly the reasons for those changes. Putterman's experience was that the Chair could make changes to patient services and faculty practice components based reasons they alone determine to be valid and without a requirement to negotiate or obtain the permission of the faculty member, although on occasion Chairs do negotiate individually with faculty members.

If the faculty member disagreed with the Chair, he/she had recourse to the Dean. Once the Chair and the Dean were in agreement about the proposed change, Putterman checked that there was a valid reason for the change - that it was not arbitrary - by reviewing the information given to her by the Chair, seeking additional information if necessary, and by relying on her 20

years of experience, her sense of fair play and her knowledge of the purpose of both patient services and faculty practice salary components. The list of reasons, she considered to be valid in the past and approved, were numerous, including, among other reasons, individual productivity changes and decreased faculty practice revenue collections as well as discontinuation of a faculty practice guarantee and decreased clinical or administrative duties (R-29).

In support of its hypothesis that the parties' practice was that reductions in clinical salary components were made for limited individualized reasons, the AAUP relies on statements that Putterman made during negotiations and on an internal confidential memo she prepared during negotiations (CP-33; R-22) to summarize the University's and Dean's positions on the various AAUP proposals. These arguments are not persuasive.

First, during negotiations for the 2004-2009, when discussing the parameters of the past practice, AAUP Chief Negotiator Schorr repeatedly gave an example of when it would be valid to reduce a clinical salary component, citing when a faculty member goes from full-time to part-time employment. Putterman agreed that this would be a valid reason. Her statements, however, do not support the AAUP's contention that this was the only reason Putterman considered to be valid. It was only an example of one reason, she agreed would be valid to support such a reduction.

As to the internal memo, in it Putterman refuted the AAUP's belief, as expressed during negotiations, that patient services components are reduced arbitrarily for inappropriate reasons. Putterman wrote that based on her review of modifications over an 11-month period, there were only 11 reductions to patient services components, and all were based on valid reasons, such as "transfer of clinical activities to the VA, reductions of clinical activities or hours, moving patient services money into another salary component with no overall decrease in salary, or prior contractual agreement with the faculty member" (CP-33; R-22). Like Putterman's statements, the memo only confirms that the reasons articulated in her memo were valid reasons in her opinion, not that these were the only reasons she considered to be valid or were the only reasons that were given and approved in the past to reduce clinical salary components.

Finally, the AAUP also asserts that because Putterman provided to the Deans and Department Chairs a list of reasons (R-29) she considered to be valid for modifying clinical components in conjunction with new notification procedures agreed to in negotiations for the 2004-2009 collective agreement, there were only a limited number of reasons for modifications that could be valid. However, the testimony supports that R-29 was only a guide and not a definitive or finite description of the reasons for modifying clinical salary components.

Based on these facts, I concluded that the past practice is that the University, through its Department Chairs, unilaterally increased, decreased and/or eliminated both faculty practice and patient services salary components of individual clinicians for many reasons considered by the Chairs and the University to be valid.

Setting aside specific examples provided by Dr. Putterman of changes to clinical salary components she approved that were outside the specific reasons described by the AAUP as the only reasons it considered to be valid and consistent with past practice, and setting aside the exhibits establishing that changes to patient services and faculty practice components were made frequently, the specific reasons that propelled the Chairs and Administration to approve modifications to clinical salary components are not the real issue. The fact that the University through its Department Chairs solely and unilaterally determined valid reasons for modifying these salary components is at the heart of the matter before me. That is the practice of the parties.

Dr. Anthony Boccabella, one of the AAUP's chief negotiators in recent collective negotiations, confirmed that when the AAUP came to the bargaining table for the recent collective negotiations, he understood that the University's practice regarding modifications to clinical salary components was a quagmire controlled by the University. There was no uniformity

in how clinical salary components were set or modified.

Boccabella described faculty being treated differently by Chairs as to each other within a department or as between departments and/ or between medical schools. According to Boccabella, the AAUP sought in negotiations to get the University to define what it was doing.

AAUP Executive Director Osofsky was also concerned going into negotiations that Department Chairs made arbitrary changes to clinical salary components. Dr. Catherine Monteleone, who was on the AAUP advisory committee for the negotiations, testified that the AAUP was concerned that the Administration would take it upon itself to make changes to clinical salary components without a reason or, at least, a reason that had been negotiated with the AAUP.

This testimony supports that the past practice was that the University solely determined the reasons for reducing or eliminating clinical components (the AAUP does not appear to be arguing that it sought or seeks to negotiate how the University awards increases clinical salary components). That is the parameter of the past practice which has not changed since UMDNJ I. The AAUP, therefore, sought in negotiations for the current agreement to impose limits and criteria regarding modifications to these salary components, particularly reductions to clinical salary components, similar to what it had successfully achieved regarding academic base.

The issue remains whether the elimination of Dr. Klein's faculty practice component in 2004 and the reduction to the clinical components of faculty at NJMS and RWJMS in 2007 deviated from the parties' past practice. I find that the University acted in all instances consistently with the parties' past practice - the status quo was maintained. The Department Chairs determined that the clinical salary components at issue had to be eliminated or reduced due to individual changed circumstance, to decreased department revenues based on decreased funding from University Hospital, or to decreased revenues from faculty practices income all reasons determined by Putterman to be valid.

Even were I to accept the AAUP's "understanding" of the past practice, namely that clinical components can be reduced in limited individualized circumstances as described by the AAUP, such as a reduction in clinical activity where the activity is tied to receipt of the clinical component, I find that the elimination of Dr. Klein's clinical salary component was still consistent with the past practice described by the AAUP.

Specifically, after a dispute with Dr. Kushins, Klein lost his medical privileges at RWJUH and was unable to participate in clinical activities at the hospital. Klein's Department Chair, Dr. Christine Hunter, eliminated Klein's faculty practice salary component after Klein refused to comply with the requirements of the Credentials Committee in order to regain his medical privileges at RWJUH, namely to undergo retraining and submit to a

physical and mental evaluation. Hunter determined that Klein's inability to treat patients and, thereby, contribute to the revenue generated by the department to support its budget validated her decision to eliminate his faculty practice salary component. Klein indicated to her that he intended to continue his appeals without increasing his activities in non-clinical areas to make up for his inability to contribute through clinical activities at the hospital. Putterman approved Hunter's decision finding the reason for the elimination to be valid.

The AAUP asserts that Klein's salary was never dependent on his clinical activities and, therefore, there was no change in his individualized circumstance warranting Hunter's decision. Thus, the AAUP contends, there was no valid reason for the elimination which represents a departure from the parties' past practice. In support of its argument, the AAUP points to an alleged 20-year history of no relationship between Klein's clinical activities and the amount of his faculty practice salary component. The AAUP's assertions in this regard are misplaced, and its characterization of Klein's salary history is incorrect.

First, Klein was Department Chair until 1999, and, as such, was not part of the AAUP negotiations unit. Any compensation related to his duties and responsibilities as Chair are irrelevant to the parties' past practice in regard to AAUP unit members. After 1999, both his former and current Chairs, Dr. Kushins and Dr. Hunter, assigned and expected Klein to

participate in clinical activities in order to receive a clinical stipend as part of his overall compensation package.

The fact that Klein's inability to treat patients at RWJUH clearly affected his productivity and thereby his ability to contribute to his department's revenue stream was a valid reason upon which to base the elimination of his clinical salary component. Hunter's decision was consistent with actions the University previously took when reducing clinical salary components as evidenced by the specific examples cited by the University in the matter before me.

The elimination of Klein's clinical component was also comparable to the actions taken previously by the University in reducing the clinical stipend of Dr. Stanley Weiss because Weiss failed to obtain a grant to offset the stipend he received and that could not be funded from the department's budget. Both Weiss and Klein had their clinical components reduced due to departmental budget considerations and their inability to contribute sufficiently to the budgetary bottom line. UMDNJ I.

As to the reductions in faculty practice and patient services components at both RWJMS and NJMS triggered by the 2007 budget cuts, the AAUP asserts that those reductions represented a change in the past practice because the reductions were not made for valid reasons based on a change in the faculty members individual circumstance. Rather, it contends, the reductions were based solely on the decision by the Department Chairs that

some faculty member's compensation was too high with no change in their duties or responsibilities. Thus, the AAUP argues, the University changed the status quo represented by the parties' past practice. I disagree.

The reductions may have been triggered by budget shortfalls, but as in the past, the Chairs made the decisions to reduce clinical salary components after analysis of their department revenues and expenditures; the recommended personnel actions to modify the clinical salary components of their faculty were subsequently reviewed and approved by Putterman as valid. This comports with the parties' past practice whereby reductions were made to clinical salary components based on a department's earnings or revenue and individual productivity.

As to the reductions to patient services components at NJMS, University Hospital reduced funding to NJMS for care provided by NJMS faculty to uninsured patients at the hospital. The result of the hospital's actions was a severe budget shortfall and a significant decrease in monies available to each department for clinical activities. Chairs were instructed to review their expenditures and submit a plan to meet budget projections for the coming fiscal year beginning July 1, 2007. They were given no instructions as to how to accomplish this task, although the Chairs were provided with information related to productivity of their faculty and compensation figures for faculty in similar specialties in the northeast. Thus, it was left to their

discretion to manage their departments' finances based on budget projections for the coming fiscal year.

Most Department Chairs at NJMS were able to meet decreased funding without impacting individual faculty compensation. However, seven faculty members in three departments (OBGYN, Anesthesiology, and Medicine) had their patient services salary components reduced due to decreased funding from University Hospital for patient care activities, the reason approved by Putterman and that she considered to be valid. Although this was apparently the first time that patient services salary components were reduced for this particular reason^{28/}, it was also the first time that University Hospital reduced funding to this degree for patient care activities provided by NJMS faculty. Putterman concluded that the situation was comparable to the common occurrence of reducing faculty practice components when faculty practice revenue collections from patient care activity decreased. Here, she reasoned, the revenues collected for uninsured patients were being decreased by the actions of University Hospital, thus, there was less money available for distribution to clinicians providing patient care at University Hospital.

28/ In 2006, Dr. John Parsons had his patient services salary component eliminated due to decreased University Hospital funds for distribution to NJMS faculty. The AAUP did not object to this action nor seek negotiations.

The decision of the Chairs of the three departments were taken after careful review of their department budgets. the contributions of the seven physicians who were providing patient care at University Hospital, and/or the reduced funding from University Hospital that was the source of funding for uninsured patient care activities. For instance, OBGYN Chair Dr. Gerson Weiss determined that Dr. Michael Cho provided only 10% of what other faculty in his department provided to University Hospital in clinical patient services. Based on this productivity figure, Weiss decided to reduce Cho's patient services component.

In the department of medicine, Chair Dr. Bunyad Haider reviewed all 94 faculty in his department. Haider felt that since University Hospital provided funding for patient care activities at the hospital, there was a direct link between low productivity and the amount of compensations received through the patient services salary component. As part of his review, therefore, Haider looked to RVUs (relative value units) that are a reflection of productivity related to patient care.

Eventually, Haider identified three physicians (Kaluski, Meggs and Levin) who, he felt, had low productivity in regards to patient care at University Hospital. He reduced their patient services components to bring them into "sync" with what Haider felt was the activity of other clinicians in his department.

Finally, Dr. Ellise Delphin, Chair of the Department of Anesthesiology at NJMS, addressed the budget cuts to her

department by reducing the clinical component of four physicians - Drs. Schieble, Tilak, Patel and Davidson. Eighty percent of her department's budget was derived from University Hospital funds. These physicians were making significantly more money than other faculty in the department and, according to a national standard (MGMA) communicated to the Chairs and used by the University to evaluate compensation during the budget crisis, were making more than 75% of the physicians in the same specialty in the northeastern United States. Delphin sought to bring their compensation in line with others in the department and to meet the national standard. In the past she had increased clinical components as more funds were available to her department, and so Delphin exercised her discretion to reduce these clinical components when her funding was decreased.

It is apparent from the actions of the NJMS Chairs that decisions to reduce clinical salary components as a result of reduced funding from University Hospital were based on analysis of their department's needs and the necessity of providing patient care services to University Hospital. In determining where to cut expenditures and/or recapture savings, the Chairs examined faculty productivity as measured against each other and national standards. Putterman's office approved the Chairs' decisions.

The AAUP asserts that decreased department revenues to compensate for uninsured patient care activity was not a valid

reason to reduce a clinical component, especially with no attendant change in duties or responsibilities, and, therefore, the University's actions did not comport with past practice. In other words, the reductions were not associated with individualized changes in circumstance. However, the evidence supports that, in the past, the University made modifications to clinical components (increased, decreased and/or eliminated) for a myriad of reasons it determined to be valid, including where revenue shortfalls triggered reductions in clinical components - e.g. Dr. Stanley Weiss and Dr. Steven Schutzer among many others.

Indeed, the University presented evidence that in August 2006 the University approved the elimination of the patient services salary component of Dr. John Parsons in the department of orthopedics at NJMS due to decreased University hospital funds available for distribution to participating faculty. The AAUP never sought negotiations over this change. The reasons for modifying clinical components may have evolved over the years as circumstances changed - e.g. reduced funding from University Hospital to NJMS, but the University retained the right through its practice to determine the validity of those reasons.

The AAUP never sought to limit the University's right in this regard, even during negotiations for the current collective agreement. It could have requested a list of reasons for modifications or sought to negotiate limitations to the practice of setting and modifying clinical compensation for reasons the

AAUP considered to be invalid or arbitrary. It did not do so, and the practice remained unchanged.

Clinical components were always a matter of contract between the clinician and the University at hire, and unilaterally modified by the University thereafter. Whether the seven individuals impacted by the actions of the NJMS Chairs have claims under individual letters of appointment and/or reappointment is not before me. Also not before me is whether the University's apparent lack of written rules or policies regarding modifications to clinical salary components is, or is not, fiscally prudent. The only issue before me is whether there was a collective negotiations right triggered by the University's actions - e.g. was the status quo changed.

Finally, at RWJMS, Dr. Anthony Vintzileos, Chair of the Department of Obstetrics Gynecology and Reproductive Science reduced the faculty practice component of 25 faculty due to a decrease in faculty practice revenue collection. That department had run a deficit for several years - a deficit that was no longer tolerated by the Administration in the current climate of fiscal constraints. Also, at RWJMS, Dr. Lewis Reisman's faculty practice component was reduced by Dr. Notterman, Chair of the Department of Pediatrics, to bring his faculty practice revenues in line with his faculty practice activities. Notterman felt that Reisman was not seeing enough patients to warrant the compensation he was receiving from his clinical salary component.

These reasons for reducing faculty practice components to reflect revenue collections from faculty practice were not novel. In March 2003, the monthly reports received by the AAUP reveal that over a dozen faculty members in the OBGYN department at SOM had their faculty practice components reduced. Faculty transaction forms in evidence support that the reductions were in response to departmental budget shortfalls. Also, Dr. Voyack and Dr. Abesh in the family medicine department at SOM had their faculty practice salary components reduced due to decreased departmental faculty practice revenue collections available for distribution to participating faculty.

Whether the monthly reports themselves revealed the actual basis for the reductions or the AAUP knew that the reductions were made for this reason, the AAUP did not challenge these reductions nor is there evidence that the AAUP sought additional information to verify the reason for the reductions if the reason was not apparent in the monthly reports. Even if the past practice were narrowed, as the AAUP argues, to modifications made for reasons that the University had in the past found to be valid, reductions made in response to revenue collections or budget shortfalls as well as to productivity tied to clinical activities would be consistent with reasons for reducing clinical salary components found to be valid in the past.

The University argues, and I concur, that by narrowing the focus of my inquiry to whether a particular reason is valid as

understood by the AAUP to be valid, the AAUP is seeking to gain through this proceeding what it was unsuccessful in gaining during collective negotiations, namely limits to the University's discretion in setting and modifying clinical salary components. Department Chairs, consistent with past practice, have exercised their discretion to change clinical salary components for a myriad of reasons including reasons related to departmental clinical revenue receipts encompassing both individual clinical activities and other revenue sources - e.g. such as the grants to cover Stanley Weiss' patient services components or, as here, monies available from University Hospital to pay for the care of uninsured patients.^{29/}

The Waiver Issue

Having found that the employer has maintained the status quo by its actions, there was no duty to negotiate triggered by the

^{29/} The AAUP cites several cases for the proposition that employer's may not alter negotiable terms and conditions of employment for solely economic reasons. Denville Tp., P.E.R.C. No. 81-146, 7 NJPER 359 (¶12163 1981); Toms River Bd. of Ed., P.E.R.C. No. 92-71, 18 NJPER 62 (¶23027 1991); Middletown Tp.; County of Camden, I.R. No. 2006-18, 32 NJPER 114 (¶54 2006) recon. den. I.R. No. 2006-20, 32 NJPER 182 (¶80 2006); City of Passaic, P.E.R.C. No. 2004-21, 29 NJPER 483 (¶150 2003) recon. Den. I.R. No. 2004-2, 29 NJPER 310 (¶96 2003). These cases are inapposite because the University is not arguing that its actions in reducing clinical salary components were taken for solely economic reasons, but that it acted consistently with its past practice, namely it has consistently reduced clinical salary components unilaterally for a myriad of reasons including reduced departmental revenues without negotiations with the AAUP.

University's decision to reduce the clinical compensation of either Dr. Klein in 2004 or the seven faculty members at NJMS or the twenty-six faculty members at RWJMS in 2007. The question remains whether the AAUP waived, by implied or express conduct, its right to negotiate upon demand the topic of clinical salary components during the term of the parties' current collective agreement.

First, the AAUP contends that it has not waived its right to negotiate reductions or eliminations of clinical salary components by its past conduct of permitting similar modifications without objection or demand to negotiate. The AAUP maintains that such a waiver must be knowingly made and that it had no notice that the past practice was other than what it understood it to be, namely that modifications were made for other than the limited individualized circumstances it described at the negotiations table and that Putterman confirmed were valid reasons. The AAUP appears to be arguing that it cannot be held to have approved a reason for reducing a clinical salary component it was not aware of and consented to. This argument is disingenuous.

The Commission's decision in UMDNJ I put the AAUP on notice of the past practice, that the University acted unilaterally to increase, decrease or eliminate clinical salary components for many reasons, including the specific instance of Dr. Weiss where he was not able to get grant monies to cover his patient services

component - a reason the AAUP considered to deviate from practice and was the basis of its unfair practice charge. The AAUP, however, did not subsequently change its procedures in tracking changes to clinical salary components by heightening its scrutiny of the monthly reports or by seeking additional information, such as faculty transaction sheets which contain specific reasons for modifications, to bolster information contained in the monthly reports.

The AAUP only sought additional information where a clinician complained, such as when Klein's clinical component was eliminated or when faculty complained after the 2007 budget reductions were announced. The University's reasons for modifying clinical salary components were not a secret. Requesting the faculty transaction forms where the monthly reports did not reveal the exact reasons for a modifications to clinical salary would have enlightened the AAUP as to the University's practice. R-10 in evidence demonstrates that the University acted on numerous occasions to reduce clinical salary components without the AAUP objecting to its actions.

By not seeking additional information except in limited circumstances, the AAUP was impliedly ceding the discretion to the University to modify these clinical components for reasons determined solely by it to be valid. The AAUP cannot now claim that it did not know or have reason to know that the University acted unilaterally in regard to these modifications. Therefore,

the AAUP cannot now claim that it did not consent by its conduct of acquiescing to the University's practice regarding modifications to clinical salary components. Contrast, Borough of Somerville, P.E.R.C. No. 84-90, 10 NJPER 125 (¶15064 1984) (union had no reason to know of employer practice where only one prior incident involving one unit member who resigned month before union negotiated first collective agreement with Borough).

Next, the University contends that it is not obligated to negotiate the topic of clinical components until negotiations commence for a successor agreement, because the AAUP has expressly waived its right to negotiate based on its conduct during recent negotiations and its execution of both an MOA and the 2004-2009 collective negotiations agreement. I agree.

In N.J. Turnpike Auth., P.E.R.C. No. 99-49, 25 NJPER 29 (¶30011 1998), the Commission explained that there is a duty to negotiate mid-contract as to subjects which were neither discussed in successor contract negotiations nor embodied in contract terms. It determined that the Authority had an obligation to negotiate over sexual harassment procedures that were not discussed in pre-contract negotiations. See also, Rahway Valley Sewerage Auth., P.E.R.C. No. 99-79, 25 NJPER 134 (¶30060 1999) (union did not waive its mid-contract right to negotiate over layoff and recall procedures by not raising subjects in previous contract negotiations).

Here, however, recognizing that the University routinely modified clinical salary components using its own discretion, the AAUP proposed in negotiations for the 2004-2009 collective agreement to limit the University's discretion and submitted, among other items, two proposals: (1) patient services salary components could not be reduced without a written agreement between the faculty member and the University and (2) as to faculty practice, faculty members be given an annual written contract specifying the terms of their faculty practice compensation as well as the ability to grieve violations of the individual contracts. These proposals, however, were not among the AAUP's top priorities during negotiations. According to Osofsky (R-13), the items of greatest interest to the AAUP in negotiations were moving from merit-based increases (a concession won by the University in negotiations for the predecessor agreement) to across-the-board increases to academic pay as well as implementing a new procedure for challenging unsatisfactory performance evaluations and gaining extra float holidays.

The University's top priority was to maintain the status quo represented by its sole discretion in setting and modifying clinical salary components. The University bargained hard in regard to clinical salary components, although it agreed to a new notification procedure outside the collective agreement - e.g. to provide faculty with written notification of the reasons for

modifications to their clinical salary components and to provide the faculty, annually, with departmental budgets.

The AAUP withdrew its proposals on clinical salary components in exchange for a procedure to notify faculty of any change in clinical salary and a reason for the change, and because the University's negotiators told the AAUP that the University would not agree to a collective agreement containing a provision limiting its discretion on clinical components. It also withdrew its proposals based on Putterman's representation during negotiations that alterations to clinical salary components would be made for valid reasons and her good faith representation that she would personally review all modifications to ensure that changes made by Department Chairs were for valid reasons. The AAUP never requested a list of valid reasons or sought to circumscribe the University's ability to determine whether a particular reason was valid.

The University also agreed in negotiations to give the AAUP concessions on across-the-board increases to academic base pay as well as a more formalized appeal procedure for unsatisfactory evaluations and two additional float holidays, concessions that were higher priorities at the negotiations table for the AAUP negotiators than the issue of clinical salary components. In the give-and-take of negotiations, the parties reached agreement for the 2004-2009 collective agreement. The AAUP executed a memorandum of agreement. Mark Schorr, the AAUP chief negotiator,

testified that unless the status quo as represented by the parties' past practice was changed, negotiations on the topic of the clinical salary components were completed when the MOA was signed, and the AAUP did not reserve the right to continue negotiating on the topics of clinical components absent this contingency.

While the AAUP contends that it did not agree in negotiations that the University could modify clinical components for "any reason" or that Putterman would be the sole gatekeeper of whether a modification was done for a valid reason, I found that is what the practice between the parties was and that is what the AAUP negotiated for and got when it signed the MOA and executed the 2004-2009 collective agreement - maintenance of the status quo as defined by the past practice. Several of the AAUP witnesses, including the negotiators, confirmed that as a quid-pro-quo for withdrawing its proposals on clinical components, they relied on Putterman's good faith in reviewing and approving only those changes that she considered to be valid and consistent with the University's past practices. Additionally, the AAUP unit was given new notifications procedures. Nothing else changed. Namely, the University, through its Department Chairs, retained the discretion to modify faculty clinical salary components for reasons the Chairs determined were necessary. Recommendations for modifications were then submitted to the Administration for review and

approval, and Putterman or her staff reviewed and approved the modifications at issue here.

The AAUP was not and never has been involved in the above approval process. Its proposals in the 2004-2009 negotiations would have limited the University's discretion to modify clinical salary components. Those proposals were withdrawn. The AAUP got what it negotiated for in regard to modifications of clinical components - the continuation of the existing practice.

The AAUP also suggests that the University, facing budget constraints, could have resorted to laying off or non-renewing faculty under Articles XXIII and XXV or the parties' collective agreement. Some Department Chairs did in fact non-renew members of their departments. Indeed, the vast majority of Chairs at NJMS were able to meet budget projections without resorting to modifying clinical salary components, although a couple of Chairs, after reviewing all available options, did do so in addition to implementing other cost-saving measures. Although the University could have exercised its rights under these Articles, that does not negate their ability to address departmental budget shortfalls through reductions to patient services or faculty practice components consistent with past practice.

Based on the conduct of the parties in negotiations, the AAUP has waived the right to negotiate over clinical salary components for the term of the current agreement absent a change

in the status quo. The topic of clinical components was fully discussed and consciously explored during negotiations for the 2004-2009 agreement and the AAUP withdrew its proposals regarding clinical salary components, signing an MOA (J-2) with a zipper clause and a collective agreement (J-1) with a fully-bargained clause. Cases cited by the University to support its argument that the unchanged status quo is binding on the AAUP until negotiations for a successor agreement are apposite. Deptford Bd. of Ed.; Tp. of Verona; City of Newark. The current collective agreement expires in June 2009. Absent a change in the status quo, if the AAUP seeks to negotiate over clinical salary components - e.g. to place limits or set criteria for the modification of clinical salary components, it may do so when negotiations for a successor agreement commence.

Based on the foregoing, I do not find that the University violated 5.4a(1) and (5) of the Act under the consolidated Docket Nos. CO-2005-220 and CO-2007-271.

CE-2006-003

The University asserts that the AAUP repudiated the 2004-2009 collective agreement in violation of 5.4b(3) of the Act. Specifically, the University alleges that the AAUP sought to avoid the consequences of negotiations for the current agreement when it executed the MOA withdrawing its proposals to limit the University's discretion in modifying clinical salary components

and then filed charges challenging the University's decisions to modify Dr. Klein's clinical component in 2004 and the clinical components of faculty at NJMS and RWJMS in 2007. Thus, the University argues, the AAUP's filing of the unfair practice charges represents a repudiation of the parties' agreement to maintain the status quo regarding clinical salary components. In particular, the University relies on the testimony of its chief negotiator, Abdel Kanan who testified that his understanding of conversations and correspondence with AAUP Negotiator Schorr was that the AAUP had completed negotiations on the topic of clinical components once it signed the MOA, but was reserving its right to negotiate in a successor collective agreement over these topics.

The University cites Essex County College, H.E. No. 86-66, 12 NJPER 561 (¶17212 1986) in support of its argument. There the College refused to execute a tentative collective agreement it had ratified "subject to clarification". The Hearing Examiner determined that the College's refusal to execute the agreement constituted a repudiation because, by its demand to reduce the minimum salary level for certain employees, the College was seeking, not to clarify but, to modify the collective agreement. The University contends here that the AAUP is attempting to modify the 2004-2009 collective agreement by seeking limits on the University's ability to modify clinical salary components, limits that it attempted but was not able to achieve in negotiations for the 2004-2009 agreement.

The AAUP disagrees. It states that it had no intention when it signed the MOA of returning to the table. The AAUP concedes that the parties negotiated the subject of clinical salary components, reached an agreement on a new notification procedure prior to executing the MOA and agreed that the status quo by which the University could change clinical components for a variety of reasons would continue. The AAUP argues, however, that it never agreed to waive the right to demand negotiations during the current contract term if the University acted contrary to the status quo or past practice.

The AAUP also contends that the filing of its charges is a protected activity that cannot constitute a violation of our Act. Citing Bergen County Special Services Sch. Dist., P.E.R.C. No. 90-97, 16 NJPER 274 (¶21115 1990), it asserts that the filing of a charge of unfair practices with the Commission is, as a matter of public policy, an absolute right. It characterizes the University's charge as an attempt to transform a defense to the AAUP's unfair practice charge into a separate violation of the Act.

Finally, citing Merchantville Bd. of Ed., D.U.P. No.92-18, 18 NJPER 280 (¶23119 1992), the AAUP argues that the University would have to show that its actions in filing the charge adversely affected overall negotiations or was an impediment to reaching an agreement. In dismissing the charge, the Director rejected the Board's 5.4b(3) argument that merely notifying its

affiliate that a Board member, who was also a member of a union affiliated with the Respondent local union, of derogatory comments made by the Board member during negotiations was intended to intimidate the Board member and interfered with negotiations.

5.4b(3) provides that an employee organization violates the Act when it refuses to negotiate in good faith with the employer, in particular when, by its actions, the majority representative adversely impacts negotiations or is an impediment to reaching an agreement. I agree with the AAUP that, under the totality of the circumstances, the mere filing of its charge did not rise to the level of bad faith negotiations sufficient to establish a violation under 5.4b(3). Borough of Flemington, P.E.R.C. 88-82, 14 NJPER 240 (¶19087 1988) (police union failed to negotiate in good faith by not attending scheduled negotiations sessions, changing negotiators, secretly taping conversations, charging borough negotiator with extortion); Downe Tp. Bd. of Ed., P.E.R.C. No. 86-66, 12 NJPER 3 (¶17002 1985) (union's request to move to more formal negotiations did not constitute bad faith refusal to negotiate or rejection of agreed-upon ground rules); Phillipsburg Bd. of Ed., P.E.R.C. No 83-34, 8 NJPER 569 (¶13262 1982), recon. den. P.E.R.C. No. 83-67, 9 NJPER 23 (¶14011 1982) (Board did not violate duty to bargain in good faith by insisting on ground rules where union declared impasse after only two sessions in light of parties' 15-year bargaining history).

Essex County College, cited by the University, is not dispositive. The Commission reviewed the Hearing Examiner's decision and reversed, finding that the Charging Party was not the majority representative and, therefore, had no standing to litigate the charge. Essex County College, P.E.R.C. No. 87-81, 13 NJPER 75 (¶18034 1986). Additionally, I find the facts in Essex County distinguishable from the instant matter. There, the College refused to execute the collective agreement that it had tentatively ratified. Here, the parties signed an MOA and executed the 2004-2009 agreement before the AAUP filed its charge, therefore, the filing of the charge did not act as an impediment to negotiations.

In New Jersey Department of Human Services, P.E.R.C. No. 84-148, 10 NJPER 419 (¶15191 1984), the Commission held that mere breach of contract claims based on good faith differences in contract interpretations over ambiguous contract clauses did not rise to the level of a refusal to negotiate under 5.4a(5). However, the Commission also determined that a claim an employer repudiated a term and condition of employment may be an unfair practice under 5.4a(5). It found that repudiation may be established by a contract clause that is so clear on its face that an inference of bad faith arises from a refusal to honor it or by factual allegations indicating that the employer has changed the parties past and consistent practice in administering a disputed clause. Finally, the Commission indicated it would

also entertain charges of 5.4a(5) violation where there are allegations of a specific indicia of bad faith over and above a mere breach of contract or there are policies of the Act at stake.

Here, the University alleges a bad faith repudiation under 5.4b(3), the mirror image of claims under 5.4a(5), based on the AAUP's filing of a charge. The facts in this record, do not fit any of the circumstances outlined by Human Services to establish a violation under the Act. This matter does not involve a clear unambiguous contract clause. The term and condition of employment at issue is set by the parties' past practice outside the collective agreement. It appears, therefore, that the University is alleging that when the AAUP challenged what it perceived to be a change in the status quo, it repudiated the collective agreement. I disagree.

Prior to executing the final collective agreement but after the signing of the MOA, the parties' negotiators - Kanan and Schorr - engaged in an exchange of correspondence outlining their respective positions vis-a-vis the finalization of the 2004-2009 collective agreement. Kanan was under pressure from University President Petillo to settle the collective agreement with the AAUP, although Kanan and Petillo were not willing to settle at any cost. Schorr, on behalf of the AAUP, also wanted the agreement finalized. Clinical salary components and, by extension, the Klein issue were not the top priority for the AAUP

negotiations team. Basically, the issue raised by the elimination of Dr. Klein's clinical salary component could not be resolved, and the parties' agreed to disagree, execute the collective agreement and resolve the Klein issue afterwards. Therefore, I cannot find that under the totality of the parties' conduct, the AAUP acted in bad faith during negotiations or that its conduct was an impediment to reaching an agreement.

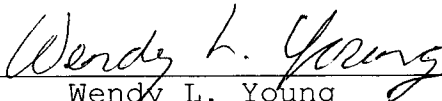
Conclusions of Law

The University did not violate 5.4a(1) and (5) of the Act when it eliminated Dr. Sanford Klein's faculty practice component in 2004 and reduced the clinical components of faculty at NJMS and RWJMS in 2007.

The AAUP did not violate 5.4b(3) of the Act when it filed an unfair practice charge under Docket Nos. CO-2005-220 or CO-2007-271.

Recommendation

I recommend the Commission ORDER that the Complaint as to Docket Nos. CO-2005-220, CO-2007-271 and CE-2006-003 be dismissed.



Wendy L. Young
Hearing Examiner

DATED: October 27, 2008
Trenton, New Jersey

Pursuant to N.J.A.C. 19:14-7.1, this case is deemed transferred to the Commission. Exceptions to this report and recommended decision may be filed with the Commission in accordance with N.J.A.C. 19:14-7.3. If no exceptions are filed, this recommended decision will become a final decision unless the Chairman or such other Commission designee notifies the parties within 45 days after receipt of the recommended decision that the Commission will consider the matter further. N.J.A.C. 19:14-8.1(b).

Any exceptions are due by November 7, 2008.