JABURG | WILK
Attorneys at Law

3200 N. Central Avenue, 20th Floor, Phoenix, AZ 85012

jaburgwilk.com

Kraig J. Marton

kjm@jaburgwilk.com
602.248.1017 - Direct Phone
602.248.0522 - Main Fax

January 9, 2014

Via E-Mail to hartaw@email.arizona.edu and First Class Mail.

Ann Weaver Hart
President
University of Arizona
Administration Building, Room 712
1401 East University Boulevard
P.O. Box 210066
Tucson, Arizona 85721-0066

Re: Dr. Rainer W.G. Gruessner's Whistleblower Claim

Dear President Hart:

This firm represents Rainer W.G. Gruessner, M.D. with respect to his dealings with the University of Arizona and University Physicians Healthcare. The purpose of this letter is to serve as Dr. Gruessner's formal and written "whistleblower" complaint protesting the adverse actions taken against him for his prior disclosure of wrongful conduct. This complaint is served pursuant to ABOR Policy 6-914.

Dr. Gruessner has reported wrongful conduct involving two instances: (1) he reported Dean Steve Goldschmid's mismanagement, abuse of authority, and waste of public funds at the College of Medicine to members of the Committee of 11, and (2) Dr. Gruessner uncovered and informed UAMC's CEO and management of incorrect UNOS transplant reporting, which constitutes mismanagement and a specific danger to public health and safety.

On Friday, December 13, 2013, Dr. Gruessner received notice from University Physicians Healthcare that his membership in that organization was terminated effective immediately. See letter attached as **Exhibit A**. Dr. Gruessner believes in good faith that this termination was in retaliation for reporting the wrongful conduct.

Due to the legal relationships and coordinated action between UPH and the College of Medicine, Dr. Gruessner believes this whistleblower complaint is properly filed against both organizations under ABOR Policy 6-914. Dr. Gruessner's contract with the College of Medicine is likely dependent on his remaining in good standing with UPH, and the College of Medicine has indicated it

intends to recommend termination of Dr. Gruessner's tenure as a result of UPH's action. See email attached as **Exhibit B**.

This written complaint is hereby submitted and filed within 30 days of the adverse action taken against Dr. Gruessner as required by Policy 6-914. The complaint is being served upon the university's president, the provost, the chairman and president of the Arizona Board of Regents, the chairman and president of University of Arizona Health Network, and the organizations' respective attorneys in order to ensure satisfaction of the requirements of the policy. Dr. Gruessner files this complaint in order to preserve his rights as a whistleblower against both organizations, and to seek the relief allowed under ABOR Policy.

Dr. Gruessner reported alleged wrongful conduct to a public body on a matter of public concern; he suffered an adverse personnel action after reporting the alleged wrongful conduct; and the adverse action was the result of his prior disclosure and was a knowing retaliation.

In December 2012, Dr. Gruessner was asked to speak to members of the University's Committee of 11 to provide input regarding the state of the College of Medicine under Dean Steve Goldschmid's leadership. Dr. Gruessner agreed and told various members that he was concerned about Dean Goldschmid's leadership. He explained how the college's NIH ranking had not improved, how key faculty in the Cancer Center and clinical departments had left and could not be replaced, and how a climate of fear and retaliation had been fostered by the Dean, resulting in low morale among faculty and staff. Dr. Gruessner provided his opinion that Dean Goldschmid would not be able to take the college to the next level and attain a national reputation. At some point thereafter, Dr. Gruessner's comments to these members of the Committee of 11 were conveyed to Dean Goldschmid.

Dr. Gruessner has received nothing but high praise for his performance as Chairman of the Department of Surgery. See reviews attached as **Exhibit C**. However, on July 22, 2013, Dean Goldschmid called Dr. Gruessner using Skype from his vacation home in Canada and asked Dr. Gruessner to step down, citing a "record of poor performance." Dr. Gruessner was shocked. He had never received any complaints about any alleged underperformance, nor had his performance been reviewed as required by ABOR policy. He refused to step down. One week later, Dr. Gruessner received a Notice of Reappointment from your office dated July 25 that reappointed him as Chairman of the Department of Surgery. Nonetheless, shortly thereafter, Dean Goldschmid again demanded that he step down. Again, Dr. Gruessner refused, at least initially.

After careful reflection, Dr. Gruessner decided he would rather not go to war with his supervisor, and he decided to step down on certain conditions. Dean Goldschmid and Dr. Gruessner came to an agreement where, among other things, Dr. Gruessner would transition out of his administrative duties as Chairman of the Department of Surgery but would maintain the title for a period of at least six months.

On September 9, 2013, as part of his transition out of his administrative positions, Dr. Gruessner requested a count of the liver transplants he had performed during his time at UAMC. Dr. Gruessner made the request to Mike McCarthy, UAMC's manager of business systems for transplant services. Since UAMC did not have a director for transplant services, Mr. McCarthy was the most logical person in UAMC Transplant Services with whom to discuss reported transplant data. That same day, Mr.

McCarthy informed Dr. Gruessner that UAMC's UNOS data indicated he had served as primary surgeon on only 12 transplants over the previous six years. This low number surprised Dr. Gruessner because he served as the Director of UAMC's liver transplant program and oversaw all clinical aspects, including the assignment and role of all transplant surgeons in the actual procedures. Dr. Gruessner was involved in well over 75 liver transplants during that time, and most of them as the primary surgeon.

Dr. Gruessner reviewed the most recent UNOS data and found that junior surgeons, or surgeons who had not been the primary surgeon, were incorrectly listed as the primary surgeon. Mr. McCarthy suggested that UAMC's transplant coordinators likely misreported the "transplant surgeon on call" or the "attending surgeon based on the call schedule" as primary surgeon rather than based on the actual operating room notes. In his positions, Dr. Gruessner had no oversight over entry or maintenance of data concerning the identity of the primary surgeon to UNOS. The responsibility of data reporting lies with the hospital as the official OPTN member.

This misreporting by UAMC has potentially grave consequences for the hospital and university. UNOS maintains very demanding standards for the surgeons it qualifies to perform liver transplants. By reporting incorrectly, UAMC and the College of Medicine may have improperly qualified a surgeon as Director of the Liver Transplant Program who is apparently not qualified. Furthermore, and according to UNOS policies, that surgeon's OR log should have been signed by the previous program director. But Dr. Gruessner was never contacted to sign any such log. It would appear that false information has been provided to UNOS by UAMC about who performed what prior transplants, and if so, UNOS has unwittingly agreed to a change in directorship, to which it would not have agreed with accurate information. It would appear that UAMC has an active liver transplant program that is based on incorrect and possibly fraudulent information.

UAMC's actions related to abdominal transplants has created a significant danger to public health. It would appear that a non-qualified surgeon is now in the position of director. Dr. Gruessner also understands that at least two patients have died on the waiting list and the only liver transplant performed since Dr. Gruessner's suspension has been disastrous: the patient required 250 units of blood and was taken back to the operating room three more times including for a blocked blood vessel. The patient's long-term outcome is uncertain. UAMC's and the College's actions also raise questions about whether the costs of the transplant surgeries have been properly billed. As Medicare payments for a Transplant Program is contingent on UNOS Certification, a Program that has received UNOS Certification based on erroneous or fraudulent representation may be guilty of Medicare Fraud.

On September 10, 2013, Dr. Gruessner met with Mr. McCarthy to review additional UNOS reporting data based on the actual OR notes for previous UAMC liver transplants. The data reported to UNOS were almost entirely inaccurate as to the identity of the primary and assisting surgeons. At that meeting, Dr. Gruessner wrote the initials of the correct names of the primary surgeon and first assistant surgeon on copies of the actual OR notes and provided those notes to Mr. McCarthy. Dr. Gruessner told Mr. McCarthy that the hospital administration needed to be informed about the inaccuracies and suggested that the records be corrected. Of these suggested changes, Dr. Gruessner needed to be added as primary surgeon to most and be removed as primary surgeon on another.

On September 11, 2013, Dr. Gruessner met with the hospital's CEO Karen Mlawsky. He then informed her, too, about the incorrect reporting to UNOS. Ms. Mlawsky said she would get back to him on the matter. That same day, Mr. McCarthy also informed Ms. Mlawsky of the incorrect reporting by email.

After not hearing back from Ms. Mlawsky, Dr. Gruessner sent a confirmatory email to her on Monday, September 16, 2013. Ms. Mlawsky responded, simply, "We are looking into this." See email attached as **Exhibit D**.

Within hours of Ms. Mlawsky's response, Dr. Gruessner received an email from Dean Goldschmid, with letters placing him on administrative leave with pay from both UPH and University of Arizona based on allegations that he "either altered or directed others to alter records related to transplant procedures." See email and letters attached as **Exhibit E**. But Dr. Gruessner did not "alter or direct others to alter records"—he merely pointed out that data reported to UNOS was incorrect and needed to be corrected. Moreover, no one ever questioned Dr. Gruessner about what he had done or why before suspending him. Instead, he was suspended based on little or no investigation, despite being in good standing with UPH and the College for more than six years.

It appears now that the incorrect data reporting may have been purposeful, as Dean Goldschmid did not want Dr. Gruessner to continue in his capacity as Chief of Transplantation. Based on this course of events, it appears that the Dean's long-term plan was to substitute Dr. Gruessner with a non-qualified surgeon, and to see that Dr. Gruessner was removed entirely from any role with UPH or UAMC. Dr. Gruessner uncovered this potentially fraudulent scheme in the Eleventh Hour. His immediate suspension and, now, termination with no hearing reeks of a plot to silence and discredit him.

Dr. Gruessner responded to the allegations, explaining that the reporting was incorrect and clarifying how the primary and assisting surgeons are identified. See response attached as **Exhibit F**. Thereafter, both organizations kept him suspended and in limbo, which forced him to file a lawsuit in Pima County Superior Court on November 13, 2013. He did not sue for damages but instead sought reinstatement and a hearing so he could demonstrate that the reporting was actually incorrect, that he never altered records or directed others to alter records, and that the suspension was in retaliation for speaking adversely of Dean Goldschmidt to members of the Committee of 11 and for uncovering and reporting the incorrect UNOS reporting.

On December 13, 2013, just days before the scheduled hearing for the preliminary injunction seeking reinstatement, UPH delivered the letter purporting to terminate Dr. Gruessner's membership with the organization. See **Exhibit A**. This complication was a clear tactic to delay and derail Dr. Gruessner's bid for reinstatement because his entire lawsuit was based on the argument that UPH and the College of Medicine were illegally holding him in limbo and refusing to take action.

Conclusion

Dr. Gruessner disclosed wrongful conduct to UPH and the University of Arizona in good faith. As a result of this disclosure, he suffered the adverse personnel action of termination from UPH and the threat of commencement of removal proceedings by the University of Arizona. Because of this joint

action, Dr. Gruessner believes this whistleblower complaint is properly filed against both organizations in accordance with ABOR Policy 6-914. Dr. Gruessner hereby invokes his rights under this policy and demands review of these actions as required by that policy.

Sincerely,

JABURG & WILK, P.C.

Kraig J. Marton

Approved:

Rainer W.G. Gruessner, M.D.

KJM:akh

ENC.:

Exhibit A – UPH Membership Termination Letter
Exhibit B – Email from University of Arizona re Commencement of Termination Proceedings
Exhibit C – Reviews of the Department of Surgery Under Dr. Gruessner
Exhibit D – Email Chain with CEO Karen Mlawsky
Exhibit E – Email and Suspension Letters from Dean Goldschmid
Exhibit F – Dr. Gruessner's Response to Allegations

cc: Mr. Rick Myers, Chairman, Arizona Board of Regents (rick.myers@azregents.edu)
Ms. Eileen Klein, President, Arizona Board of Regents (eileen.klein@azregents.edu)
Dr. Andrew C. Comrie, Provost, University of Arizona (comrie@email.arizona.edu)
Dr. Michael Waldrum, President & Chief Executive Officer, (michael.waldrum@uahealth.com)
University Physicians Healthcare & University of Arizona Health Network
Dr. Michael Covert, Chairman, UAHN (michael.covert@palomarhealth.org)
Dr. Joe G.N. "Skip" Garcia, Vice President, Academic Health Center (skipgarcia@email.arizona.edu)
Vicki Gotkin, Attorney for University of Arizona (vickig@email.arizona.edu)
Amy Gittler, Attorney for UPH & UAHN (gittlera@jacksonlewis.com)
Michael Goodwin, Assistant Attorney General (michael.goodwin@azag.gov)

Exhibit A

Kraig J. Marton

From: Gittler, Amy J. (Phoenix) [mailto:GittlerA@jacksonlewis.com]
Sent: Friday, December 13, 2013 3:01 PM
To: Kraig J. Marton; Kimberly M. Rogers; Aaron K. Haar
Cc: Chenowth, Karen M. (Phoenix); Coleman, Stephen B. (Phoenix); Goodwin, Michael (Michael.Goodwin@azag.gov); Gotkin, Vicki - (vickig) (vickig@email.arizona.edu)
Subject: Dr. Gruessner

Good afternoon. I believe Kraig is meeting with Dr. Gruessner now. Please be sure the attached document is delivered promptly.

Thank you.

Regards,

Amy J. Gittler
Attorney at Law
Jackson Lewis P.C.
2398 E. Camelback Road, Suite 1060
Phoenix, Arizona 85016

602.714.7057 | Direct
602.714.7045 | Fax

gittlera@jacksonlewis.com

www.jacksonlewis.com

Representing management exclusively in workplace law and related litigation.

Confidentiality Note: This e-mail, and any attachment to it, contains privileged and confidential information intended only for the use of the individual(s) or entity named on the e-mail. If the reader of this e-mail is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that reading it is strictly prohibited. If you have received this e-mail in error, please immediately return it to the sender and delete it from your system. Thank you.

UPH
UNIVERSITY PHYSICIANS HEALTHCARE

Sent Regular Mail and Delivery Service

December 13, 2013

Rainer W.G. Gruessner, MD, FACS
6408 N. Placita del Zopilote
Tucson, Arizona 85750

Dear Dr. Gruessner:

This letter will serve to advise you that your University Physicians Healthcare membership and employment status has been terminated, effective immediately. You will be contacted by a representative of the company to arrange for an orderly disposition of any remaining matters related to your employment.

Sincerely,

Michael R. Waldrum, MD, MS, MBA
President and Chief Executive Officer
University Physicians Healthcare

Exhibit B

Kraig J. Marton

From: Gotkin, Vicki - (vickig) [mailto:vickig@email.arizona.edu]
Sent: Friday, January 03, 2014 3:32 PM
To: Kraig J. Marton
Subject: Dr. Gruessner's University Employment

Dear Kraig,

I am advised that Dr. Gruessner has been terminated from his UPH membership, effective December 13, 2013. The Dean of the College of Medicine and the Provost are prepared to recommend Dr. Gruessner's dismissal from his tenured faculty position based on Dr. Gruessner's loss of membership in UPH, in accordance with Arizona Board of Regents policies. As you know, Dr. Gruessner's original University letter of offer, his appointment and subsequent renewals of his appointment with the University were contingent, among other things, upon his maintaining membership and employment in good standing with UPH. Dr. Gruessner's administrative duties as Head of the Department of Surgery were terminated in September 2013, and his other University duties (before he was placed on administrative leave by the University pending UPH's investigation) were performed in conjunction with his surgical practice for which he required membership in UPH and privileges at the hospitals the practice plan staffs. Those requirements were an express condition of his continued employment with the University.

Before initiating any action to dismiss Dr. Gruessner from his tenured position at the University under ABOR Policy 6-201(J), et seq., the University wanted to give Dr. Gruessner an opportunity to resign. It would be willing to offer terms similar to those offered prior to the holidays – essentially giving Dr. Gruessner a clean slate vis-à-vis his University employment, and salary through the end of the fiscal year in exchange for his release and dismissal of his lawsuit against the University, as set forth in the agreement we initially tendered. Dr. Gruessner's resignation could be effective as late as June 30, 2014.

I'm sure your client would want to avoid a dismissal proceeding. This is purely a contractual matter – I believe there are no facts in dispute on the issue of whether Dr. Gruessner is unable to fulfill the terms of his employment with the University now that he has lost UPH membership. You originally said that you would be able to offer UPH a counterproposal when you returned on or about January 4. Given the circumstances, we would like to give your client some time to think about this proposal, so please respond by close of business on January 10, 2014, with Dr. Gruessner's decision. The University will refrain from moving forward with any action until that date.

I look forward to hearing from you in the spirit of reaching a settlement.

Vicki

Vicki Gotkin, J.D.
Senior University Attorney

Office of the General Counsel
The University of Arizona
Administration Building, Room 103
PO Box 210066
Tucson, AZ 85721-0066
Telephone: 520.626.7451
Facsimile: 520.626.7540
E-mail: vickig@email.arizona.edu

Exhibit C

Cleveland Clinic

Department of General Surgery
9500 Euclid Avenue
Mail Stop: A100
Cleveland, OH 44195

John J. Fung, MD, PhD
Office of the Chairman
216-444-3776 (office)
216-444-2153 (fax)
fungj@ccf.org (e-mail)

April 13, 2010

Gail Burd, PhD
Vice Provost for Academic Affairs
Administration Building 512
PO Box 210066
University of Arizona
Tucson, Arizona 85721-0066
gburd@email.arizona.edu

Dear Vice-Provost Burd:

Enclosed is the final report of our 2010 academic review of the Department of Surgery at the University of Arizona. All members of the review group have contributed and edited this document and agree upon the substance and concepts highlighted here. As you requested, we have provided an Executive Summary along with the comprehensive report. It expands upon the comments made at the exit interview but does not differ in concepts presented at that meeting.

On behalf of the entire group, we greatly appreciate the opportunity to participate in this critical review as well as the hospitality provided. Please feel free to contact any of us, should you have any questions.

Sincerely,

John J. Fung, MD, PhD
Professor of Surgery
Chairman, Department of General Surgery
Chairman, Department of HPB/Transplant Surgery

Encl.

EXECUTIVE SUMMARY

We would like to thank all involved in the APR, for the opportunity of participating in this review. We felt that the Department of Surgery has made tremendous strides and that this progress will foster excellence that will enhance programmatic development throughout the University of Arizona. Not only have the clinical services greatly improved, but Dr. Gruessner's vision will take the department and institution to a level of distinction not previously achieved in Tucson. We urge all parties to look beyond the short-term and continue the support that will lead to a continued fulfillment of your potential.

1) The recent successful coalescence of the three clinical entities, the College of Medicine (COM), the Practice Plan (University Physicians Healthcare), and the Hospital (UMC), is recognized as a major advance in promoting efficiencies, establishing transparency and permitting logical programmatic evaluation.

2) We envision the development of a series of business plans that would include metrics incorporating: a) clinical activities, b) educational opportunities, c) investigative promise, and d) financial returns. Any proposed activity (from any discipline or department) should be supported with a document detailing each of the above components. Emphasis would be placed on multi-departmental and multi-disciplinary collaboration within the COM and the University. We were impressed with the enthusiasm of University of Arizona faculty at all levels toward efforts to break down the "silos". We witnessed this within the Department of Surgery and believe that this philosophy can constructively metastasize to other arenas in the COM and the University.

3) The Department of Surgery at the University of Arizona is unique in the modern day academic surgery world as it represents a most inclusive university-based surgery program, incorporating nearly all surgical disciplines.

4) All faculty surveyed complimented Dr. Gruessner as a strong chairman, who negotiates on behalf of the entire department, with tangible benefits to the hospital and other departments.

5) Dr. Gruessner has accomplished an extraordinarily successful period of faculty development during his early tenure as Department Chair. The first wave of recruitment is clearly aligned with the stated pillars of the UMC Board – specifically, the priorities of cancer, transplantation, trauma, diabetes, and cardiovascular diseases.

6) In spite of these improvements, there remain significant challenges and deficiencies in clinical services. As noted in the 2003 APR, pediatric surgery, plastic surgery, otolaryngology, neurosurgery, and pediatric urology remain deficient. This is the focus of the second wave of recruitment proposed by Dr. Gruessner.

7) Following a generation of national distinction within Cardiothoracic Surgery at University of Arizona, this program is currently in decline. We support an evolution in leadership with the recruitment of a new division chief and the addition of a senior level truly academic CT surgeon. This division has an opportunity to return to national pre-eminence that will foster a constructive ripple effect throughout the University.

8) The Trauma/Acute Care Surgery program is an example of a completely new – but, now fully mature - surgical service that will foster academic/clinical/educational/financial excellence throughout the Hospital and COM. Maintaining sufficient support will be critical in allowing this group to provide trauma and acute care services for UMC and UPHH.

9) The current comprehensive multiorgan transplant program is another example of a new program with wide penetrance throughout the school and hospital. This group has acquired superb faculty with overall surgical outcomes at or above expected survival. There has been an increase in volume of cases. The faculty also participate in HPB surgery with increasing volumes in pancreatic and hepatic resections (total cases approximately 60/year). A mission support agreement has been approved, where the majority (70%) of funds has been designated for support departments (Medicine and Anesthesiology). We recognize this as an excellent model for multi-disciplinary programmatic development.

10) In the assessment of the return on investment of the first phase development for the Department of Surgery, we were struck by the lack of transparency in budget details for UMC. Hopefully the historic lack of cooperation by UPH, UMC and COM will be solved by the anticipated upcoming merger.

11) The surgical residency program was placed on probation recently due to work hour violations, which when solved will necessitate the inclusion of additional paramedical personnel.

12) The surgical residency was also cited for a poor American Board of Surgery pass rate. The Department has rectified this problem with an impressive study curriculum provided by recently recruited academic surgeons.

12) Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off. The burst of programmatic surgical development (with its constructive penumbra influence on other COM disciplines) has not yet , in our view, been completed.

13) In accordance with the stated goal of building the basic and clinical research enterprise in the Department of Surgery, both at the level of the faculty and residency programs, it will be necessary to provide for sufficient release time from clinical duties, adequate career-development mentoring, and connections with the broader campus-wide research community. The cadre of highly qualified, newly hired faculty are particularly at risk if these needs are not attended to quickly.

Academic Program Review
Department of Surgery
University of Arizona
April 1-2, 2010

John Fung, MD, PhD
Professor and Chairman
Department of General Surgery
Director, Transplantation Center
Cleveland Clinic

Alden H. Harken, MD
Professor and Chief
UCSF-East Bay Department of Surgery

Dixon B. Kaufman, MD, PhD
Fowler McCormick Professor and Vice Chair
Department of Surgery
Division of Transplantation
Northwestern University

Baltassare Stea, MD
Professor and Chair
Department of Radiation Oncology
University of Arizona

Kate Dixon, PhD
Professor and Chair
Department of Molecular and Cellular Biology
University of Arizona

Richard Carmona, MD, MPH, FACS
17th Surgeon General of the United States
UA Distinguished Professor
Vice Chairman, Canyon Ranch
CEO, Canyon Ranch Health Division
President, Canyon Ranch Institute

I. Benjamin Paz, MD
Professor and Vice Chair of Surgery
Director, Rita Cooper Finkel and J. William Finkel Women's Health Center
City of Hope National Medical Center

Academic Program Review
Department of Surgery
University of Arizona
April 1-2, 2010

REVIEW COMMITTEE:

1. External Committee Members:

John Fung, MD, PhD
Professor and Chairman, Department of General Surgery
Director, Transplantation Center, Cleveland Clinic
Cleveland Clinic Main Campus
Email: fungj@ccf.org

Alden H. Harken, MD
Professor and Chief
UCSF-East Bay Department of Surgery
Email: alden.harken@ucsfmedctr.org

Dixon B. Kaufman, MD, PhD
Fowler McCormick Professor and Vice Chair
Department of Surgery Division of Transplantation
Email: d-kaufman2@northwestern.edu

2. Internal Committee Members:

A. Within UA College of Medicine
Baltassare "Dino" Stea, MD – Professor and Chair, Dept. of Radiation Oncology
E-mail: bstea@azcc.arizona.edu

B. Other UA Colleges
Kate Dixon, PhD – Professor and Chair, Dept. of Molecular and Cellular Biology
E-mail: dixonk@email.arizona.edu

3. Community Committee Member:

Richard Carmona, MD, MPH, FACS
17th Surgeon General of the United States
UA Distinguished Professor
Vice Chairman, Canyon Ranch
CEO, Canyon Ranch Health Division
President, Canyon Ranch Institute
E-mail: rcarmona@canyonranch.com

4. Alumni:

I. Benjamin Paz, MD
Professor and Vice Chair of Surgery
Director, Rita Cooper Finkel and J. William Finkel Women's Health Center
City of Hope National Medical Center
E-mail: BPaz@coh.org

MATERIALS:

Self-study materials
Interviews:

Administration

- Gail Burd, PhD – Vice Provost for Academic Affairs
- Bruce Coull, MD – Vice Dean, College of Medicine, Deputy Dean for Clinical Affairs
- Steve Goldschmid, MD – Dean, College of Medicine
- Larry Aldrich – President and CEO, University Physicians Healthcare
- Kevin Burns – UMC President and CEO
- Steve Moody – Department of Surgery Administrator
- William Crist, MD – Vice President for Health Affairs

Faculty: Department of Surgery – Self Study Committee

- Hugo Villar, MD
  Deputy Chairman, Department of Surgery
  Chief, Division of Surgical Oncology
  Professor of Surgery and Radiation Oncology
- Peter Rhee, MD
  Professor and Vice Chair, Clinical Affairs
  Chief, Division of Trauma, Critical Care and Emergency Surgery
- Ronald Heimark, PhD
  Professor of Surgery, Pathology, Cell Biology & Anatomy
  Vice Chair, Surgical Research
- Randall Friese, MD
  Associate Professor of Surgery
  Division of Trauma, Critical Care and Emergency Surgery
- G. Michael Lemole, Jr., MD
  Associate Professor of Surgery
  Chief, Division of Neurosurgery
- Amy Waer, MD
  Assistant Professor of Clinical Surgery
  Director, General Surgery Residency Program

Faculty: Department of Surgery

- Jack Copeland, MD
  Professor of Surgery and Radiation Oncology
  Chief, Division of Cardiothoracic Surgery
- Mitchell Sokoloff, MD
  Professor of Surgery
  Chief, Division of Urologic Surgery
- Joseph Mills, MD
  Professor of Surgery
  Chief, Division of Vascular Surgery
- David Armstrong, DPM, PhD
  Associate Professor of Surgery
  Director, SALSA
- Khalid Khan, MD, MRCP
  Director, Transplant Hepatology

- Rifat Latifi, MD
  Associate Director, Arizona Telemedicine
- Jonathan Daniel, MD
  Assistant Professor of Surgery
  Division of Thoracic Surgery
- Marlon Guerrero, MD
  Assistant Professor of Surgery
  Division of Surgical Oncology
- Tun Jie, MD
  Assistant Professor of Surgery
  Division of Transplant Surgery
- Terence O'Keeffe, MD
  Assistant Professor of Surgery
  Division of Trauma Surgery
- Vassiliki Tsikitis, MD
  Assistant Professor of Surgery
  Division of Surgical Oncology
- Julie Wynne, MD
  Assistant Professor of Surgery
  Division of Trauma Surgery
- Carlos Galvani, MD
  Associate Professor of Surgery
  Division of Bariatric Surgery
- Michael Moulton MD
  Associate Professor of Surgery
  Division of Cardiothoracic Surgery
- James Warneke, MD
  Associate Professor of Surgery
  Division of Surgical Oncology

Faculty: Other Department

- Steven Barker, MD, PhD
  Professor of Anesthesiology
  Chairman, Department of Anesthesiology
- Achyut Bhattacharyya, MD
  Professor of Pathology
  Chairman, Department of Pathology
- Kathryn Reed, MD
  Professor of Obstetrics and Gynecology
  Chairman, Department of Obstetrics and Gynecology

Residents

- Adam Hansen, MD – General Surgery (PGY 5)
- Felipe Maegawa, MD – General Surgery (PGY 4)
- Atanu Biswas, MD – General Surgery (PGY 3)
- Erica Salinas, MD – General Surgery (PGY 3)
- Mustafa Raoof, MD – General Surgery (PGY 2)
- Matthew Mino, MD – General Surgery (PGY1)

CHARGE:

As enunciated by Gail Burd, PhD – Vice Provost for Academic Affairs – UA SOM, the Academic Program Review (APR) is mandated by the University of Arizona every 7 years. The APR is designed to assess the quality of clinical program and its faculty, the interaction between faculty, the quality of teaching of residents and medical students and the contribution to the community.

The charge for the review committee is to provide a SWOT (Strength, Weakness, Opportunities and Threats) analysis with recommendations to serve as guidance for the Dean, the Provost, the UMC CEO and the department chairman.

OVERVIEW:

Facilities

The University of Arizona Department of Surgery is an academic department in the College of Medicine, which is housed at the University Medical Center (UMC). Additional clinical facilities include the off-campus facilities: the University Physicians Healthcare Hospital at Kino (UPHH); the Southern Arizona Veterans Affairs Health Care System (SAVAHCS); Tucson Medical Center and Tuba City.

Mission:

"The mission of the Department of Surgery is to foster excellence in patient care, surgical education, research and technical innovation. We strive to be leaders and role models of excellence, innovation, and caring in what we do, and we are committed to train the next generation of surgeon leaders. Our actions exemplify our core values of compassion, integrity, respect, pursuit of knowledge, responsibility and diversity."

Organization:

The Department of Surgery consists of 9 divisions:

a) Abdominal Transplantation
b) Cardiothoracic Surgery
c) General Surgery
d) Neurosurgery
e) Reconstructive Surgery
f) Surgical Oncology
g) Trauma
h) Urology
i) Vascular Surgery

Research facilities of the Department of Surgery include approximately 10,000 sq ft including class 10000 clean room for cellular transplantation, a large animal training facility, and a simulation center, as well as shared research space in the cancer center.

Training programs:

ACGME accredited residency programs within the Department of Surgery include: General Surgery (6), Urology (1.5), Neurosurgery (1) and Vascular Surgery (2). ACGME accredited fellowships exist in Cardiothoracic Surgery (3) and Vascular Surgery (1). A critical care fellowship (1) was also recently approved.

In February 2010, the Department of Surgery was notified of the decision by the RRC to put the general surgery residency program on probation status in response to violations of the 80-hour work rule and academic deficiencies that accumulated prior to the change of departmental leadership. It is anticipated that this probation period will last 2 years.

Since 2009, a MS/PhD in Medical Sciences has been offered – currently 1 resident is enrolled and funded through an endowment.

There are proposals to expand the breadth of fellowships in Trauma, Transplantation, and Surgical Oncology.

Faculty:

Division and Current Level of Staffing:

Abdominal transplantation:
UMC: 6 clinical, 2 PhD

Cardiothoracic:
UMC: 10 clinical, 2 PhD

General Surgery:
UPHH: 4 clinical
SAVAHCS: 4 clinical

Neurosurgery:
UMC: 3 clinical
SAVAHSC: 2 clinical

Reconstructive surgery:
UMC: 1 clinical

Surgical Oncology:
UMC: 8 clinical, 2 PhD

Trauma:
UMC: 7 clinical

Urology:
UMC: 6 clinical
UPHH: 1 clinical
SAVAHSC: 1 clinical

Vascular surgery:
UMC: 5 clinical
SAVAHSC: 1 clinical

Education Program Directors:

Dr. Amy Waer - General Surgery Residency Program Director
Dr. Shari Meyerson – Cardiothoracic Fellowship Program Director
Dr. Joseph Mills – Vascular Surgery Residency Program Director
Dr. Mitchell Sokoloff – Urologic Surgery Residency Program Director
Dr. Martin Weinand – Neurologic Surgery Residency Program Director
Dr. Evan Ong – Medical school coordinator

ASSESSMENT:

The Department of Surgery at the University of Arizona is unique in the modern day academic surgery world – it represents one of the most inclusive university based surgery programs, incorporating nearly all surgical disciplines (with the exception of orthopedic surgery and OB/GYN). Urology and Neurosurgery are not typically included in contemporary surgery departments, since they are commonly stand-alone departments. In addition, it is our understanding that ENT and Pediatric Surgery are being considered as new Divisions within the Department of Surgery.

In the 43-year history of the Department of Surgery, there have been 5 departmental chairmen. The history of the department has been marked by periods of disarray and discord on many levels. During the most recent APR conducted in 2003 (of which one of the current External Reviewers, Dr. Benjamin Paz and one of the current Internal Reviewers, Dr. Dino Stea, were members), a scathing assessment was provided. Concerns were made on the lack of leadership, lack of financial management, inability to recruit or retain surgical faculty, lack of mentorship, ongoing conflicts within the department for a unified mission (especially noted was cardiothoracic surgery), insufficient or absence of critical services (transplant, ENT, pediatric surgery, plastic surgery) as well as the lack of a unified governance structure (including the University Physicians Health, University Medical Center and the College of Medicine). Although that report highlighted several stable platforms in the Department of Surgery, including neurosurgery, trauma, the general surgery residency program, since the 2003 report there has been deterioration in other areas. Specifically, loss of faculty in trauma and neurosurgery led to further erosion of clinical services and volume of cases with mounting operating losses and the general surgery residency program suffered from its worst academic performance evident by the 100% failure rate in the American Board of Surgery exams in the 2007 graduating class. Clearly by 2007, the Department of Surgery was in serious jeopardy of losing its residency program and ceasing to exist in any semblance of a functioning academic department of surgery.

Fortunately, the leadership in the College of Medicine, the University Physicians Health Plan and the University Medical Center embarked on an earnest recruitment for an academic surgical leader. In July 2007, an internationally recognized academic surgeon, Dr. Rainer Gruessner was recruited to the University of Arizona. Armed with a clear vision to rejuvenate the department and a recruitment package to implement this vision [$12.5 million clinical initial investment - breakdown COM (~10%), UPH (~30%), UMC (~60%)], notable achievements have been made since his arrival.

a. Recruitment:
   Thirty-two new faculty added with nationally recognized division leaders in transplantation, trauma, research, urology and neurosurgery as well as faculty with expertise in bariatric surgery, endocrine surgery, colorectal surgery, vascular surgery and transplant. Addition of 1 Editor,1 Biostatistician, and 1 Development director
b. Certification
   Achieving American College of Surgeons Level I Trauma designation
c. Clinical volume:
   Yearly incremental increase in OR cases, averaging 17% per year
   Yearly incremental increase in total charges, averaging 19% per year
   Yearly incremental increase in net patient revenue, averaging 16% per year
d. Faculty metrics:
   i. Academics:
      Increase in publications averaging 35% from 2007 to present
      Increased representation in societal leadership
   ii. Morale:
      Improved satisfaction and optimism
      Initiation of collaboration with other University of Arizona departments
e. Education:
   Increased number of resident participation in publication (100% increase since 2007)
   Improved passage rate for American board of surgery and absites score

The first wave of recruitment was aligned with the stated pillars by the UMC Board: oncology, transplantation, trauma, diabetes, and cardiovascular diseases. Examples of this include: expansion of hepatopancreatobiliary surgery in oncology, multiorgan transplantation, ACS level I certification, formation of SALSA by Dr. Armstrong as the largest service of this type for diabetics, and recruitment of two thoracic surgeons.

The faculty surveyed expressed that Dr. Gruessner is a strong chairman, charismatic, who negotiates on behalf of the entire department, with tangible benefits to the hospital and other departments. The majority of faculty feels he provides a compelling vision, articulates a clear mission, and embraces shared values. He was described by his senior leadership peers as setting high standards for excellence in the quality of his recruitments, representing those standards himself.

He has taken what was initially not a classic academic department and the faculty appreciates the current efforts to return to academic model. For the most part, the faculty is also supportive of faculty mentorship and development opportunities. The attention to surgical education is exemplified by a positive impact of increased faculty involvement, which has allowed for selection of optimal rotations and structure. In response to the probation imposed on the general surgery residency, a structured education program with mandatory research is being implemented. The faculty also expressed that their primary objective are to be involved in academic endeavors and welcome the opportunity to participate in the development of a new surgical program from the "ground up". They are concerned about their academic productivity and the competing interests between a successful academic career and their economic viability. They also expressed concerns about the lack of programmatic support (OR availability and residents/house staff providers).

In spite of these improvements, there remain significant challenges with important deficiencies in clinical services. As noted in the 2003 APR – pediatric surgery, plastic surgery and ENT remain deficient. This is the focus of the second expansion proposed by Dr. Gruessner. There was also

discussion of the potential benefit of bringing the Department of Orthopedic Surgery within the Department of Surgery. This will provide leadership and recruitment synergy and alignment with other services such as neurosurgery, reconstructive surgery, and ENT. On the other hand, this could stretch available resources, jeopardizing the Department of Surgery's development and growth. Further comments on this issue are beyond the scope of this review.

Outside of the clinical services, additional support was provided in other areas: recruitment of Ph.D. ($2 million); research space ($6 million); graduate education of residents ($0.6 million); administrative core group ($0.6 million).

STRENGTHS

1) The recent proposed coalescence of the three clinical entities (the Medical School, The Practice Plan –University Physicians Healthcare—and the Hospital – UMC) in June 2010, will be a major advance in promoting efficiencies, establishing transparency and permitting a rational programmatic expansion and evaluation.

2) Current chairman is perceived to be strong, charismatic, with a focused visionary strategic plan – he has the support of the majority of faculty (78% rated very satisfied or satisfied with direction of department).

3) The first phase of recruitment has been perceived to be quite successful – 75% ranked quality of care to be excellent or good. This is also the perception of other clinical departments – as noted by Dr. Kathryn Reed from the Department of OB/Gyne, there is a changed culture of excellence that is driving other academic departments. The reviewers were impressed with the quality of the new faculty. They all have recruited from leading surgery programs including: UCSF, Mayo, MD Anderson, Brigham and Women's, University of Minnesota, etc.

4) The medical students and residents commended the new faculty for their educational involvement and commitment as well as their expertise in their respective fields.

5) The "halo" effect has benefited others in the medical center – for example, Dr. Achyut Bhattacharyya from the Department of Pathology noted that with the expansion of surgery, the department of pathology has seen increased activity and an increased breadth of interesting cases. The recruitment of additional pathologists will double the number of pathology staff which will result in their specialization into organ subspecialties enhancing their mission as academic pathologists. In addition, the growth has positively affected transfusion medicine and laboratory medicine.

6) The recruitment in surgery has been aligned with institutional priorities – for example, the trauma service is now first class. This specific division has been re-organized in an extremely innovative way that may set the standard for other surgery departments in the future. It is considered the Division of Acute Care Surgery that encompasses: general acute care surgery, trauma, and surgical ICU care. This strategy protects the academic mission of surgeons within other sections by keeping them from providing trauma and acute care call.

7) Newly developed research endeavors in surgery are innovative and have led to collaboration with other departments within the University. These include programs being developed in: pelvic floor reconstruction; bariatric surgery; and hepatic, pancreatic, intestinal and cellular transplantation.

8) There are unique programs in the Department of Surgery that also provide important care to the community and enhance its academic stature in research and training. These features provide national distinction to the Department of Surgery and include;

a) Medical Simulation – Arizona Simulation Technology and Education Center (ASTEC) – Allen Hamilton, MD
b) Telemedicine Department of Surgery – Rifat Latifi, MD
c) South Arizona Limb Salvage Alliance – David Armstrong, DPM and Joseph Mills, MD
d) Heart and lung transplantation – Jack Copeland, MD (also see "Weaknesses")

Specific Division Comments on strengths:

Abdominal transplantation:

The current comprehensive multiorgan transplant program has acquired notable faculty with overall outcomes at or above expected survival. There has been an increase in volume of cases. The faculty also participate in HPB surgery with increasing volumes in pancreatic and hepatic resections (total cases approximately 60/year). A mission support agreement has been approved, where the majority (70%) of designated funds is being designated for support departments (Medicine and Anesthesiology). Dr. Steven Barker from Department of Anesthesia has had to hire additional anesthesiologists to deal with the added surgical load, including transplantation. There were no committed funds for this increase, resulting in a $300,000 deficit, resulting from additional support required for call schedule, estimated at an additional $133k per staff. Hopefully these funds will help to support these critical areas.

Cardiothoracic:

This section has notable senior faculty (Drs. Copeland, Sethi, Larson, Meyerson, McDonagh) with a history of innovations. Recent developments include the recruitment of additional general thoracic surgery, which has aided in the credentialing of their CT fellowship program.

General Surgery:

There is now stability with the additions of Drs. Waer, Kettelle and McClenathan. Rotation of PGY2 and PGY4 resident to UPHH (total cases 971 in 2008) has helped to expand the geographical coverage and cases performed. Acute care surgery at UMC has provided more than adequate volume of general surgery cases for the residents on the trauma services -1500 cases for emergency general surgery. The addition of bariatric/minimally invasive surgery will enhance the more advanced cases that are needed for residency and fellowship training, as well as to address the demands for MIS procedures.

Neurosurgery:

The division chief clearly recognizes the current limitations of staffing and expertise, depending on relationships with private neurosurgery group at TMC for residency training.

Reconstructive Surgery:

With only one faculty member, this remains a distinct deficit (addressed below).

Surgical Oncology:

With the increase volume of general surgeons, those that have focused on surgical oncology have seen increasing case volume (450 cases per year in breast, HPB, CORS, melanoma). The multidisciplinary commitment is clearly there and will help to propel further expansion.

Trauma:

This is clearly one of the keystones of the Department of Surgery and a success story in the first phase of development in the Department of Surgery – this recently led to ACS Level I certification of the trauma program. There is a large volume of trauma (5000 admissions per year). In addition, the stability brought on by the recruitment of the trauma team allowed for formation of the Acute Care Surgery program. In addition, these faculty are also surgical critical care certified and will provide coverage in 20 bed SICU, with anticipation of increasing SICU to 49 beds in the future. Trauma services are not only a benefit the community, but could bring the remarkable financial benefits to the hospital. For example, in one study, it was found that the net revenue multiplier, the dollars collected by the hospital for facility services generated for each dollar collected by the orthopedic surgeon, was 7.81. (Vallier HA, Patterson BM, Meehan CJ, Lombardo T.: Orthopedic traumatology: the hospital side of the ledger, defining the financial relationship between physicians and hospitals. J Orthop Trauma. 2008 Apr;22(4):221-6.)

Urology:

In spite of recruitment of full time academic urology at UMC, UPHH and SAVAHCS, there are still areas of services that are lacking, requiring collaboration with private urology at TMC and Phoenix Children's Hospital.

Vascular surgery:

Established division with excellent clinical care and a good regional reputation of senior faculty – leaders with strong clinical growth and integration of new vascular procedures. Good balance between open and endovascular procedures and commitment to training.

WEAKNESSES

1) In the assessment of the return on investment on the first phase of expansion of the Department of Surgery, we were struck by the lack of transparency in budget details for UMC. Hopefully the historic lack of cooperation by UPH, UMC and COM will be solved by the anticipated upcoming merger
2) In the proposal for second phase development in the Department of Surgery, there was a notable lack of business plans for new programs – this would be critical in determining how to prioritize proposed program development in the second phase – details will also assist in determining schedule and magnitude of support
3) Lack of hospital cost data hampers the ability of achieving meaningful cost reductions and competitive contracting.
4) Lack of cooperation by UPH, UMC and COM also inhibits the optimization of services and finances (see below)
5) As one would anticipate, there was some degree of alienation and non-cooperation by some senior faculty that were present prior to the first phase of development. For the most part, the faculty has fallen into step with the chair (with one notable exception).

6) Persistent services deficiencies - referral of UMC patients to outside surgeons due to lack of expertise in certain areas, limitations in personnel and resources
7) Faculty assessment of research activities is still poor (58% rated fair or poor)
   a. Overcommitted clinical efforts
   b. Lack of research infrastructure, e.g. research coordinators, data managers, etc
8) Deterioration of clinical performance and poor mentoring of faculty in the Division of Cardiac Surgery.
9) Lack of academic programs in ENT, plastic surgery and pediatric surgery.
10) Under-developed Department of Orthopedic Surgery that hinders the successful development of the Neurosurgery denying access to high quality care to the community and quality training of neurosurgery residents.

Specific Division Comments:

Abdominal transplantation:

The lack of transplant hepatologists is a challenge to building the waiting list, which drives the number of transplants being done. For comparison, Mayo Scottsdale has more than 10 times the number of candidates on the waiting list, while Good Samaritan has 18 times the number. For the kidney transplant list, the range of deficiency in the waiting list is less severe, but UMC has the smallest kidney transplant program of all programs in Arizona. It will be important to provide sufficient resources to recruit the medical support services for transplant programs. The financial impact of a transplant hepatologist was recently analyzed. For every 1 dollar billed by hepatology, the hospital system generated an additional 26.95 dollars in charges (51.03 dollars for the orthotopic liver transplantation patients, and 14.26 dollars for the non-orthotopic liver transplantation patients). (Cohen SM, Gundlapalli S, Shah AR, Johnson TJ, Rechner JA, Jensen DM.: The downstream financial effect of hepatology. Hepatology. 2005 May;41(5):968-75.)

Cardiothoracic:

In spite of the notable contributions by the current Division Chief, Dr. Jack Copeland, the division leadership and department reputation is lagging and falling quickly. Lack of mentorship has translated into discontent and departure of the junior faculty to competing hospitals and the significant decline in clinical volumes at UMC. This also has resulted in the recent threat of CMS decertification and the reduction in heart transplant volumes.

The lack of rotating CT fellows to hospitals where CT faculty practice (400 at TMC vs. 500 at UMC) does not maximize training opportunities and threatens to fractionate faculty. In addition, there is a benefit of creating a cardiovascular institute or center for comprehensive heart care in order to compete with well established community heart programs.

General Surgery:

In order to optimize the bariatric surgery program, a comprehensive multidisciplinary program with appropriate UMC marketing will be needed. Specially designed operating rooms should be developed for both bariatric and advanced MIS procedures.

Neurosurgery:

As noted before, the lack of neurosurgical subspecialists, limits the expansion and services provided by this Division. Strategic recruitment in Orthopedic Surgery and ENT can help with

the development of a state-of-the-art spine and base of skull surgery programs. Interventional ORs that can accommodate both vascular surgery and neurosurgery are critical to bringing the best care and advanced options to patients.

Reconstructive Surgery:

One important component of the services at a tertiary care center and as part of the trauma service is the need for reconstruction by both ENT and plastic surgery. Clearly this has the potential to add to several areas, including breast surgery, burn surgery, transplantation, and other oncologic areas, e.g. orthopedic, esophageal, cutaneous oncology.

671 patients who underwent hand surgery procedures in 2004 at the University of Michigan were examined. The net professional revenue was $1,069,836 while the net facility revenue was $5,500,606. Facility operating income was 908,071 dollars, or 16.51 percent of net facility revenues. (Hasan JS, Chung KC, Storey AF, Bolg ML, Taheri PA: Financial impact of hand surgery programs on academic medical centers. Plast Reconstr Surg. 2007 Feb;119(2):627-35.)

Surgical Oncology:

As the growth of surgical oncology is realized, there will be further subspecialization needed. Going forward it will be necessary to integrate all cancer surgery provided outside the division of surgical oncology into one program under the umbrella of the cancer center to ensure an integrated and multidisciplinary model of delivery. Many tertiary care centers have colorectal surgeons that do not participate in other surgical oncology procedures. With the expansion of this service it might be necessary to expand the colorectal program in general surgery as well as within surgical oncology. At UMC, there is only one clinical colorectal surgeon who has a 20% research commitment and is already too busy. Strategic recruitment should be considered.

The growth of breast cancer services will also be dependent on providing reconstructive services. The best cosmetic outcome is achieved with simultaneous breast surgery and reconstruction which is also financially sound. At the University of Michigan, 97 patients undergoing postmastectomy breast reconstruction in 2006 were analyzed. The professional revenue was $242,078 while the facility revenue was $1,109,678 (net profit of $165,786 (15 percent). (Alderman AK, Storey AF, Nair NS, Chung KC.: Financial impact of breast reconstruction on an academic surgical practice. Plast Reconstr Surg. 2009 May;123(5):1408-13.)

Trauma:

Expansion of clinical duties to include acute care surgery, trauma surgery and critical care surgery, as well as the desire of junior faculty to engage in academic efforts will also require additional staffing. It will be important to integrate trauma faculty into other sections in order to prevent competition for elective cases with the Department of Surgery. Currently, funding for the trauma services comes from multiple sources and has allowed this section to be cost-neutral. However, any reduction in the lines of support potentially has a significant negative impact on the staffing and services that can be provided.

Urology:

As noted above, there remain areas of deficiency, e.g. pediatric urology - hopefully the Diamond Children's hospital will be an attraction for recruitment.

Vascular surgery:

As noted in the deficiencies in Neurosurgery, there are antiquated facilities in the OR. Clearly a biplanar fluoroscopic OR interventional suite(s) needs to be constructed in order to provide state-of-the-art facilities and world-class patient care.

OPPORTUNITIES

The recent announced imminent coalescence of UPH, UMC and SOM should be harnessed as an example of a more global visionary approach to all University of Arizona programmatic strategic planning (both North and South of "Speedway"). We envision the development of a series of business plans that would include metrics incorporating: A) clinical activities, B) educational opportunities, C) investigative promise, and D) financial returns. Any proposed activity should be supported with a document detailing each of the above components. Emphasis would be conferred to multi-departmental and multi-disciplinary collaboration within the COM and the University. We were impressed with the enthusiasm of University of Arizona faculty at all levels toward efforts to break down the "silos". We witnessed this within the Department of Surgery and believe that this philosophy can constructively metastasize to other arenas in the COM and the University.

The addition of minimally invasive and bariatric surgery, pediatric surgery, otolaryngology, pelvic floor services and reconstructive surgery are all rational and needed. These services are essential and they are part of tertiary care programs across the country. They could be persuasively promoted with the development of a structured "business plan" as delineated above. Pivotal to this process is providing access to the clinical/financial impact on Hospital programs enabling evaluation of the plan and establishing priorities. One interesting concept is Dr. Gruesner's idea of "recycling dollars". As individual faculty become independent of support dollars, the freed money can then be used to support new faculty. The same can be done from the programmatic point of view for the non-salary support. This will provide an incentive for individuals and research programs to become economically independent.

Additional initiatives that are under consideration include the creation of Level III trauma designation at UPHH to offload non-Level I admissions thereby decreasing crowding and diversions from UMC. In addition, creation of a Burn Center at UPHH is being considered.

Increasing OR capacity and efficiencies by utilization of Alvernon ambulatory surgery center and UPHH operating rooms will allow UMC to respond to the increasing OR demand, without massive construction of new operating rooms. With the OR shortage in UMC and underutilization at Alvernon and UPHH, it makes sense to move ambulatory services to Alvernon and to locate certain other services at UPHH, for example, reconstructive and plastic surgery. This is clearly the best way to increase efficiency and reduce costs (Abouleish AE, Dexter F, Epstein RH, Lubarsky DA, Whitten CW, Prough DS.: Labor costs incurred by anesthesiology groups because of operating rooms not being allocated and cases not being scheduled to maximize operating room efficiency. Anesth Analg. 2003 Apr;96(4):1109-13,)

In order to bring expertise to fill surgical areas of need in the Department of Surgery, establishing incentives to attract select community surgeons back to University will allow for immediate clinical and financial payback while minimizing alienation of community surgeons

Under the proposed merger, the hospital will assume outpatient costs (provider based clinic) which should help to improve the financial picture of the department, due to cost shifting of expenses that were used to support clinics, particularly in vascular surgery and urology.

The focus on research efforts in the Department of Surgery should translate into enhanced collaborations across the health sciences and other departments at the University of Arizona with resultant increasing NIH funding.

THREATS

Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off. The effect of the burst of programmatic surgical development (with its constructive penumbra influence on other COM disciplines) has not yet, in our view, been realized. While only slightly more than half of the deficiencies identified by the 2003 APR have been addressed, this is due in part to several other important deficiencies that have arisen from 2003 to the time that Dr. Gruessner took over in 2007. Failure to completely reconstitute the Department of Surgery will not only perpetuate mediocrity of the department, but may threaten the retention of the promising new faculty that has been recruited. Clearly the impact of failure to sustain the formidable academic/clinical/educational/fiscal growth would be devastating. . Furthermore, the lack of academic and programmatic support might truncate promising academic careers and drive the faculty to pursue less onerous and more lucrative private practice opportunities.

In one publication from the Clinical Coordinating and Planning, The University of Arizona College of Medicine, it was determined that the recruitment, hiring and lost clinical income cost of replacing a surgical subspecialist was $587,125. (Schloss EP, Flanagan DM, Culler CL, Wright AL.: Some hidden costs of faculty turnover in clinical departments in one academic medical center. Acad Med. 2009 Jan;84(1):32-6.).

The discord in the Division of Cardiothoracic Surgery has reached a critical state. The lack of leadership has been recognized as a contributing factor to morale issues, failure to retain faculty and other issues. It is recommended that the leadership be transitioned to another Division member or another senior member of the Division. Dr. Steve Goldschmid – Dean, College of Medicine acknowledged that leadership issues needed immediate attention.

COMMENTARY

A proposal by Dr. Gruessner has been made to renew the support package to the Department of Surgery for the next 5 years. This funding is requested for the new programs, ENT, Bariatric/MIS, Pelvic Floor disorders, UPHH – Level III Trauma, Burn Center, Pediatric Surgery, CT Surgery and Reconstructive Surgery. Dr. Kathryn Reed, Department of OB/Gyne, confirmed the perception of most COM departments that Dr. Gruessner and the Department of Surgery do successfully leverage and share resources amongst the different UMC departments. Her example of this joint effort was the pelvic floor program involving OB/Gyne, Urology, General Surgery and Anesthesiology.

In order to assess the priorities for support and to fit the resources and priorities of the newly merged UMC/COM/UPH entity, it will be incumbent upon the groups to provide a mission support schedule and detailed accounting of currently expended funds for the first phase. The department should be assured that the success to date in addressing the clinical service deficiencies will continue to be supported along the timeframe that was agreed upon in 2007. A plan to address remaining clinical service deficiencies, in particular ENT, neurosurgery, cardio-thoracic surgery and reconstructive surgery should be put forward with a detailed business plan (as noted above) for the second phase of recruitment. We all acknowledged the formidable national recognition reflected upon the University of Arizona by the section of Cardio-thoracic surgery. An evolution in leadership is now important.

Full access to previously proprietary business information from UMC is needed, in order to create robust business plans. Future planning will benefit from a RVU based assessment of clinical activity to assess return on investment for both practice plan and the medical center. The tripartite administrative group will need to prioritize recruitment timeline based on academic priorities, clinical need and revenue generation. This figure shows the relative hospital margin per RVU by clinical service from a University of Pennsylvania study. (Resnick AS, Corrigan D, Mullen JL, Kaiser LR.: Surgeon contribution to hospital bottom line: not all are created equal. Ann Surg. 2005 Oct;242(4):530-7). It is important to understand that the programmatic ROI is almost certainly institution-specific. What happens at Penn may not translate to Arizona – the message, however, is that programs confer widely different returns. This can, and must, be examined openly in any business plan proposal.

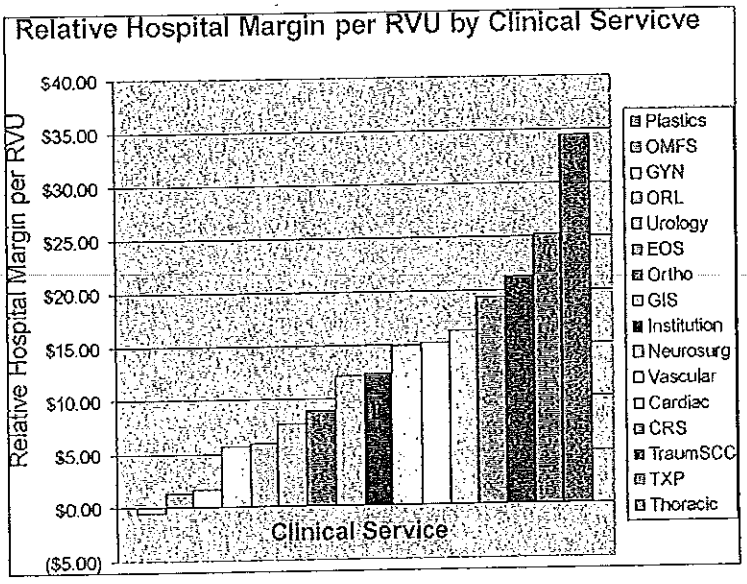

Figure Legend: Relative hospital margin (RHM0 per RVU varies greatly by service. Mean RHM per RVU was 12.64 mu (standard deviation = 9.76 mu) with range from a loss of 0.57 mu per RVU (plastic surgery) to a gain of 34.55 mu per RVU (thoracic surgery). GIS, gastrointestinal surgery; TXP, liver, kidney, and pancreas transplant; CRS, colorectal surgery division; EOS, endocrine and oncologic surgery; ORL, othorhinolaryngology; TraumSC, trauma and surgical critical care; GYN, gynecologic surgery; Ortho, orthopedic surgery; OMFS, oral maxillofacial surgery.

We agree with Kevin Burns – UMC CEO, that the merged entity of administration should work closely with the clinical departments to improve the financial health of the entire organization. Clearly the APR committee felt that there are many ways to do this - by reducing expenses, by

extracting efficiencies, by improving contracting opportunities, marketing the clinical programs, and to selectively add to the clinical services that differentiate a quaternary from tertiary care center.

As these issues of clinical development are taking place, other challenges for the Department of Surgery are being created, such as the opening of the COM Phoenix campus. Although a mandate of the Arizona Board of Regents, which oversees priorities for College of Medicine, the resources to provide appropriate clinical venues to train the medical students and to coordinate clinical programs at the two sites will require more than financial support. Clearly there is insufficient staffing and financial support to manage this from the Tucson campus.

The previous educational programs within the Department of Surgery were essentially non-existent due primarily to the paucity of available teaching surgical faculty. Although the current departmental administration and faculty are addressing RRC probation of general surgery residency (with an impressive schedule of teaching conferences and mock written/oral examinations) and looking at objective measures of improving resident performance, the challenges of growing the department with limited resident availability will necessitate the inclusion of healthcare extenders, not only at a departmental level, but at an institutional level.

In the absence of a long academic tradition and role models it is necessary to provide for the future development of the newly hired faculty, especially at the assistant professor level. A formal mentoring team that includes both clinicians and researchers should be established for every new assistant and associate professor recruited. Support for grant writing and submission and for IRB development should be instituted. Mechanisms should be established to facilitate interactions and collaborations with the broader research community within the COM and across the UA campus. If the highly qualified new hired faculty become overburdened with clinical responsibilities and are not provided with help and encouragement for the development of their research programs, the current opportunity for building a truly academic Surgery Department will be lost.

Lastly, we would like to thank all involved in the APR, for the opportunity of participating in this review. We felt that the Department of Surgery has made tremendous strides and that their efforts will substantially improve all aspects of the University of Arizona and health systems. Not only have the clinical services greatly improved, but the vision enunciated by Dr. Gruessner will take the department and institution to a level of reputation never achieved before. We urge all parties to look beyond short-term gains and to provide support that will lead to accomplishments in line with the potential that exists. It is also important to provide strategic support to non-surgical departments that are being affected by the surgical expansion (anesthesia, pathology) and to invest in the infrastructure that houses the surgical program to prevent faculty exodus to competing programs and hospitals. Several faculty expressed concerns in the business infrastructure (billing, collection and contracting) that supports the clinical mission and the impact on the financial viability of individual faculty and services within the surgical department. The structure along strategic mission driven multidisciplinary programs (oncology, transplant, diabetes and limb salvage, trauma, etc.) might provide additional fund raising and academic recognition opportunities, as well as help with competitive grant funding. There is clearly the need to establish metrics to measure individual and programmatic success and to establish intermediate steps that lead to successful and fulfilling academic and clinical careers. Furthermore, in the absence of a long academic tradition and role models is necessary to establish a one to one mentorship for every new assistant and associate professor recruited.

FINAL REPORT
ADMINISTRATIVE REVIEW
Rainer Gruessner, MD
Professor and Head
Department of Surgery, College of Medicine
11/1/2012

I. Charge to the Committee

In accordance with University policy that all administrators be evaluated at five year intervals (UHAP 5.09), the Dean of the College of Medicine appointed a committee to review Dr. Gruessner, Head of the Department of Surgery. This was the first review of Dr. Gruessner as Head of Surgery.

II. Composition of the Committee

Alexander Chiu, M.D., Professor, Department of Surgery [Chair]
Lisa Chan, M.D., Professor, Department of Emergency Medicine
Randall Friese, M.D., Associate Professor, Department of Surgery
Michael Lemole, M.D., Professor, Department of Surgery
Ole Thienhous, M.D., Professor and Head, Department of Psychiatry

III. Data Acquisition by the Committee

The Committee began its meetings on June 15, 2012 at which time it received its charge from Anne Wright, PhD, Senior Associate Dean for Faculty Affairs. At this meeting, the Committee also received Dr. Gruessner's self-study and a copy of the questionnaire used by previous review committees. Members of the Committee met with Dr. Gruessner on September 14, 2012 to discuss the questionnaire and to give him the opportunity to discuss his accomplishments in the past five years and his plans for the next five years. The Committee distributed the questionnaire to members of the Department of Surgery, including faculty and academic professionals, residents and fellows, and staff, as well as all College of Medicine department heads and selected UA Healthcare administrators. In addition, the Committee solicited input from Departmental faculty and staff either in person or in writing.

IV. Report of the Committee

1. Brief History of Dr. Gruessner's Administrative Career and Accomplishments as Chair

Dr. Gruessner became Head of the Department of Surgery on July 1, 2007. This is his first administrative review. Prior to Dr. Gruessner's arrival in 2007, the Department of Surgery (DOS) numbered 35 faculty, including 23 full-time clinical faculty at UAMC. Over the fiscal period between 2003-2007, the DOS clinical program's operating losses exceeded 2.4 million dollars. Core surgical programs to the vast majority of successful academic institutions, such as Otolaryngology, Plastic surgery and Abdominal transplantation, did not exist. In addition to the clinical vacuum that existed prior to Dr. Gruessner's arrival, the academic enterprise of the

DOS was failing. 100% of the graduating chief residents in general surgery failed their written board examinations in 2007 and departmental grant money totaled 1.9 million in FY08.\

Since Dr. Gruessner's arrival, the DOS has experienced a tremendous growth in clinical, academic and educational production. By 2012, the department has grown to a faculty size of 88 surgeons with resultant clinical professional charge volumes that are the strongest in the college of medicine. Core surgical programs that had failed to exist in the past have now been created (Otolaryngology, Abdominal Transplantation, Plastic and Reconstructive Surgery) and programs that had been weakened by faculty turnover and/or traditionally weak (Neurosurgery, Cardiothoracic Surgery, Trauma Surgery) have been rebuilt to become locoregional and nationally recognized programs of strength. Since 2007, the development of minimally invasive and robotic surgery across all divisions has been an intense focus of development, positioning the DOS as an innovative program leader in the Southwest United States.

Since 2007, the educational mission and activities with the DOS has greatly improved. In the existing residency programs (General Surgery, Neurosurgery and Urology), the number of categorical residents per year has increased. 1 new residency program was created (Vascular Surgery) and 2 others are in the process of being established (Otolaryngology, Cardiothoracic Surgery.) General Surgery residency board pass rates have significantly improved and the program came off probation from the ACGME on 2011. 5 new surgical fellowships have been created, an annual national CME course has been started (Otolaryngology) and numerous surgical faculty have received teaching awards from the college of medicine. The DOS developed a large animal training facility which now offers 6 training courses in minimally invasive and robotic surgery for 8 general surgery residents per year. Finally, an endowment of 1.64 million dollars was used to develop a MS/PhD program which has been obtained by 5 departmental residents since 2009.

Grant funding and research dollars have significantly increased since FY07. 19 DOS faculty members currently receive funding for a total grant money support of 4.2 million dollars in FY12 (as compared to 1.9 million prior to Dr. Gruessner's arrival). Individual faculty members continue to garner national and international academic reputations, as evidenced by leaderships on society boards, textbook authors, serving as editor-in-chief of academic journals, functioning as course directors of international society CME courses and being frquently invited visiting professors at peer institutions.

Lastly, the DOS has had a tremendous impact on the Tucson and Arizona community. The expert clinical care performed and deft dealings with the media and community during and following the Giffords shooting in 2011, brought unprecedented prestige and internal pride to the University of Arizona college of medicine and UAMC. This could not have been achieved without the leadership of Dr. Gruessner and the 2 division chiefs that he personally recruited to rebuild the trauma and neurosurgery programs (Rhee and Lemole) as well as the other surgery division programs that were consulted in the care of the shooting victims.

2. Comments on the Interview with Dr. Gruessner

The committee met with Dr. Gruessner on September 14, 2012. Dr. Gruessner presented his perspective on performance as Head of the Department of Surgery over the past 5 years. As evidenced by his accomplishments detailed above, Dr. Gruessner was pleased with his ability to build a strong clinical, academic and research oriented department. He has performed a remarkable job with recruiting surgeons to Tucson. He has been effective in recruiting talented division chiefs of national renown and accomplishments, as well as junior faculty from many of the leading training institutions in the country. Despite being of large size with 9 divisions, he has built a cohesive department that prides itself on hard work, academic productivity, innovation and clinical excellence.

Over the next 5 years, Dr. Gruessner's strategic plans include expanding the basic science research and funding within the department with hopes of each division having a funded research lab. His goals are to propel the DOS in the top 25 nationally in NIH funding and to successfully recruit established researchers who can continue their work as well as mentor existing junior faculty. Dr. Gruessner also recognizes that his rebuilding efforts are not yet complete. He is hopeful that he will receive the needed support to build the pediatric surgical subspecialties and strengthen the surgical oncology division. He also recognizes a mission critical importance to improve the hospital infrastructure needed to sustain the growth of the surgical programs. The hospital clinics and operating rooms are barely able to accommodate the surgical volumes that have been created and continued growth will be severely hampered by the current facilities. In addition, in order for the DOS to become a national leader, the educational infrastructure, including dedicated surgical skills labs for residents and medical education classrooms that are found in the vast majority of academic institutions, is sorely needed to elevate the academic profile of the department as well as institution.

Finally, Dr. Gruessner is eager to build the University of Arizona brand on a regional and national level. He has begun building referral centers in Las Vegas, Phoenix and New Mexico to recruit tertiary level surgical cases to UAMC. He has started this initiative in transplant surgery but is hopeful he can lay the groundwork to expand to the other surgical divisions. The ultimate goal is to make the UA DOS a top 20 department over the next 5 years.

3. Results of the Survey Questionnaire

a. Respondents

The questionnaire used to survey faculty and staff opinion of Dr. Gruessner's performance as Head of the Department of Surgery included both numeric and open-ended portions (see Appendix for a copy of the form used). By September 2012, 109 individuals completed the questionnaire.

Of the 109 surveys completed, 43 faculty, 14 residents or fellows, 43 classified staff and 9 department heads responded. 39% of the faculty were Professors and the vast majority surveyed (85.6%) were primarily located at the UAMC campus.

b. Numerical Results by Core Content Area

The respondents addressed twelve general categories pertaining to issues such as their perception of Dr. Gruessner's 'leadership,' 'commitment to scholarly activity,' 'ability to recruit and retain new faculty,' etc. Under each of these general categories were up to 13 separate questions about specific issues for a total of 91 specific items. The queries were posed in a positive fashion with possible responses ranging from "strongly agree" down to "strongly disagree". Respondents were also asked to provide an 'Overall' assessment of Dr. Gruessner's performance as Head of the Department of Surgery.

After the surveys were completed, the standardized forms were tabulated by the Office of Faculty Affairs. Responses were organized into 5 groups: faculty, staff, residents/fellows, department heads and an overall average. A 1-5 point scale was used with a 5 being the highest possible rating (ie."strongly agree").

For an overall evaluation, Dr. Gruessner received a score of 4.34. Overall scores from each individual group: faculty – 4.37; staff – 4.00; Residents/fellows – 4.53; Department Heads – 4.35.

Categorical breakdown:

A. Faculty: (overall 4.37)

Strongest scores in:

1. Procurement of resources – 4.46
2. Recruitment and affirmative action – 4.20
3. Morale and working environment – 4.16

Weakest scores in:

1. Conflict resolution – 3.79
2. Mentoring – 3.87

B. Staff: (overall 4.00)

Strongest scores in:

1. Procurement of resources – 4.50
2. Recruitment – 4.17
3. Performance evaluations and salary adjustments – 4.00

Weakest scores in:

1. Conflict resolution – 3.13
2. Goal setting – 3.14

C. Residents/Fellows (overall 4.53)

Strongest scores in:

1. Mentoring – 4.49
2. Recruitment – 4.48
3. Commitment to scholarly activities – 4.52

Weakest scores in:

1. Conflict resolution – 3.92
2. Performance evaluations – 3.94

D. Department heads (overall 4.35)

Strongest scores in:

1. Morale and working environment – 4.35
2. Communication – 4.31
3. Management of fiscal affairs – 4.29

Weakest scores in:

1. Performance evaluations and Salary Adjustments for faculty/staff – 3.29
2. Procurement of resources – 4.00

c. Subjective Portion of the Questionnaire

Dr. Gruessner received an extraordinary amount of praise in regards to his ability to recruit faculty, serve as an inspirational leader and his accomplishments in building the department of surgery and his relationship with the community.

Examples of comments in regards to his recruitment efforts include "The number of quietly hard-working yet amazing new faculty and staff that he has recruited and continue to support, is incredible." "The division chiefs are from top caliber institutions and training programs. Most of these faculty come to the UA because of Dr. Gruessner's reputation and a desire to be part of his vision for building a premier academic and clinical program both nationally and internationally."

On relationships with the community: "Dr. Gruessner is an excellent ambassador for the department, college, university and health network." "is very highly regarded by community leaders." "highly respected among other departments. Always committed to representing the department and the COM in the best manner possible."

On leadership: "Outstanding; creates a vision and is showing us how to get there." "A very strong goal orientation. Effective in getting his agenda realized." "He is one of the most effective and inspiring leaders that I've known." "Brought national visibility and recognition for our medical center." "visionary leadership that has grown the department to unprecedented levels."

On his ability to build a program and procure resources: "He has worked tirelessly to build internal and external bridges." Does a good job of advocating for the dept of surgery." "highly interest in increasing research funding."

Although the vast majority of the comments were positive, there were some areas of improvement that were cited by a few. Some mentioned the sagging of morale, especially during the current time of limited financial resources and hospital leadership turnover: "Dr. Gruessner is the reason I remain here. The COM and UAHN leadership has created an environment of strife and ineffectiveness. It is very stressful and contentious environment. Dr. Gruessner continues to remind us of what we have achieved, why we are here and our vision." "Morale problems are due to administration and lack of vision and not due directly to the chairman." "Serious morale issues regarding business office mismanagement of people have left faculty and staff questioning his judgement."

One other relative weakness that has been identified in the survey is in the area of conflict resolution. "Dr. Gruessner has created conflict with other departments. Some of that is inevitable as DOS has grown considerably and others see that as unfair or a threat." "Prefers to disseminate conflict management issues to section heads."

Other useful comments

V. Summary and Comment

In summary, Dr. Gruessner has performed an admirable job in his 5 years as Head of the Department of Surgery. All throughout the surveys, comments on his visionary and inspirational leadership, effective recruitment of faculty, commitment to the DOS and his achievement in program building have characterized his first 5 years as not only successful, but instrumental in improving the locoregional reputation of the hospital and national academic reputation of the DOS. Areas of weakness are relative, as even his weakest areas garnered scores that were very positive in nature. Areas to improve upon include his ability to resolve conflicts, both internally and within the college of medicine, and from a faculty and staff perspective, to improve the organization and effectiveness of his business office. This committee is greatly impressed by Dr. Gruessner's accomplishments over the past 5 years and look forwards to his next 5 years.

Signature Page

for

Rainer Gruessner, M.D., Administrative Review

_____

Alexander Chiu, M.D., Chair
Professor of Surgery
Chief, Division of Otolaryngology

_____

Lisa Chan, M.D.
Professor of Emergency Medicine

_____

Randall Friese, M.D.
Associate Professor of Surgery

_____

Michael Lemole, M.D.
Professor of Surgery
Chief, Division of Neurosurgery

_____

Ole Thienhaus, M.D.
Professor and Head
Department of Psychiatry

Exhibit D

From: Mlawsky, Karen D. [mailto:Karen.Mlawsky@uahealth.com]
Sent: Thursday, September 19, 2013 8:51 AM
To: Rainer Gruessner
Cc: Mlawsky, Karen D.
Subject: RE: incorrect records?

Rainer,

Thank you for your email, which was sent while I was away from the office on retreat for several days. We are looking into this.

Karen D. Mlawsky
CEO, UAMC

From: Gruessner, Rainer W.G.
Sent: Monday, September 16, 2013 3:01 PM
To: Mlawsky, Karen D.
Subject: incorrect records?

Karen,
last week when was I was asking for information regarding my liver transplant numbers it came to my attention that the data entered in OTTR regarding primary and assistant/co-surgeon is frequently incorrect and not based on the actual OR reports. I bring this to your attention as the data needs to be corrected according to the actual OR reports. For example and as you may remember, after there were 2 deaths on the operating table in liver transplant recipients last year, all liver transplants since (n=10) were only performed when I was present and performed the critical parts of the procedure. However, this is not how the information was entered in OTTR. Let me know how you would like to proceed to correct the records.

Rainer Gruessner, MD, FACS
Professor of Surgery and Immunology
Chairman, Department of Surgery
University of Arizona
rgruessner@surgery.arizona.edu
Office Phone: (520) 626-4409
Fax: (520) 626-9118

Exhibit E

From: Steve Goldschmid
Sent: Thursday, September 19, 2013 3:15 PM
To: Rainer Gruessner
Cc: Waldrum, Michael R. (Michael.Waldrum@uahealth.com)
Subject: Meeting today

Dear Rainer,

Because you were unable to attend the meeting I scheduled today, I am providing you notification from both UPH and the University of Arizona that, effective immediately, you are being placed on administrative leave with pay from both of those organizations. Those communications are attached. You are not permitted to return to campus without first making arrangements through UAMC security to do so. Because we want to give you an opportunity to retrieve any personal belongings you may have in your office and obtain your keys please contact Harry at 694-6541 or his cell at 400-0698 to make arrangements to accomplish these things no later than 10 am tomorrow morning, September 20th.

I was hopeful that I would be able to deliver these letters to you personally; however, that was not possible given your schedule.

Sincerely,
sg

Steve Goldschmid, M.D.
Dean
University of Arizona College of Medicine
Tucson, AZ 85724-5017
Phone: (520) 626-4555
Fax: (520) 626-6252

THE UNIVERSITY OF ARIZONA
Office of the Provost

Administration Building, Room 512
1401 E. University Boulevard
P.O. Box 210066
Tucson, AZ 85721-0066
Tel: (520) 621-1856
Fax: (520) 621-9118

MEMORANDUM

TO: Rainer Gruessner, M.D.

FROM: Andrew Comrie, Ph.D.
Senior Vice President for Academic Affairs and Provost

RE: Notice of Placement on Leave with Pay

DATE: September 19, 2013

I am placing you on leave with pay from your faculty position of Professor in the Department of Surgery pursuant to Arizona Board of Regents policy 6-201.J.3, the Conditions of Faculty Service, effective *immediately*. The President has delegated to me the authority to make decisions and act on her behalf in placing faculty on leave with pay. I have determined that your continued presence on the University campus is likely to constitute a substantial interference with the orderly functioning of the University and the Department of Surgery, and therefore direct that you not return to campus until further notice. (See ABOR section 6-201.J.3. http://azregents.asu.edu/rrc/Policy%20Manual/6-201-Conditions%20of%20Faculty%20Service.pdf.

I have received information from UAHN that you either altered or directed others to alter records related to transplant procedures by substituting your own name as primary surgeon for others who may have actually served as primary surgeons, and that you removed your name as primary surgeon on other cases where adverse events may have occurred and substituted the names of other surgeons as primary surgeons in those cases. Rather than proceeding according to usual protocol established by UAHN for identifying potential anomalies and working with appropriate administrators to make these changes, you made these changes unilaterally, which is inconsistent with appropriate protocol. Because your employment with the University is conditioned upon your maintaining membership in good standing with UPH, and that membership is in jeopardy based on this alleged conduct, I am placing you on leave at this time pending further action by UPH.

Under ABOR Policy, you have an opportunity to respond to these allegations in writing to me within fifteen (15) days of receipt of this notification to contest being placed on administrative leave with pay. If I do not receive a written response from you within this time frame, you will continue to be on leave with pay until further notice. If I do hear from you within this time period, then I will issue a written decision regarding your continued leave, which will be provided to you and Dean Goldschmid. Meanwhile, you will not be permitted to return to campus until you are notified that 1) you are free to return to campus without restriction; or 2) disciplinary proceedings will be instituted and you may return to campus pending conclusion of those disciplinary proceedings. Alternatively, you may be instructed that you will remain on leave pending conclusion of the disciplinary proceedings, during which time you may not return to campus.

An administrative leave with pay is not considered a disciplinary sanction, and you will continue to receive your full salary and benefits during the term of the leave.

cc: Ann Weaver Hart, President
Joe G.N. "Skip" Garcia, Senior Vice President for Health Sciences
Steven Goldschmid, Dean, College of Medicine
Michael Waldrum, CEO & President, The University of Arizona Health Network, Inc.

THE UNIVERSITY OF ARIZONA HEALTH NETWORK

MEMORANDUM

Human Resources Department

To: Rainer Gruessner, MD, Department of Surgery

From: Michael Waldrum, MD, MSc, MBA, President and CEO, The University of Arizona Health Network, Inc.

Date: September 19, 2013

Re: Paid leave

I am placing you on paid leave from your position until further notice. The reason for this leave is that information has come to our attention that you either altered or directed others to alter records related to transplant procedures by substituting your own name as primary surgeon for others who may have actually served as primary surgeons, and that you removed your name as primary surgeon on other cases where adverse events may have occurred and substituted the names of other surgeons as primary surgeons in those cases. Rather than proceeding according to usual protocol for identifying potential anomalies and working with appropriate administrators to make these changes, you did so unilaterally, which is inconsistent with appropriate protocol.

Although you will be on leave you are expected to be available by telephone and attend pre-arranged and authorized meetings, as needed. At this time, there are no such scheduled meetings. You are restricted from visiting any UAHN premises, unless it is specifically authorized by me, or as a result of a medical necessity covered by EMTALA provisions.

Should you have any questions, please do not hesitate to contact me at (520) 694-6535 or via email michael.waldrum@uahealth.com.

Exhibit F

3200 N. Central Avenue, 20th Floor, Phoenix, AZ 85012

jaburgwilk.com

Kraig J. Marton

kjm@jaburgwilk.com
602.248.1017 - Direct Phone
602.297.5017 - Direct Fax

October 9, 2013

Via E-Mail [GittlerA@jacksonlewis.com]

Amy J. Gittler, Esq.
Jackson Lewis, LLP
2398 E Camelback Rd Ste 1060
Phoenix, AZ 85016-3451

Re: Dr. Rainer W.G. Gruessner

Dear Amy:

By letter dated October 4, 2013 you asked for information about our client, Rainer Gruessner, M.D. One purpose of this letter is to provide that information.

However, before answering your questions, we want to express our grave concerns about what was done to Dr. Gruessner. As you know, by letter dated September 19, 2013 from Dr. Waldrum, Dr. Gruessner was placed on an immediate "paid leave" by the University of Arizona Health Network and presumably by the University Physicians Healthcare (here, jointly called "UPH"). At the same time he was placed on "leave with pay . . . effective immediately" from the University of Arizona and its College of Medicine in a letter from the University Provost. Those actions have been widely reported in the media and have been the talk in hospital hallways and among Dr. Gruessner's patients. Dr. Gruessner just attended the annual convention of the American College of Surgeons where he was approached by his colleagues about being on leave, too.

In other words, the very action of placing Dr. Gruessner on leave has been seriously damaging to him, his reputation and his career.

Worse, no one ever asked him anything before he was placed on leave. No one from UPH or the University asked him what he did or why he did it. Instead, he was shocked to learn that he was placed on an immediate leave without any warning. This is not the way to treat any tenured professor, and certainly not one who has over six years of such dedicated service.

To make matters even worse, Dr. Gruessner asked for and was told that he was entitled to see records. Yet when he finally got records on October 4 (after a long delay), it turns out that not all of them were given (5 of 31 operative notes were missing) and the method by which the medical records were produced violated HIPAA and likely involve HITECH. Patient records (obvious PHI) were actually left with a housekeeper at Dr. Gruessner's home when he was not even

present. In fact, he did not even know two of the three people who were cleaning his house at the time.

Then, when we finally started getting records and received answers to at least some of our questions, we have learned that the initial basis for the suspension is not correct, either.

Both of the September 19 letters said essentially the same thing. The Provost explained it this way in his letter:

> I have received information from UAHN that you either altered or directed others to alter records related to transplant procedures by substituting your own name as primary surgeon for others who may have actually served as primary surgeons, and that you removed your name as primary surgeon on other cases where adverse events may have occurred and substituted the names of other surgeons as primary surgeons in those cases. Rather than proceeding according to usual protocol established by UAHN for identifying potential anomalies and working with appropriate administrators to make these changes, you made these changes unilaterally, which is inconsistent with appropriate protocol.

When we asked University Counsel (Ms. Gotkin) for all records related to this, we were informed that the University has no records and they relied entirely on UPH.

When we asked you for clarification, we learned that:

1. There is no evidence that Dr. Gruessner "altered records."

2. There is no written protocol at all.

3. No one, apparently, has any evidence of just what was altered or not altered. Instead, Dr. Gruessner was presented with OTTR records as they currently appear.

4. When I asked for any records beyond the incomplete records that Dr. Gruessner was provided, you indicate there is no other record, and

5. UPH refuses to allow him access to the remainder of the medical records as to the listed patients.

All of this is gravely concerning. We believe that the act of suspending Dr. Gruessner without any investigation and all of what followed was malicious and likely actionable. Dr. Gruessner is responding to your inquiry without waiver of his right to pursue whatever claims he has arising out of what your client has done to him.

SPECIFIC RESPONSE TO YOUR QUESTIONS

In your October 4, 2013 letter you asked questions which we will now answer:

You ask: *"I would like a written explanation from Dr. Gruessner explaining in detail the bases and reasons for Dr. Gruessner's direction to change the OTTR database for each of the 31 liver transplants involved."*

Preliminarily, you have incorrect numbers. Dr. Gruessner received Operative Reports (OR's) on only 26 liver transplants, not 31. Even as to those, he did not receive all of the OR's or any other medical record related to any of those transplants. He also received OTTR printouts on an additional 4 patients, but none of those four had any Operative Report or any other accompanying record.

Second, you make a false assumption. You state, as if fact, that Dr. Gruessner gave "direction to change the OTTR database." He did not. Instead, he pointed out errors, and indicated that the administration may wish to change them. As for the rest of what you ask, it is best answered by answering in the context of the next two questions you asked.

You asked for: *All factual bases for Dr. Gruessner's direction that these changes be made [and] Why he chose to direct that the changes be made when he did.*

By way of background, by early September 2013, it was apparent to Dr. Gruessner that he would soon be stepping down from all administrative duties as Chair of the Department of Surgery and other related administrative positions. With my assistance he was negotiating terms of an acceptable agreement with the U of A College of Medicine and with UPH. He was also considering the possibility of departing the University, and he wanted to know what the records showed as to the number of transplants he had performed.

As you may know, patient medical records are kept through an Electronic Medical Record system (EMR), but an additional database is kept for transplant patients, for use by the United Network for Organ Sharing (UNOS). The UNOS database is kept through OTTR software. OTTR is not a patient record, but it does contain information useful to UNOS in its functions.

On September 9th, Dr. Gruessner in his capacity as the UNOS Surgical Director of Transplant Services at UAMC contacted Mike McCarthy (Manager, Business Systems, and Transplant Services). Dr. Gruessner was aware of the fact that the following day he would relinquish the position of UNOS Surgical Director and wanted to make sure that under his tenure AZUA reporting to UNOS and all records were accurate and correct.

Dr. Gruessner contacted Mr. McCarthy because to Dr. Gruessner's knowledge he was the highest level person in the administrative transplant program – this is because the previous hospital director for transplant services had recently left UAMC and a new director had not yet been appointed.

Dr. Gruessner discussed the abdominal transplant program with Mr. McCarthy and requested information regarding the liver transplant program, including the number of liver transplants that Gruessner had performed. Dr. Gruessner needed this information in connection with his future dealings with UNOS, especially if he were no longer affiliated with the UAMC. Dr. Gruessner was surprised and confused when he was told by Mr. McCarthy that OTTR showed he was the primary surgeon on only 12 liver transplants over the past > 6 years. Dr. Gruessner quickly realized that the liver transplant reporting to UNOS was incorrect because about 100 liver transplants had been performed under Dr. Gruessner's watch, and he had been the primary surgeon on a majority of them. While Dr. Gruessner had, of course, been very involved in the actual medical records (EMR) of his patients, he had not had occasion to review OTTR records in this context before.

When Dr. Gruessner asked Mr. McCarthy why the records were so incorrect, Mr. McCarthy replied that he thought that it might have been because the transplant coordinator would have reported to UNOS the name of the transplant surgeon on call or the attending surgeon based on the call schedule but not based on the actual OR notes.

Dr. Gruessner then realized that in the absence of a hospital transplant quality coordinator, incorrect reporting to UNOS had in fact occurred for quite some time. Despite several requests from the previous hospital transplant director, the hospital had not hired any quality coordinator who would have overseen correct reporting to UNOS. We also understand that the hiring of a quality coordinator had been recommended in the last two UNOS/CMS audits. Had there actually been a quality coordinator, more likely than not, the hospital's incorrect reporting would have not occurred or been corrected much sooner.

Dr. Gruessner then asked Mr. McCarthy to print out the actual OR notes, specifically for the last 10 cases. Dr. Gruessner initially focused on these 10 cases because he was the primary surgeon on all of them: before these 10 cases were performed, two patients in the two previous transplants had died on the operating table and Dr. Gruessner had informed the transplant surgeons, in agreement with the CMO, Mike Theodorou, MD, that subsequent liver transplants had to be approved and performed by Dr. Gruessner. Dr. Gruessner believed that review of these 10 cases would indeed prove that incorrect reporting to UNOS had occurred.

On September 10th, Dr. Gruessner met with Mr. McCarthy again and went over the actual OR notes that Mr. McCarthy had obtained (now closer to 25 of them). Dr. Gruessner noted incorrect reporting and scribbled down on the OR notes the correct initials of the primary surgeon and the first assist based on who did the critical parts of the procedure. Dr. Gruessner did not "direct" Mr. McCarthy to change records, but he did tell Mr. McCarthy that the records were wrong and that they needed to be corrected. We suspect (but do not know) that Mr. McCarthy thereafter changed the OTTR database to reflect the proper primary surgeon and assisting surgeon for each procedure.

Dr. Gruessner did all of this openly. Indeed, he was troubled that the OTTR database had incorrectly reported information to UNOS. After noticing that numerous incorrect reporting had occurred, Dr. Gruessner told Mr. McCarthy that the hospital administration needed be informed about all of this incorrect reporting. Dr. Gruessner felt that Mr. McCarthy was the most proper person for these communications in the absence of a hospital director for transplant services.

In other words, Dr. Gruessner did tell Mr. McCarthy that the OTTR records needed to be corrected and he also told Mr. McCarthy to inform the hospital administration that their OTTR records had been incorrect.

On September 11th, the hospital CEO, Ms. Karen Mlawsky came to Dr. Gruessner's office. She was distressed about Dr. Gruessner's resignation as the UNOS surgical transplant director the day before. She also seemed angered by the fact that Dr. Gruessner had informed UNOS about his resignation at the same time he had informed the hospital about his decision. Dr. Gruessner wanted to inform UNOS without delay as the surgical directors get frequently mail from UNOS that may require immediate responses that Dr. Gruessner could no longer reply to. Ms. Mlawsky then asked Dr.

Gruessner if he was willing to continue as primary surgeon and he told her that he would do it as long as he is practicing at UAMC.

At the same meeting Dr. Gruessner told Ms. Mlawsky about the incorrect reporting of liver transplants to UNOS and mentioned to her that OR notes needed to be pulled to identify all record inaccuracies. In other words, Dr. Gruessner openly told Ms. Mlawsky that the OTTR records had been incorrect. He was not hiding anything –he was reporting an error and possible problems for the facility since it had sent incorrect reports to UNOS. Again, in the absence of a hospital director for transplant services, Dr. Gruessner wanted to make sure that the hospital CEO knew about the hospital's incorrect reporting.

Dr. Gruessner expected the hospital to correct the records and to inform UNOS about the prior erroneous reporting. Since Dr. Gruessner did not hear back from Ms. Mlawsky for the rest of the week as he had hoped, he sent her a follow-up email on September 16th. That email read, in part:

> last week when was I was asking for information regarding my liver transplant numbers it came to my attention that the data entered in OTTR regarding primary and assistant/co-surgeon is frequently incorrect and not based on the actual OR reports. I bring this to your attention as the data needs to be corrected according to the OR reports . . .

On September 19th Dr. Gruessner was informed by email by Ms. Mlawsky that "we are looking into this".

At this point, Dr. Gruessner expected the hospital to contact him on how to proceed and he expected assurances that the records would be corrected and accurate information sent to UNOS. Instead, on September 19th at 3:15 p.m. Dr. Gruessner was informed by the Dean by email that the Dean was placing Dr. Gruessner on immediate administrative leave. He also received a similar letter from UPH, doing the same thing.

So in answer to your questions, Dr. Gruessner openly suggested that the OTTR database had incorrect information. He reported it to the proper person (Mr. McCarthy) and he even reported it to the hospital CEO. He did so because the records were incorrect and because incorrect information had been sent to UNOS. He did so openly, and he did so according to the procedure he thought most appropriate.

You then ask for*: "Any supporting authority, citation or other documents upon which he relied, or which he believes, support his actions."*

The best authority supporting what happened can be found in the actual Operative Records that were (incorrectly) left at Dr. Gruessner's home. They reflect what Dr. Gruessner established when he put initials on them. The OR notes made available to Dr. Gruessner on October 4th demonstrate that Dr. Gruessner was the most senior surgeon in 23 of the 26 liver transplants and only 3 transplants were done when he was not in town. The OR records reflect that what is currently in the OTTR database is correct.

Other supporting authority for what happened comes from Dr. Gruessner's history with the program. In his capacity as the surgical director of the liver transplant program, all liver transplants had

to be approved by Dr. Gruessner. In the vast majority of the transplants Dr. Gruessner was the primary surgeon with one or two faculty surgeons assisting. The primary surgeon by the program's definition (as per the surgical director) is the one who performs the critical portion(s) of the operation or oversees/directs the critical portion even if the suturing is done by others. The first assistant is the one who helps throughout the operation, does parts of the procedure but follows the directions given by the primary surgeon. The most critical part of the procedure is the transplant/implant with the vascular connections, the second most critical part the removal of the recipient liver.

Aside from Dr. Gruessner, the following surgeons have been involved in the program since Dr. Gruessner's arrival in 2007:

Dr. Renz accepted liver transplants and called the recipients in. He would call Dr. Gruessner before removal of the recipient liver and they would often do the vascular anastomoses (the most critical part) together.

Dr. Desai would call Dr. Gruessner to get his approval for a liver transplant and he would call Dr. Gruessner to help with the critical parts of the transplant procedure.

Dr. Jie has done most liver transplants at UAMC in the presence of a more experienced liver transplant surgeon (Drs Gruessner, Renz, Desai, and Abbas).

After the departure of Drs. Renz, no liver transplants were done without Dr. Gruessner's approval.

Additional Specific responses to the charges.

The two suspension letters say essentially the same thing. Here follows the wording used by Dr. Waldrum and Dr. Gruessner's specific responses:

> you either altered or directed others to alter records related to transplant procedures by substituting your own name as primary surgeon for others who may have actually served as primary surgeons, and that you removed your name as primary surgeon on other cases where adverse events may have occurred and substituted the names of other surgeons as primary surgeons in those cases. Rather than proceeding according to usual protocol for identifying potential anomalies and working with appropriate administrators to make these changes, you did so unilaterally, which is inconsistent with appropriate protocol.

In answer:

1. *Dr. Gruessner neither "altered or directed others to alter" anything*. Instead, he informed the most appropriate person - Mr. McCarthy and then the CEO of the hospital - of problems with the OTTR database and suggested that they correct those records.

2. *The so called records are not actual medical records*. The so called records are actually information contained in an OTTR database that contains information used by UNOS. The implication that these are medical records is false.

3. Dr. Gruessner was in no ways "substituting your own name as primary surgeon for others who may have actually served as primary surgeons." Again, Dr. Gruessner did not substitute anything. He did not and would not know how to enter any record in the OTTR database. Besides, any review of the actual OR records will reflect that Dr. Gruessner was, indeed, the primary surgeon on those cases where he put his initial on a records saying he was. You need to understand that transplant surgery is a team effort, and different surgeons participate in different ways, but when the OR records are reviewed, they clearly show that Dr. Gruessner was the primary surgeon on those where he said he was.

4. *Dr. Gruessner did not and could not "remove your name" from anything.* Again, he did not change any record. Yes, he did indicate he was not the primary surgeon on a case because he was not. Assuming you are referring to the same case, he did not arrive until after the patient had been opened and the liver removed – on his arrival he learned that the patient had already lost significant blood that led to a demise.

5. *There was no "usual protocol" for Dr. Gruessner to follow.* You admit in a recent email to me that: "The Provost's letter was inartfully worded; there is no written protocol." But beyond that, just what protocol was expected? Dr. Gruessner informed the highest ranking person in the transplant administration and then he informed the hospital CEO about record errors that needed to be corrected. He followed the best protocol possible based on his more than six year as Chair of the Department of Surgery and his role as Director of Surgical Transplant Services for UNOS.

6. *Dr. Gruessner did work with "appropriate administrators*." As noted, he not only orally informed them, he actually sent an email to the hospital CEO about the problem. Just what administrator should he have worked with beyond those he did contact?

Conclusions[1]**.**

This entire suspension was unnecessary. It was also ill advised, inappropriate and, we believe illegal and imposed for bad reasons

We are particularly concerned about a possible bad motive for this suspension. We have learned that correcting the records may have negative implications for the future of the liver transplant program at UAMC. If the corrections of the number of primary surgeons and first assists leads to a reduction of liver transplants in Dr. Jie's log, he may not qualify for the UNOS surgical liver transplant position and this could result in the program's inactivation. This may be the reason why steps were taken to attack and suspend Dr. Gruessner for allegedly changing records rather than acknowledging that he had noticed incorrect records that needed to be corrected to comply with UNOS policies and to protect AZUA, UAMC, UAHN and Dr. Gruessner.

[1] Because he was placed on leave by the University, I am copying their counsel with this letter.

Now that we have answered, we request that this so called paid leave be immediately lifted. Not only that, we request that efforts be made to address Dr. Gruessner's reputation together with an acknowledgment that the suspension was improper and should not have occurred. We will also be exploring other areas of concern, but for now we ask that Dr. Gruessner be immediately reinstated.

Very truly yours,

JABURG & WILK, P.C.

Kraig J. Marton

KJM:kmr

Approved:

Rainer Gruessner, M.D.

cc: Vicki Gotkin, Esq
Laura Johnson, Esq.