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3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012
602.248.1000

Kraig J. Marton (003816)
kjm@jaburgwilk.com
Neal H. Bookspan (014343)
nhb@jaburgwilk.com

*Attorneys for Plaintiff*



**SUPERIOR COURT OF ARIZONA**

**COUNTY OF PIMA**

G20136289

| | |
|---|---|
| RAINER W. G. GRUESSNER, M.D., an individual,<br><br>Plaintiff,<br><br>v.<br><br>UNIVERSITY PHYSICIANS HEALTHCARE, an Arizona non-profit corporation; ARIZONA BOARD OF REGENTS a legally established agency and political subdivision of the State of Arizona; UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE, a legally established agency and political subdivision of the State of Arizona; UNIVERSITY OF ARIZONA HEALTH NETWORK, an Arizona non-profit corporation,<br><br>Defendants. | Case No.<br><br>**VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF** |

CARMINE CORNELIO

Plaintiff alleges:

**PARTIES, JURISDICTION & VENUE**

1. Plaintiff Rainer W. G. Gruessner, M.D. ("Plaintiff" or "Dr. Gruessner") is a physician who resides in Pima County, Arizona.

2. Defendant University Physicians Healthcare ("UPH") is an Arizona non-profit corporation that employs medical staff at the University of Arizona Medical Center ("UAMC").



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3. Defendant Arizona Board of Regents (the "Board") is a legally established agency and political subdivision of the State of Arizona.

4. Defendant University of Arizona College of Medicine is a legally established agency and political subdivision of the State of Arizona ("COM").

5. Defendant University of Arizona Health Network ("UAHN") is an Arizona non-profit corporation that integrates University Physicians Healthcare and the University Medical Center.

6. This Court has personal jurisdiction of the parties, and venue of this case is proper pursuant to A.R.S. §§ 12-401(5).

## GENERAL ALLEGATIONS

7. By this Complaint, Dr. Gruessner seeks an order requiring the defendants to vacate orders placing him on leave with pay ("suspension") from his positions as COM faculty, surgeon, medical staff member and Chair of the Department of Surgery at the University of Arizona and University of Arizona Medical Center;

8. The suspension was without cause, in violation of applicable University Rules, and in violation of Dr. Gruessner's due process rights and so Dr. Gruessner seeks injunctive relief to compel Defendants to vacate the suspension and allow him to immediately return to work at the University of Arizona College of Medicine and at the University of Arizona Medical Center.

9. Dr. Gruessner does not, in this complaint, seek damages, but he reserves the right to do so in a separate proceeding.

10. As further explained below, Dr. Gruessner, the surgeons he supervises, his patients, and the general public will suffer irreparable harm and injury if the Court does not grant him the relief he seeks here.

### Dr. Gruessner's Medical Background, Career, and Reputation

11. Dr. Gruessner is a world renowned transplant and general surgeon who was selected after a long national search and has served for more than six years as a

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Tenured Professor and Chair of the Department of Surgery at the University of Arizona and University of Arizona Medical Center ("UAMC"); A true copy of his Curriculum Vitae is attached as **Exhibit A**.

12. Dr. Gruessner has performed hundreds of transplant surgeries and has authored or coauthored approximately 600 scholarly publications and 70 book chapters.

13. He is jointly employed by the University of Arizona in an academic capacity and by University Physicians Healthcare ("UPH"), which employs medical practitioners at UAMC.

14. A true copy of Dr. Gruessner's contract with UPH and the COM is attached as **Exhibit B**).

15. At UAMC, Dr. Gruessner has also served as the Chief of Transplantation and as the Surgical Director of Transplant Services for the United Network for Organ Sharing ("UNOS"), the organization that manages the nation's organ transplant system. (Id.).

16. Dr. Gruessner has been a tremendous asset to the University of Arizona's College of Medicine and UAMC.

17. As Chairman of the Department of Surgery, he successfully led the Surgery Department from an abysmal and slumping state to a nationally recognized and revered program.

18. During his tenure at UAMC, Dr. Gruessner recruited and helped hire a total of 72 faculty members, including six nationally known division chiefs.

19. Dr. Gruessner also rebuilt the UAMC divisions of transplantation, trauma, otolaryngology, reconstructive surgery, neurosurgery and cardiothoracic surgery, added three new residency programs and expanded the existing residency programs, substantially improved patient care and oversaw a significant increase in operating room case volume.

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20. He also built many new clinical programs that did not exist in Tucson before, and allowed patients to seek treatment locally rather than traveling to Phoenix or out of state.

21. In an April 2010 Academic Program Review of the Department of Surgery, conducted three years into Dr. Gruessner's tenure in Tucson, the reviewers wrote that the "Department of Surgery has made tremendous strides and . . . this progress will foster excellence that will enhance programmatic development throughout the University of Arizona."

22. A true copy of that Review, called Academic Program Review, Department of Surgery, is attached as **Exhibit C**.

23. The reviewers stated that, "[n]ot 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." The report continued: "Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off."

24. In a November 2012 Five-Year Administrative Review of the Department of Surgery, the reviewing committee reported high praise for Dr. Gruessner's accomplishments.

25. A true copy of that Five Year Administrative Review, Department of Surgery, is attached as **Exhibit D**.

26. The committee preparing **Exhibit D** detailed the "tremendous growth in clinical, academic and educational production" on Dr. Gruessner's watch, including his successful recruitment of revered faculty, creation of new surgical programs, bolstering of previously weak programs, increased grant and research funding, and development of innovative surgical techniques.

27. The Five Year Administrative Review, **Exhibit D**, even praised the surgery department's expert clinical care and adroit media relations during and immediately following the shooting of Congresswoman Gabrielle Giffords in 2011.

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28. According to that Five Year review, **Exhibit D,** the Surgery Department's skilled navigation of that unfortunate event brought "unprecedented prestige and internal pride" garnered by "the leadership of Dr. Gruessner and the 2 division chiefs that he personally recruited."

29. The Five Year review, **Exhibit D,** also stated that, "[d]espite 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."

30. By contrast, the 2013 Academic Program Review of the Department of Medicine determined that it was "an underperforming department . . . [that] lacks a clear identity and focus."

31. A true copy of the Academic Program Review, Department of Medicine, is attached as **Exhibit E**.

32. The Academic Program Review, **Exhibit E**, lamented that research was not a priority in the Department of Medicine, leadership was not providing adequate mentorship, and there were divided loyalties among faculty members. (Id.).

**Differences of Opinion Between Dean Goldschmid & Dr. Gruessner**

33. There are many and have been many disagreements and differences of opinion between Dean Goldschmid, Dean of the College of Medicine, and Dr. Gruessner.

34. As Chairman of the Department of Surgery, Dr. Gruessner has an intrinsic interest in improving the direction of the medical school. The school's standing directly affects his ability to achieve the goals he has set for his department.

35. In December 2011, Dr. Gruessner was asked by members of the University of Arizona's Committee of 11 (the "Committee of 11") to provide input regarding the state of the College of Medicine under Dean Goldschmid's leadership.

36. The Committee of 11 is an official committee that evaluates and seeks solutions to faculty problems within the College of Medicine.

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37. Dr. Gruessner told members of the Committee of 11 that he was concerned about Dean Goldschmid's leadership.

38. Dr. Gruessner told the Committee of 11 that the College's NIH ranking had not improved, key faculty in the Cancer Center and clinical departments had left and could not be replaced, and a climate of fear and retaliation had been created which had resulted in low morale among faculty and staff.

39. Dr. Gruessner also told members of the Committee of 11 that he felt that Dean Goldschmid would not be able to take the college to the next level and attain a national reputation.

40. Upon information, Dean Goldschmid learned what Dr. Gruessner had told members of the Committee of 11.

41. Dr. Steve Barker, the Chair of the COM Anesthesiology Department, was also asked to talk to members of the Committee of 11.

42. Upon information, Dr. Barker told the Committee of 11 that he was very critical about the course of the COM and its leader, Dean Goldschmid.

43. Dr. Barker was terminated by the Dean in May 2013 for reasons that should not have justified termination.

44. Dean Goldschmid has been Dr. Gruessner's direct supervisor for the last six years.

45. Under University rules, Dean Goldschmid was required to provide an annual review to Dr. Gruessner. Dean Goldschmid was also required to provide a more extensive five year review as well.

46. Those reviews are required by these sections in The University Handbook For Appointed Personnel (UHAP): Section 5.08 (called "Annual Performance Review") and Section 5.09 (called "Guidelines For Five-Year Reviews Of Deans And Department Heads.").

47. The Current UHAP rules are available online at the following website: http://uhap.arizona.edu/Chapter_5#5.08.

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48. Dean Goldschmidt failed to provide Dr. Gruessner any annual evaluation (as required), or the Five-Year Administrative Review (as required).

49. Dean Goldschmid failed to provide any written communication to Dr. Gruessner about any failings of Dr. Gruessner as the Chair of the Department of Surgery.

50. On July 22, 2013, Dean Goldschmid called Dr. Gruessner using Skype from his vacation home in Canada and asked Dr. Gruessner to step down from his position as chairman of the Department of Surgery.

51. In making that request, Dean Goldschmid said there was a "record of poor performance."

52. Dr. Gruessner was stunned and shocked, and refused to step down.

53. On July 29, 2013, Dr. Gruessner received a Notice of Reappointment dated July 25 that reappointed him to the position of Chair of the Department of Surgery for the next year.

54. Dean Goldschmidt thereafter again asked Dr. Gruessner to step down as Chair.

55. After careful reflection Dr. Gruessner decided it was not worth the effort to be at odds with his supervisor, and so he decided to step down on certain conditions.

**Dr. Gruessner and Dean Goldschmid Ostensibly Settle their Differences**

56. Dean Goldschmid and Dr. Gruessner, after negotiations, came to an agreement.

57. Dr. Gruessner agreed he would transition out of administrative duties as Chairman of the Department of Surgery, but would maintain the title of Chair for a period of at least six months.

58. Dr. Gruessner asked that he be allowed to continue to serve as Chief of Transplantation at UAMC but Dean Goldschmid refused to allow it.

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59. Dr. Gruessner has complied with all obligations required of him under his agreement with UPH, COM, and Dean Goldschmidt.

**Dr. Gruessner Discovers Errors in UNOS Records**

60. Before Dr. Gruessner relinquished his position as Chairman of the Department of Surgery and to meet UNOS requirements, he requested a count of the number of liver transplants he had performed during his time at UAMC.

61. Among his many other responsibilities, Dr. Gruessner was the hospital's UNOS Surgical Transplant Director.

62. Because of the complexity involved with transplant surgery, UNOS maintains very demanding standards of the surgeons that it qualifies to perform the life-saving procedure.

63. Doctors must assist on a certain number of transplants and must perform as primary surgeon a certain number of transplants before they are approved by UNOS to receive organs for transplantation.

64. On September 9, 2013, Dr. Gruessner requested a count of the number of liver transplants he had performed during his time at UAMC.

65. Dr. Gruessner made this request to Mike McCarthy who was UAMC's Manager of Business Systems for Transplant Services.

66. At that time, UAMC did not have a director for transplant services.

67. Dr. Gruessner therefore believed that Mr. McCarthy was the most logical person in UAMC Transplant Services with whom to discuss transplant records

68. On September 9, McCarthy informed Dr. Gruessner that the UNOS reporting records indicated Gruessner was the primary surgeon on only 12 transplants during the previous six years.

69. Dr. Gruessner has been involved in well over 75 liver transplants during that time, in many of them as the primary surgeon.

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70. The primary surgeon is the surgeon who performs the critical portion of the operation or oversees and directs the critical portion even if the suturing is done by junior attendants.

71. The first assistant is the one who helps throughout the operation and performs parts of the procedure, but follows the directions given by the primary surgeon.

72. Dr. Gruessner reviewed the most recent UNOS records and found that junior surgeons, or surgeons who had not been the primary surgeon, were incorrectly listed as the primary surgeon.

73. Mr. McCarthy suggested that UAMC's transplant coordinator(s) 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, sometimes called "Operative Reports" ("OR notes").

74. UAMC was responsible for entering data in the UNOS reporting records and reporting it to UNOS.

75. It is and was UAMC's obligation to accurately report the identity of the primary surgeon to UNOS.

76. Dr. Gruessner had no role in entering or maintaining data about the identity of the lead surgeon in UNOS reporting records.

77. Dr. Gruessner had no oversight over UNOS reports about the identity of the lead surgeon.

78. It is important to UNOS and to those working with it that all records provided to UNOS be accurate.

79. If UNOS receives incorrect records about the identity of the primary surgeon and assistant surgeons, it might allow an otherwise unqualified surgeon to perform transplants.

80. Ensuring proper reporting to UNOS about the identity of the primary surgeon would have been the responsibility of UAMC.

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81. UNOS had on two occasions audited UAMC and on both occasions had recommended that it obtain a quality coordinator to assist with the quality of transplant services.

82. The Centers for Medicare & Medicaid Services had also audited UAMC and also recommended that it obtain a quality coordinator to assist with the quality of transplant services.

83. Notwithstanding those recommendations, UAMC did not hire any quality coordinator and the transplant director left UAMC in early September in part because of a lack of support.

84. On or around September 9, 2013, Dr. Gruessner requested that Mr. McCarthy print out the OR notes for the immediate past 10 cases

85. Dr. Gruessner requested the last 10 cases because he had been the primary surgeon on every one of them.

**Dr. Gruessner Suggests Correcting the UNOS Reporting**

86. On Tuesday, September 10, 2013, Dr. Gruessner met with Mr. McCarthy to review additional UNOS reporting records along with OR notes for previous UAMC liver transplants.

87. The UNOS reporting records shown to Dr. Gruessner were almost entirely inaccurate about the identity of the primary and assistant surgeons.

88. In that meeting and upon review of the actual OR notes, Dr. Gruessner wrote the initials of the correct names of the primary surgeon and the first assistant surgeon on copies of the OR notes.

89. Dr. Gruessner told Mr. McCarthy that the hospital administration needed to be informed about the inaccuracies and suggested that the records should be corrected.

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90. On Wednesday, September 11, at a meeting with the hospital's Chief Executive Officer Karen Mlawsky, Dr. Gruessner informed her about the incorrect reporting to UNOS.

91. In that meeting, Dr. Gruessner told Ms. Mlawsky that he had identified multiple incorrect reports to UNOS and that Mr. McCarthy had pulled OR notes so the UNOS records could be corrected accordingly.

92. Ms. Mlawsky said she would get back to him on the matter.

93. On the same day, Ms. Mlawsky was also informed by email by Mr. McCarthy about the incorrect reporting issues.

94. A true copy of the email from Mr. McCarthy to Ms. Mlawsky is attached as **Exhibit F**.

95. Mr. McCarthy's email confirmed the course of events as stated by Dr. Gruessner.

96. After not hearing anything back from Ms. Mlawsky, Dr. Gruessner sent a confirmatory email to her on Monday, September 16, 2013.

97. A true copy of Dr. Gruessner's email to Mlawsky with her response is attached as **Exhibit G**.

98. In her Response, **Exhibit G**, Ms. Mlawsky stated: "We are looking into this." (Id.).

**Dr. Gruessner Is Suspended from University of Arizona and UAMC**

99. Within hours of receiving Ms. Mlawsky's response, Dr. Gruessner received an email from Dean Goldschmid stating: "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." A true copy of that September 19, 2013, email is attached as **Exhibit H**.

100. Dean Goldschmid also stated: "You are not permitted to return to campus without first making arrangements through UAMC security to do so." **(Exhibit H)**.

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101. Attached to the email were signed letters stating that each organization was placing Dr. Gruessner on administrative leave.

102. A true copy of the letter from UAHN/UPH is attached as **Exhibit I**.

103. The attached letter from UPH, **Exhibit I,** was sent on University of Arizona Health Network letterhead, and stated:

> 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.

104. The attached letter from the COM, **Exhibit J,** stated: "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." It continued: "I have received information from UAHN that you either altered or directed others to alter records related to transplant procedures...[the remainder mirrors the allegations contained in the UPH letter]."

105. The letter from the COM, **Exhibit J,** then stated that, "[b]ecause 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." (Id.).

106. Dr. Gruessner was not offered a hearing or any opportunity to defend himself prior to the suspension from either organization.

107. Both organizations summarily suspended him without asking Dr. Gruessner for any information about the suspension.

108. The letter from the COM, **Exhibit J,** gave Dr. Gruessner 15 days to respond in writing to contest the allegations.

109. Dr. Gruessner did respond to the allegations and he denied them.

110. Dr. Gruessner's explanation made no difference.

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111. Dr. Gruessner has been given no hearing, or even offered one, where he could defend against the charges.

112. The charges against Dr. Gruessner do not justify a suspension or any form of discipline.

113. The suspension was unwarranted, and, on information, based solely on the personal and philosophical differences between Dr. Gruessner and Dean Goldschmidt.

**Consequences of Immediate Leave on Clinical Programs and Patient Care**

114. Dr. Gruessner's suspension is and has already been detrimental to clinical programs as well as to patient care and quality of that care.

115. Specifically, Dr. Gruessner's suspensions has caused the following problems:

A. The Chronic Pancreatitis and Islet Transplant Program, one of only four programs in the country, has been closed with the false implication that Dr. Gruessner is no longer practicing at UAMC.

B. A true copy of a letter reflecting this (with patient identity redacted) is attached as **Exhibit K**;

C. The UAMC Liver Transplant Program has noted two patient deaths of patients on the waiting list since Dr. Gruessner was suspended.

D. Not a single liver transplant has been performed at UAMC since Dr. Gruessner was placed on leave;

E. Community Referrals to the Kidney Transplant and out-of-state referrals to the Hepatopancreaticobiliary Programs have decreased significantly,

F. As the only program in Arizona that treats intestinal failure, patients with intestinal failure are no longer being seen at UAMC in Dr. Gruessner's absence;

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G. The follow-up care of many patients with complex ailments related to transplants are no longer offered by UAMC because other surgeons do not have the necessary experience.

H. Upon information, many islet transplant patients have been informed by UAMC that they will now have to go elsewhere or travel out of state for their follow-up care.

116. The above listed closing of clinical programs and absence of follow-up care has a profound negative impact on the teaching experience and education of medical students, residents, and fellows who are studying at the COM.

117. Upon information, many surgery faculty members have been interviewing at other institutions for jobs because they are under the perception that Dr. Gruessner's suspension will not be lifted.

118. Since Dr. Gruessner recruited over 75% of the current faculty, his continued presence will help to stop the dangerous exodus of faculty.

119. In addition, the suspension is damaging to Dr. Gruessner.

120. The fact of his suspension has become widely known among his peers.

121. It is important for a surgeon to maintain his skills and abilities by continued practice.

122. Dr. Gruessner's reinstatement to his position as UAMC Chairman of the Department of Surgery will allow programs to re-open or remain functioning—it will prevent Tucson patients from having to travel long distances to obtain much needed surgical care elsewhere.

**Post-Suspension Course of Events**

123. Immediately after he was suspended, Dr. Gruessner responded by email on Friday, September 20, 2013, and requested additional information to ensure he could respond as fully and accurately as possible.

124. A true copy of Dr. Gruessner's September 20, 2013, email is attached as **Exhibit L**.

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125. The Provost of University of Arizona responded to Dr. Gruessner's request by stating that, in light of the requested clarification and supporting records, he would extend the time for responding until Dr. Gruessner had the opportunity to review the underlying documentation.

126. A true copy of the Provost's September 20, 2013 email is attached as **Exhibit M**.

127. Through counsel, Dr. Gruessner followed up on the requested clarification and documentation on September 26, October 1, and October 2, 2013 and true copies of those emails are attached as **Exhibit N**.

128. On October 4, 2013, an attorney representing UPH sent a letter that stated the requested records would be delivered to Dr. Gruessner's home that day and demanded that he respond within five (5) business days; a true copy of that letter is attached as **Exhibit O**.

129. Dr. Gruessner was out of town on that day, and was unable to even begin reviewing the documents until the five day deadline was nearly expired.

130. Dr. Gruessner's counsel told UPH counsel that Dr. Gruessner was out of town in an October 4, 2013 email, a true copy of which is attached as **Exhibit P.**

131. On the afternoon of October 4, 2013, documents were still delivered to Dr. Gruessner's home and left with a cleaning crew who was working in his home.

132. The documents that were delivered to Dr. Gruessner's home contained patient information, including OR notes

133. Leaving those documents with a cleaning crew was a violation of the HIPAA Privacy Rules, as found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and 45 CFR Part 160 and Part 164, Subparts A and E.

134. Dr. Gruessner was able to review the documents upon his return home.

135. Although the cover letter claimed the package included documentation on 31 liver transplant cases, there was documentation for only 30 cases, and the package

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was missing OR notes for four of the 30 cases that were provided. Hence, full documentation was only provided in 26 of the 31 cases.

136. In response to an inquiry as to whether Dr. Gruessner would ever receive the missing documents, UPH responded evasively: "Yes, this is among what was delivered to his house on 10/4" a true copy of the email reflecting this, dated October 9, 2103, is attached as **Exhibit Q**.

137. In the initial suspension letter from UPH/UAHN, it was claimed that Dr. Gruessner did not proceed "according to usual protocol for identifying potential anomalies." (**Exhibit I**).

138. When Dr. Gruessner asked for a copy of that protocol, UPH stated that, in fact, there was no written protocol and that the suspension notice was "inartfully worded." (**Ex. Q**).

139. Despite the short notice and incomplete documentation, Dr. Gruessner provided his response to UPH within the five-day deadline.

140. A true copy of Dr. Gruessner's October 9, 2013 letter is attached as **Exhibit R**.

141. In his October 9, 2013 letter, **Exhibit R,** Dr. Gruessner responded fully to all questions posed to him and explained what had happened.

142. In his October 9, 2013 letter, **Exhibit R,** Dr. Gruessner requested that his suspension be lifted.

143. UPH finally responded nearly two weeks later, and a true copy of their response is attached as **Exhibit S**.

144. The response, **Exhibit S,** does not appropriately address Dr. Gruessner's explanations; it ignores some of them and misinterprets others, and fails to provide any basis for a suspension or any form of discipline against Dr. Gruessner.

145. The response, **Exhibit S,** does not lift the suspension and fails to provide Dr. Gruessner with any way by which it might be lifted.

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146. The response, **Exhibit S,** does not provide Dr. Gruessner with any right to a hearing or any avenue to address his concerns other than to "meet to attempt to negotiate a transition."

147. After sending its response, **Exhibit S,** UPH continues to refuse to reinstate Dr. Gruessner or provide him with any hearing in order to clear his name.

148. UPH has used Dr. Gruessner's suspension as a negotiation tool to force him to resign; one example of this is reflected in the October 25, 2103, email attached as **Exhibit T:** "If we are unable to reach a resolution, UPH will determine if Dr. Gruessner has violated any policy or bylaw."

149. Dr. Gruessner refuses to resign because he has done nothing wrong; he has been wrongfully suspended, and the real reason for his suspension is that Dean Goldschmidt wants him out of the COM and UPH.

150. Dr. Gruessner informed UPH and the COM that he intended to sue if he was not reinstated; a true copy of an October 30, 2013 email reflecting this is attached as **Exhibit U**.

151. UPH and the COM continue to refuse to reinstate Dr. Gruessner.

152. Although Dr. Gruessner has been suspended since September 19, 2013, UPH and the COM have failed to take any action related to the suspension.

153. UPH and the COM have failed to offer Dr. Gruessner with any hearing or any ability to clear his name.

154. Dr. Gruessner now remains in limbo.

**The suspension is illegal**

155. Dr. Gruessner has a constitutionally protected property interest in his employment as a tenured professor and as chair of the Department of Surgery.

156. It was a violation of his due process rights to suspend Dr. Gruessner without notice and without asking for his response.

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157. It is a separate violation of his due process rights to suspend Dr. Gruessner for almost two months and to fail to provide him with a hearing about whether the suspension was warranted.

158. It is yet a separate violation of his due process rights to leave Dr. Gruessner suspended without specifying charges against him or providing him with a hearing in order to clear his name.

159. Dr. Gruessner has been told that the suspension has nothing to do with the quality of his patient care.

160. However, Dr. Gruessner has been prevented from seeing patients or providing patient care.

161. UAMC has adopted Bylaws and those Bylaws cover corrective action in Article VII, entitled "Peer Review, Professional Practice Evaluation, and Corrective Action" ("UAMC Bylaws").

162. In summarily placing Dr. Gruessner on administrative leave with pay and keeping him suspended indefinitely, Defendants did not follow UAMC Bylaws, Rules & Regulations.

163. The conduct listed in the Suspension letters, if true, would be covered conduct that should be reviewed by peer review, under the UAMC Bylaws, § 7.2.1.

164. No peer review has been provided to Dr. Gruessner,

165. No UAMC medical staff committee has been involved in any investigation about Dr. Gruessner.

166. To the extent that Dr. Gruessner's suspension is preventing him from seeing patients his due process rights as a medical staff physician have been violated, and he is therefore entitled to an injunction pursuant to A.R.S. §36-445.02(B).

167. Dr. Gruessner also has due process rights as a tenured COM faculty member.

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168. In summarily placing Dr. Gruessner on administrative leave with pay and keeping him suspended indefinitely, Defendants did not follow the relevant Arizona Board of Regents' policies.

169. Dr. Gruessner has tenure as described in the Conditions of Faculty Service ("Conditions") found in the Arizona Board of Regents ("ABOR") Policy Manual at section 6-201(C)(19).

170. Under Conditions Section J(1)(a), a tenured faculty member cannot be suspended or terminated without "just cause".

171. There is no just cause to take any action against Dr. Gruessner, by way of suspension or otherwise.

172. Under Conditions Section 6-201(J)(3)(b)(1), a decision to place a faculty member on leave with pay "[m]ay be made only after the faculty member has been provided an opportunity to respond to the allegations."

173. Dr. Gruessner was placed on leave with pay without being given any opportunity to respond to the allegations.

174. Under Conditions Section 6-201(J)(3)(d), "The period of leave may extend no longer than the duration of an investigation."

175. Upon information, Defendants have not investigated the allegations; even if they have, the investigation has long been completed.

176. Dr. Gruessner is also entitled to injunctive relief because, upon information, he was unfairly and unlawfully placed on administrative leave with pay:

A. in retaliation for providing opinions critical of Dean Goldschmidt to members of the Committee of 11; and /or

B. in retaliation for uncovering and suggesting corrections to inaccurate UNOS reporting.

**COUNT ONE**

**INJUNCTIVE RELIEF**

Jaburg & Wilk, P.C.
3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012
602.248.1000

177. Dr. Gruessner incorporates by reference all prior allegations as if set forth herein.

178. Pursuant to A.R.S. § 12-1801 and Rule 65, Arizona Rules of Civil Procedure, Dr. Gruessner seeks injunctive relief after the issuance of an order to show cause requiring Defendants to show cause why they have placed Dr. Gruessner on administrative leave with pay and continue to keep him suspended without taking action on the allegations.

179. Dr. Gruessner is entitled to injunctive relief compelling Defendants to reinstate Dr. Gruessner to his position as professor and chair of the Department of Surgery.

180. Placing Dr. Gruessner on indefinite administrative leave is an action for which there is no adequate remedy at law.

181. Placing Dr. Gruessner on indefinite administrative leave unlawfully interferes with Dr. Gruessner's ability to keep his surgical skills honed and affects patient safety in such a manner and to such an extent that the possibility of irreparable harm exists if the suspension is allowed to continue.

182. The harm imposed on Dr. Gruessner as a result of the suspension is substantially greater than any harm that would be imposed on Defendants by ordering reinstatement.

183. Enjoining the suspension would advance significant public interest by prohibiting the Defendants from further wielding disciplinary measures as a political and retaliatory device. Furthermore, injunctive relief would preserve stability in the Department of Surgery as well as to current and future patients of the various programs that Dr. Gruessner oversees.

184. Pursuant to A.R.S. § 12-1801, Dr. Gruessner is entitled to injunctive relief prohibiting continued administrative leave and reinstating him as professor and chair of the Department of Surgery.

Jaburg & Wilk, P.C.
3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012
602.248.1000

WHEREFORE, Plaintiff Rainer W.G. Gruessner, M.D., prays for the following relief:

A. For affirmative injunctive relief requiring Defendants to immediately reinstate Dr. Gruessner to the same positions he held with them before he was suspended, including: (1) Chair of the Department of Surgery; (2) Member of the faculty of the College of Medicine; and (3) Member of the medical staff of UAMC ;

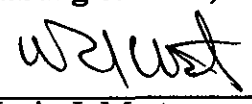
B. Prohibiting Defendants from further implementing, adopting, and/or otherwise enforcing the administrative leave with pay.

C. For fees and costs of suit pursuant to A.R.S. §§ 12-341 & 36-445.02.

D. For any other relief as the Court deems just and proper under the circumstances.

DATED this 12th day of November, 2013.

**Jaburg & Wilk, P.C.**



Kraig J. Marton
Neal H. Bookspan
3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012
Attorneys for Plaintiff

Jaburg & Wilk, P.C.
3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012
602.248.1000

## DECLARATION

Rainer W.G. Gruessner, MD, under penalty of perjury, states and declares that he is the Plaintiff in the above matter; that he has read the Verified Complaint for Declaratory and Injunctive Relief; and that the facts recited therein are true to the best of his knowledge and information.

I declare under penalty of perjury that the foregoing is true and correct

DATED this 12K day of November, 2013.

Rainer W.G. Gruessner, MD

JABURG & WILK, P.C.
ATTORNEYS AT LAW
3200 NORTH CENTRAL AVENUE
SUITE 2000
PHOENIX, ARIZONA 85012

# Exhibit A

# *CURRICULUM VITAE*

# RAINER W.G. GRUESSNER, M.D., FACS, FICS

---

**OFFICE ADDRESS:**

Department of Surgery
University of Arizona
1501 N. Campbell Avenue
PO Box 245066
Tucson, AZ 85724-5066
Telephone: 520 - 955 1191
E-mail: rgruessner@surgery.arizona.edu

**MARITAL STATUS:**

Angelika Gruessner, M.S., Ph.D.
2 children

**CITIZENSHIP:**

USA

**CURRENT POSITION:**

Chairman, Department of Surgery, 7/07 to present
Professor of Surgery and Immunology
College of Medicine
University of Arizona

**PREVIOUS POSITIONS:**

Professor of General and Transplant Surgery (with tenure), 9/1999-6/2007
Vice Chair, Department of Surgery, 1/2000-1/2007
Vice-Chief, Division of Transplantation, 9/1999-6/2007
Director, Intestinal Transplant Program
Co-Director, Pancreas Transplant Program
Department of Surgery, University of Minnesota

Professor of Surgery and Chairman, 7/1998 – 8/1999
Department of General and Transplant Surgery
University Hospital Zürich, Switzerland

Professor of Surgery with Tenure, 7/1996 - 7/1998
Vice-Chief, Division of Transplantation
Director, Intestinal Transplant Program
Co-Director, Pancreas Transplant Program
Associate Director, Liver Transplant Program
Department of Surgery, University of Minnesota

Associate Professor of Surgery with Tenure, 7/1994-6/1996
University of Minnesota

Assistant Professor of Surgery, 10/1991-6/1994
University of Minnesota

Staff Surgeon ("Oberarzt") 1990-1991
Philipps-Universität, Marburg, Germany

**EDUCATION AND ACADEMIC DEGREES:**

***Graduate Education:*** M.D., 1983
School of Medicine, Johannes-Gutenberg-Universität (1976-1983)
Mainz, Germany

Doctoral Thesis (summa cum laude), 1983
School of Medicine, Johannes-Gutenberg-Universität
Mainz, Germany

***Postgraduate Education:*** *Habilitation* - Professorial Thesis (German PhD Equivalent)
and appointment as ***P****rivat****D****ozent* (senior lecturer), 1991
Philipps-Universität, Marburg, Germany

**POSTGRADUATE TRAINING:**

***Internship/Residency:*** General (and Pediatric) Surgery, 1983-1987
Johannes-Gutenberg-Universität, Mainz, Germany

***Fellowship:*** Transplantation Surgery, 1987-1989
University of Minnesota, Minneapolis, Minnesota

***Additional training*:** Clinical training in Vascular Surgery, 1989-1990
Philipps-Universität, Marburg, Germany

Clinical training in Living Donor Liver Transplantation, 1996
Kyoto University Hospital, Kyoto, Japan

**CERTIFICATION:** ECFMG, 1983
Frankfurt, Germany

FLEX, 1988
Madison, Wisconsin

**BOARD CERTIFICATION:**

German Association of Surgery ("Facharzt"), 1990

**FELLOWSHIPS:** American College of Surgeons (FACS), 1995-date
International College of Surgeons (FICS), 1994-date

**LICENSURE:** State of Arizona - #36718, 2007

State of Minnesota - #33689, 1989
State of Wisconsin - #30125, 1989 (inactive)

**CLINICAL ACHIEVEMENTS:**

First split pancreas transplant (1988)
First standardized technique for living donor intestinal transplants (1997)
First laparoscopic living donor distal pancreatectomy (2000)
First robot-assisted total pancreatectomy with islet autotransplant (2012)

First living donor liver transplant, first living donor intestinal transplant, first combined living and deceased donor intestinal transplants, first split liver transplants – all in MN
First living and deceased intestinal transplants, first multivisceral transplant, first pediatric living donor liver transplant, first autologous islet transplant – all in AZ

**UNIVERSITY COMMITTEES:**

Board Member, 2012-present
UAHN Practice Plan Oversight Board

Search Committee, Senior Vice President, Academic Health Sciences Center
University of Arizona

Board Member, 2008-present
University Physicians Healthcare

Leadership Advisory Committee, 2008-present
University Physicians Healthcare

Council of Department Heads, College of Medicine, 2007-present
University of Arizona

Medical Executive Committee, 2007-present
UAMC

UPH Faculty Practice Committee, 2007-present
University Physicians Healthcare

UPH Faculty Practice Oversite Sub-Committee, 2007-present
University Physicians Healthcare

Perioperative Services Committee, 2007-Present
University of Arizona Medical Center

Chair, Protocol Review and Data Use (PRDU) Committee, 5/02-06/07
University of Minnesota

Chair, Post-tenure Faculty Review Committee, 2002-05

Department of Surgery, University of Minnesota

Member, Operating Room Committee, 5/01-06/07
University of Minnesota
Member (Alternate), Faculty Advisory Council 09/01-06/02; 09/04-06/07
University of Minnesota

Member (Substitute), Faculty Senate 02/03-06/03; 09/05-06/07
University of Minnesota

Member, Search Committee, University of Minnesota
Director, Pediatric Gastroenterology 2005
Director, Transplant Nephrology 2003

Chair, Interdisciplinary Surgery Team 07/04-06/07
University of Minnesota

Substitute, Department Heads Council 10/99-06/07
University of Minnesota
Member, Departmental Strategy Council 10/99-06/07
Department of Surgery

Member, Conference of Departmental Chairmen 7/98 – 8/99
University of Zürich

Service Director for Residents and Medical Students 1994-1997
Division of Transplantation, University of Minnesota

Rural Physician Associate Program Tutorial/Special Faculty Visits 94-98
Department of Surgery

Member, Graduate Faculty, 1994-1998
University of Minnesota

Member, Internal Review Board (IRB), 1994-1997
University of Minnesota

**REGIONAL COMMITTEES:**

Arizona Chapter, American College of Surgeons, President-Elect, 2013
Arizona Chapter, American College of Surgeons, Vice-President, 2012
Arizona Chapter, American College of Surgeons, Executive Committee, 2010-Present
United Network for Organ Sharing (UNOS), Associate Counsellor, Region 7, 2005-2007

UNOS, Counsellor, Region 7, 2007-2009 (resigned due to new position in AZ)

Member, Kidney/Pancreas Committee 2005 - 2007
Board Member, LifeSource (OPO), 2002 - 2007
Member, Research Advisory Committee, LifeSource, 1991-1997

**NATIONAL COMMITTEES:**

UNOS/OPTN, Liver Review Committee 2012 to present
UNOS/OPTN, Pancreas Committee 2009-2011
UNOS/OPTN, Chair, Pancreas Committee 2007-2009
UNOS/OPTN, Kidney (KARS) Committee, 2005-2008
UNOS/OPTN, Vice-Chair, Pancreas Committee 2005-2006
UNOS/OPTN, Policy Oversight Committee 2005-2007
UNOS/OPTN, Finance Subcommittee 2006-2007
UNOS/OPTN, Membership and Professional Standards Committee, 2005-2007
UNOS/OPTN, Data Subcommittee, 2005-2007

**ACADEMIC COMMITTEES (SOCIETIES):**

ASTS, Standards Committee, 2006-2008
ASTS, Cell Transplant Committee, 2006-2008
ASTS, Newsletter Committee, 2004-2006
ASTS, Education Committee, 2002-2004
ASTS, Bylaws Committee, 1996-1999
ASTP, Kidney-Pancreas Subcommittee, 1997-1998
ASTS, Program Committee, 1995-1996
AAS, Program Committee, 1996-1998
SUS, Committee on Social and Legislative Issues, 1997-2000

**ADVISORY BOARDS:**

Berlex Transplant Advisory Board 2004-2006
Fujisawa Transplant Advisory Board 2001-2004

**EDITORIAL BOARDS:**

Editorial Board, Dataset Papers in Medicine, 2012-present
Editorial Board, Journal of Investigative Surgery, 2006-present
Editorial Board, Transplant International, 2002-present
Editorial Board, Clinical Transplantation, 1993-present
Editorial Board, Graft, 1998-2001
Editorial Board, Zeitschrift für Kinderchirurgie, 1993-2001

**SOCIETIES:**

| | |
|---|---|
| Cellular Transplantation Society | 2013 |
| The Halsted Society | 2010 |
| Pima County Medical Society | 2008 |
| Society of Surgical Chairs | 2007 |
| Tucson Surgical Society | 2007 |
| Intestinal Transplant Association (ITA) | 2005 |
| Minnesota Medical Association (MMA) | 2005 |
| American Surgical Association (ASA) | 2000 |
| American Diabetes Association (ADA) | 2000 |
| International Liver Transplantation Society | 1997 |
| Society of University Surgeons (SUS) | 1995 |
| American College of Surgeons (ACS) | 1995 |
| International College of Surgeons | 1994 |
| American Society of Transplant Surgeons (ASTS) | 1993 |
| Association for Academic Surgery (AAS) | 1993 |
| The Transplantation Society | 1993 |
| International Pancreas and Islet Transplant Association | 1993 |
| European Society for Organ Transplantation (ESOT) | 1990 |
| Deutsche Gesellschaft für Chirurgie | 1990 |
| American Society of Transplant Physicians (ASTP) | 1989 |

**HONORARY FELLOWSHIP:**

| | |
|---|---|
| European Board of Transplantation | 2013 |

**RESEARCH PROJECTS AND GRANTS** (s*ince 9/1999)***:**

Richard L. Varco New Faculty Research Award (1999) $70,000
*University of Minnesota, Department of Surgery*
Principle Investigator: Rainer W.G. Gruessner, M.D.

Use of MMF in a Preclinical Intestinal Transplant Model by Modulation of Nitric Oxide and Use of Donor Cell Augmentation (2000) $125,000
*Roche Pharmaceuticals*
Principle Investigator: Rainer W.G. Gruessner, M.D.

Use of Rapamycin in a Preclinical Intestinal Transplant Model by Modulation of Nitric Oxide and Use of Donor Cell Augmentation (2000) $65,000
*Wyeth-Ayerst Research*
Principle Investigator: Rainer W.G. Gruessner, M.D.

Optimization of Immunosuppressive Therapy in Intestinal Transplantation in a Small Animal Model
*Minnesota Medical Foundation, The University of Minnesota* (2001) $15,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

Pancreas After Kidney Transplantation in Post-Uremic Diabetic Patients
*Fujisawa Inc.*(2001) $20,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

Comparative Trial of Mycophenolate Mofetil vs. Sirolimus Maintenance Therapy in PAK Patient
*Roche Pharmaceuticals* (2000) $301,299
PI: Raja Kandaswamy, M.D.; Co-Investigator: Rainer W.G. Gruessner, M.D.

Steroid Avoidance in SPK Recipients on Sirolimus Maintenance Therapy
*Wyeth Ayerst* (2000) $280,583
PI: Raja Kandaswamy, M.D.; Co-Investigator: Rainer W.G. Gruessner, M.D.

Hibernating State and Ischemia Reperfusion Injury in Organ Preservation
*Minnesota Medical Foundation, The University of Minnesota* (2000) $15,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

A phase II, open-label, concentration-controlled, randomized study of conventional-dose tacrolimus plus corticosteroids compared with reduced-dose tacrolimus plus sirolimus and corticosteroids in recipients of orthotopic liver allografts
*Wyeth-Ayerst* (2000) $127,977
PI: John R. Lake, M.D.; Co-Investigator: Rainer W.G. Gruessner, M.D.

A randomized, open-label, comparative evaluation of conversion from calcineurin inhibitors to sirolimus versus continued use of calcineurin inhibitors in renal allograft recipients
*Wyeth-Ayerst* (2001) $413,687
PI: Arthur Matas, M.D.: Co-Investigator: Rainer W.G. Gruessner, M.D.

Use of CAMPATH® for Induction and Maintenance Therapy in Simultaneous Pancreas and Kidney Transplantation
*Ilex Oncology, Inc.* (2004) $450,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

Immunomodulation in Intestinal Transplantation
*Roche Pharmaceuticals* (2005) $7,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

Cellular Immunomodulation in Intestinal Transplantation using Tacrolimus-based Immunossuppression
*Astellas US, Inc.* (2005) $7,300
Principle Investigator: Rainer W.G. Gruessner, M.D.

Mycophenolic Acid Trough Levels in Pancreas Recipients
*Roche Pharmaceuticals (2005)* $30,000
Principle Investigator: Rainer W.G. Gruessner, M.D.

Diabetes Prevention and Management
*Centers for Disease Control and Prevention* (2008) $258,405
PI: Horacio Rilo, M.D.; Co-Investigator: Rainer W.G. Gruessner, MD
MIS/Robotic-assisted resident training for outcome improvent and cost reduction

Educational Grants, *Covidien Plc and Karl Storz GmbH&Co.*
2008-present: $100,000/year
Principle Investigators: Carlos Galvani, MD and Rainer W.G. Gruessner, MD

International Pancreas Transplant Registry (IPTR)
*Astellas Pharma US, Inc.* (2009-present) $100,000/year
Principle Investigators: Rainer W.G. Gruessner, MD/Angelika C. Gruessner, PhD

Portable Gas Perfusion System for Pancreas Preservation - Phase II B
04/01/2014- 03/31/2017 Giner (Sub-**NIH**/SBIR)
5R44DK070400 Phase 2B
Total: $3,000,000 (Grant) Co-PI (Grant): K.Papas and L.Tempelman
Total: $973,204.02 (Sub) R.G. Gruessner, Co-investigator

Reparixin in Islet Auto Transplant (IAT)
12/1/2013-12/31/2014 Dompé (Clinical Trial)
Total: ~$2,000,000 (Grant) Co-PI: K.K. Papas/ RW. Gruessner
Under Contract negotiations

**TRAINEES AND ADVISEES (now holding academic positions):**

27 Transplant Fellows, University of Minnesota

| | |
|---|---|
| *Benoit Barrou, M.D.* | *1991 to 1992* |
| *Daniel Casanova, M.D.* | *1991 to 1992* |
| *Carlos Fasola, M.D.* | *1991 to 1992* |
| *Jon Fryer, M.D.* | *1991 to 1992* |
| *Christoph Troppmann, M.D.* | *1991 to 1995* |
| *Enrico Benedetti, M.D.* | *1992 to 1995* |
| *Nadey Hakim, M.D.* | *1993 to 1995* |
| *Basil Papaloi, M.D.* | *1993 to 1995* |
| *Jacques Pirenne, M.D.* | *1993 to 1995* |
| *Allen Farney, M.D., Ph. D.* | *1995 to 1997* |
| *Miguel West, M.D.* | *1995 to 1997* |
| *Abhinav Humar, M.D.* | *1996 to 1998* |
| *James Harmon, M.D.* | *1997 to 1998* |
| *Mark Reza Laftavi, M.D.* | *1997 to 1998* |
| *Thiagarajan Ramcharan, M.D.* | *1999 to 2001* |
| *Steven Paraskevas, M.D.,Ph.D.* | *2000 to 2002* |
| *Roger Denny, M.D.* | *2000 to 2002* |
| *Khalid Khwaja, M.D.* | *2001 to 2003* |
| *Massimo Asolati, M.D.* | *2001 to 2003* |
| *Keith Melançon, M.D.* | *2001 to 2003* |
| *Ty Dunn, M.D.* | *2002 to 2004* |
| *Miguel Tan, M.D.* | *2003 to 2005* |
| *Vince Casingal, M.D.* | *2003 to 2005* |
| *Mark Sturdevant, M.D.* | *2004 to 2006* |
| *Raquel Roca-Garcia, M.D.* | *2005 to 2006* |
| *Elizabeth Gross, M.D* | *2005 to 2007* |

*Michael Hughes, M.D.* *2006 to 2007*
37 Chief Residents, Department of Surgery, University of Arizona *2007 to present*

**M.S./Ph.D. GRADUATES:**

*Christoph Troppmann, M.D.*
*M.S. in Experimental Surgery* *1995*
*Habilitation (German PhD equivalent)* *1999*
*Brad Feltis, M.D.*
*Ph.D. in Surgery* *2003*
*Sylvester Black*
*Ph.D. in Surgery* *2007*

**EDUCATIONAL POSITION:**

Co-Director (Department of Surgery) Graduate Program in Medical Sciences, College of Medicine, University of Arizona

**TRAINEES' AWARDS:**

*2004 ATC Young Investigator Award*
*Miguel Tan: An initial experience with laparoscopic donor distal pancreatectomy for living donor pancreas transplantation*

**ORGANIZATION OF INTERNATIONAL MEETINGS** *(since September 1999)***:**

2nd International Congress on Immunosuppression, December 6-8, 2001, San Diego, CA.
Chair, Organizing Committee (Pancreas)

1st International Conference on Abdominal Organ Transplantation from Living Donors: State of the Art, June 21-23, 2002, Gubbio, Italy.
Congress Co-Organizer
http://gen.surg.uic.edu/transplant/gubbio.html

2nd International Conference on Abdominal Organ Transplantation from Living Donors: State of the Art, June 25-27, 2004, Taormina, Italy.
Congress Co-Organizer
http://gen.surg.uic.edu/transplant/taormina.html
***Clinical Transplantation*** 2004;18 (S13):1-48.

20th International Congress of The Transplantation Society, Vienna, Austria.
Early morning courses on"New Technologies and Surgical Techniques in Transplantation".
Co-Organizer and Co-Chair, September 6-9, 2004.

3rd International Congress on Immunosuppression, December 8-11, 2004, San Diego, CA
Chair, Organizing Committee (Pancreas)
http://www.icicongress.org

3rd International Conference on Abdominal Organ Transplantation from Living Donors: State of the Art, June 23-25, 2006, Sardegna, Italy.
Congress Co-Organizer

http://transplant.hospital.uic.edu/transplant/sardegna
***Clinical Transplantation*** 2006;16 (S20):1-32.

4th International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 20-21, 2008, Sorrento, Italy.
Congress Co-Organizer
http://www.uic.edu/com/surgery/sorrento/welcome.htm

5th International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 25-26, 2010, Firenze, Italy.
Congress Co-Organizer

6th International Conference on Living Donor Abdominal Organ Transplantation, State of the Art, October 5-6, 2012, Puglia, Italy.
Congress Co-Organizer

**PUBLICATIONS, BOOK CHAPTERS, INVITED LECTURES, MEETING PRESENTATIONS:**

| | |
|---|---|
| Published Manuscripts | 312 |
| Review Articles | 19 |
| Book Chapters | 76 |
| Published Abstracts | 213 |
| Editorials and Letters to the Editor | 11 |
| Meeting Presentations | > 500 |
| Invited Lectures, Visiting Professorships | 144 |

**TEXTBOOKS: 2**

*Transplantation of the Pancreas* (2004) (676 pages, published by Springer)
(www.springeronline.com)
*(N. Engl. J. Med. 2005; 353(14): 1534-1535 [Review])*

*Living Donor Organ Transplantation* (2008) (791 pages, published by McGraw Hill)
(www.mcgraw-hill.com)
*(N. Engl. J. Med. 2008; 359(3): 324-325 [Review])*
*(JAMA. 2008; 300(13): 1592-1593 [Review])*

# *BIBLIOGRAPHY*

# RAINER W. G. GRUESSNER, M.D., FACS

## TEXTBOOKS

1 **GRUESSNER, R.W.G.**, SUTHERLAND, D.E.R. (Editors). Transplantation of the Pancreas. 1st Edition (676 pages). Springer, New York, 2004**.**

2 **GRUESSNER, R.W.G.**, BENEDETTI, E. (Editors). Living Donor Organ Transplantation. 1st Edition (791 pages). McGraw-Hill, New York, 2008.

1 **GRUESSNER, R.W.G.,** NII-AMON KOTEI, D., GUTJAHR, P., HOFMANN-v. KAP-HERR, S.: Der Stellenwert der chirurgischen Behandlung des Neuroblastoms. (Surgical treatment of neuroblastoma in childhood.). Z. Kinderchir. 37:56-61 (1982).

2 **GRUESSNER, R.W.G.:** Komplikationen nach Laparotomien im Kindesalter. (Complications following laparotomies in childhood.) Dissertationsschrift (Doctoral Thesis); Mainz (1983).

3 **GRUESSNER, R.W.G.** HOFMANN-v. KAP-HERR, S., EMMRICH, P.: Der Stellenwert der Sepsis nach Laparotomien im Kindesalter. (The incidence of septicemia after laparotomies in childhood.) Z. Kinderchir. 39:305-309 (1984).

4 **GRUESSNER, R.W.G.**, PISTOR, G., ENGELSKIRCHEN, R., HOFMANN-v. KAP-HERR, S.: Appendizitis im Kindesalter. (Appendicitis in childhood.) Monatsschr. Kinderheilk. 133:158-166 (1985).

5 **GRUESSNER, R.W.G.**, RÜCKERT, K., KLOTTER, H.J., KUHNERT, A.: Ultraschall und Lavage beim stumpfen Bauchtrauma polytraumatisierter Patienten. (Ultrasound and peritoneal lavage in polytrauma patients with blunt abdominal trauma.) Dtsch. med. Wschr. 110:1521-1526 (1985).

6 **GRUESSNER, R.W.G.**, HOFMANN-v. KAP-HERR, S., WINKLER, M. PIEPER, W.M., KUHNERT, A.: Spätergebnisse nach zweit- und drittgradigen Verbrennungen im Kindesalter unter besonderer Berücksichtigung der Abschleifmethode nach Lorthioir und Thielen. (Late results of second and third degree burns in childhood with regard to the abrasion technique by Lorthioir and Thielen.) Monatsschr. Kinderheilk. 134:89-95 (1986).

7 HOFMANN-v. KAP-HERR, S., **GRUESSNER, R.W.G.**, KOLTAI, I.: Results of the smooth-muscle fold-over double-plasty (SMFD). Pädiatr. Surg. Int. 1:43-45 (1986).

8 **GRUESSNER, R.W.G.**, PISTOR, G., NII-AMON KOTEI, D., KUHNERT, A.: Relaparotomie im Kindesalter. (Relaparotomy in childhood.) Langenbecks Arch. Chir. 367:167-180 (1986).

9 PISTOR, G., ALZEN, G., DELL'AGNOLA, C.A., **GRUESSNER, R.W.G.**: Behandlung von Kindern mit Omphalozele und Gastroschisis. Operationstaktische und technische Konsequenzen der pränatalen und intraoperativen Sonographie. (Treatment of omphalocele and gastrochisis in children. The significance of prenatal and intraoperative ultrasonography with respect to surgical strategy and technical aspects.) Fortschr. Med. 104:519-521 (1986).

10 **GRUESSNER, R.W.G.**, PISTOR, G., ABOU-TOUK, B., ALZEN, G.: Significance of ultrasound for the diagnosis of hypertrophic pyloric stenosis. Pädiatr. Surg. Int. 1:130-134 (1986).

11 KLOTTER, H.J., RÜCKERT, K., MENTGES, B., **GRUESSNER, R.W.G.**, SCHILD, H.: Intraoperative Ultraschalluntersuchung in der Chirurgie. (Intraoperative sonography in general surgery.) Ultraschall 7:224-230 (1986).

12 PISTOR, G., **GRUESSNER, R.W.G.**, KOLTAI, I., HOFMANN-v. KAP-HERR, S.: Moderne Diagnostik und Therapie der traumatischen Hämobilie im Kindesalter. (Diagnosis and treatment of traumatic hemobilia in childhood.) Z. Kinderchir. 41:114-118 (1986).

13 MILDENBERGER, P., **GRUESSNER, R.W.G.**, KREITNER, K.F.: Leiomyom in B II-Restmagen. (Leiomyoma in Billroth II residual stomach.) Röntgen-Bl. 39:330-332 (1986).

14 **GRUESSNER, R.W.G.**, HINKEL, E., v. BÜLOW, M., KLOTTER, H.J.: Der Strahlenspätschaden des Dünndarms. (Late radiation injuries of the small intestine.) Akt. Chir. 22:9-13 (1987).

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4. Rana A, Gruessner A, Kaplan B, **GRUESSNER RWG**. Geographic Inequity Results in Disparate Mortality: An Intent to Treat Analysis of Liver Transplant Candidates. Submitted to Hepatology. 2013.
5. Arif-Tiwari H, Kalb B., Chundru S, Sharma P, Costello J, **GRUESSNER RWG**, Martin D. Magnetic resonance imaging of hepatocellular carcinoma. (Accepted for publication)
6. Kitzmann JP, O'Gorman D, Kin T, Gruessner AC, Senior P, Imes S, **Gruessner RW**, Shapiro AMJ, Papas, KK , "Islet oxygen consumption rate predicts clinical islet allo-transplant insulin independence for first transplants". Transplantation Proceedings, 2013.
7. Mueller KR, Scott III WE, Jie T, Weegman BP, Balamurugan AN, Kitzmann JP, Marshall H, Shaw J, Manas D, Persaud S, Huang GC, Khorsandi SE, Tempelman L, Pongratz RL, Cline GW, Gruessner AC, **Gruessner RW**, Papas, KK , "Human pancreas persufflation ameliorates hypoxia-induced impairment of islet function post-isolation. ". Transplantation Proceedings, 2013.

1 **GRUESSNER, R.W.G.**: Dehnungsbehandlung bei Achalasie. (Endoscopic Treatment of Achalasia – Indications and Long Term Outcome.) Symposium zur Behandlung der Ösophagusstenose. 3/27/87, Mainz, Germany.

2 **GRUESSNER, R.W.G.**: Pancreas Recovery, Preservation and Transplantation. 10th Meeting of the North American Transplant Coordinators (NATCO). 4/30-5/5/89, Ashville, North Carolina.

3 **GRUESSNER, R.W.G.**: Simultaneous Transplantation of Pancreas and Kidney in Pigs. 22nd International Course on Transplantation and Clinical Immunology. 5/21-23/90, Lyon, France.

4 **GRUESSNER, R.W.G.**: Comparison of Rejection in Clinical Transplantation of Pancreas Alone or Associated with Kidney Transplant. 22nd International Course on Transplantation and Clinical Immunology. 5/21-23/90, Lyon, France.

5 **GRUESSNER, R.W.G.**: Rejection in Single Versus Combined Pancreas and Kidney Transplantation. Transplantation Conference. 6/7/90, Minneapolis, Minnesota.

6 **GRUESSNER, R.W.G.**: Immunsuppression und Abstossungstherapie nach Pankreastransplantation. (Posttransplant Immunosuppression and Rejection Treatment Following Pancreas Transplantation.) National Workshop: Pankreastransplantation in Deutschland. 9/3-4/90, Tübingen, Germany.

7 **GRUESSNER, R.W.G.:** Operative Technik der Pankreastransplantation. (Surgical Aspects of Pancreas Transplantation.) 10. Tagung der Chirurgischen Arbeitsgemeinschaft Endokrinologie. (CAEK) 10/17-19/91, Marburg, Germany.

8 **GRUESSNER, R.W.G:** Perspektiven der Pankreas- und Inseltransplantation. (The Long-Term Perspective of Pancreas and Islet Transplantation.) 10. Tagung der Chirurgischen Arbeitsegemeinschaft Endokrinologie. (CAEK) 10/17-19/91, Marburg, Germany.

9 **GRUESSNER, R.W.G:** Report of the International Pancreas Transplant Registry (IPTR). 11th Workshop of the AIDSPIT Study Group of the European Association for the Study of Diabetes. 1/26-28/92, Igls, Austria.

10 **GRUESSNER, R.W.G.:** Transplants for Diabetic Patients. IBC Conference "Insulin-Dependent Diabetic Mellitus. Advances in Management, Prevention and Cure." 1/29-30/92, Philadelphia, Pennsylvania.

11 **GRUESSNER, R.W.G.:** State-of-the-Art in Pancreas Transplantation. 2nd Biennial Convention of the Transplantation Society of the Philippines. 4/24-26/92, Manila, Philippines.

12 **GRUESSNER, R.W.G.:** Kidney Transplantation – Past, Present, Future. 2nd Biennial Convention of the Transplantation Society of the Philippines. 4/24-26/92, Manila, Philippines.

13 **GRUESSNER, R.W.G.:** Current Status of Liver Transplantation. 2nd Biennial Convention of the Transplantation Society of the Philippines. 4/24-26/92, Manila, Philippines.

14 **GRUESSNER, R.W.G.:** Pancreatic Transplantation and Diabetes. Congress on Advances in Internal Medicine. 11/9-12/92, Chicago, Illinois.

15 **GRUESSNER, R.W.G.:** The Diabetic Patient on Hemodialysis. Vascular Access Problems. 5th Scientific Meeting of the Singapore Society of Nephrology. 9/4-5/1993, Singapore.

16 **GRUESSNER, R.W.G.:** Kidney, Pancreas and Islet Transplantation in Diabetic Patients. 5th Scientific Meeting of the Singapore Society of Nephrology. 9/4-5/1993, Singapore.

17 **GRUESSNER, R.W.G.,** Discordance of Rejection of Simultaneously Transplanted Allografts of the Pancreas and Other Organs. Barbara Davis Center. 12/13/1993, Denver, Colorado.

18 **GRUESSNER, R.W.G.:** The Coming of Age of Solitary Pancreas Transplantation. Transplant Grand Rounds, Loma Linda University Medical Center. 5/27/1994, Loma Linda, California.

19 **GRUESSNER, R.W.G.:** Pancreas Transplantation from Living Related Donors. 26th International Conference on Transplantation and Clinical Immunology. 6/13-15/1994, Lyon, France.

20 **GRUESSNER, R.W.G.:** Intestinal Transplantation. Grand Rounds, Department of Pediatrics. 10/19/1994, Minneapolis, Minnesota.

21 **GRUESSNER, R.W.G.:** Pancreatic Transplants: Is it Effective Treatment for Diabetes and if so, When Should it be Done? 20th Annual Endocrinology and Metabolism Update. 10/28/1994, Lansing, Michigan.

22 **GRUESSNER, R.W.G.:** Bowel Transplantation. Children's Health Care St. Paul. 5/14/1995, St. Paul, Minnesota.

23 **GRUESSNER, R.W.G.:** Use of FK506 in Pancreas Transplantation. Northwestern University Medical School. 9/21/1995, Chicago, Illinois.

24 **GRUESSNER, R.W.G.:** Acute Pancreatitis and Renal Failure: A Surgeon's Perspective. Annual Focus on the Kidney: Useful Strategies in Primary Care. National Kidney Foundation of the Upper Midwest, Inc. 11/17/1995, St. Paul, Minnesota.

25 **GRUESSNER, R.W.G.:** Pancreas Transplantation: Long-Term Results and Effects on Diabetic Morbidity. 22 ème Séminaires d'Uro-Néphrologie. 1/11-13/1996, Paris, France.

26 **GRUESSNER, R.W.G.:** Pediatric Kidney Transplantation. 23rd Biennial Congress of the Pan-Pacific Surgical Association. 1/21-26/1996, Honolulu, Hawaii.

27 **GRUESSNER, R.W.G.:** Gegenwärtiger Stand der Insel- und Pankreastransplantation. 40. Symposium der Deutschen Gesellschaft für Endokrinologie. 2/28-3/2/1996, Marburg, Germany.

28 **GRUESSNER, R.W.G.:** Severe Pancreatitis – The Surgeon's Approach. Advances and Controversies in Critical Care. 6/28-29/1996, Minneapolis, Minnesota.

29 **GRUESSNER, R.W.G.:** Recent Advances in Pancreas Transplantation. Carolinas Medical Center. 10/28-29/1996, Charlotte, North Carolina.

30 **GRUESSNER, R.W.G.:** Pancreas Transplantation from Live Donors. Kyoto Prefecturial University. 11/27/1996, Kyoto, Japan.

31 **GRUESSNER, R.W.G.:** Intestinal Transplantation from Live Donors. Kyoto University. 11/29/1996, Kyoto, Japan.

32 **GRUESSNER, R.W.G.:** Diabetics Should be Listed Sooner: Pro. ASTP Consensus Conference – Kidney. 11/30/1996, NIH Campus, Bethesda, Maryland.

33 **GRUESSNER, R.W.G.:** Intestinal and Liver Transplantation. Laboratory Medicine and Pathology Grand Rounds. 2/12/1997, Minneapolis, Minnesota.

34 **GRUESSNER, R.W.G.:** New Strategies for Rejection in Intestinal Transplantation. Northwestern University Medical School 5/14/1997, Chicago, Illinois.

35 **GRUESSNER, R.W.G.:** El Transplante de Pancreas: Estado Actual. Congress on Solid Organ and Cell Transplantation. 5/23/1997, Santander, Spain.

36 **GRUESSNER, R.W.G.:** Intestinal Transplantation. 61st Annual Course on Advances in Gastrointestinal and GI Laparoscopic Surgery. 6/18-21/1997, Minneapolis, Minnesota.

37 **GRUESSNER, R.W.G.:** Large Animal Models of Intestinal Transplantation. 5th International Symposium on Intestinal Transplantation. 7/30-8/2/1997, Cambridge, United Kingdom.

38 **GRUESSNER, R.W.G.:** Invited discussant to: Clinical Intestinal Transplantation. An Update and New Prospectives. Abu-Elmagd, K., Reyes, J., Todo, S., Starzl, T. 83rd Annual Congress of the American College of Surgeons. 10/12-17/1997, Chicago, Illinois.

39 **GRUESSNER, R.W.G.:** New Immunosuppression in Pancreas and Kidney Transplantation. 11/20/1997, Honolulu, Hawaii.

40 **GRUESSNER, R.W.G.:** Liver, Small Bowel, and Pancreas Transplantation from Live Donors. Grand Rounds. St. Francis Medical Center, University of Hawaii. 11/21/1997, Honolulu, Hawaii.

41 **GRUESSNER, R.W.G.:** Use of Antibody Induction Therapy – Pro. The International Congress on Immunosuppression. 12/11-13/1997, Orlando, Florida.

42 **GRUESSNER, R.W.G.:** Current Status in Pancreas Transplantation. Symposium on Organ Donation and Transplantation in Japan. 2/20/1998, Tokyo, Japan.

43 **GRUESSNER, R.W.G.** Transplant Options for Diabetic Patients. Surgery Grand Rounds. 2/22/1998, Sapporo, Japan.

44 **GRUESSNER, R.W.G.:** Large Animal Models of Intestinal Transplantation. Japanese Society for Organ Transplantation. 2/27/1998, Kyoto, Japan.

45 **GRUESSNER, R.W.G.**: Pancreas Transplantation: Bladder Drainage Versus Enteric Drainage. 2nd Joint Congress of the Transplantation Societies of Argentina, Brazil, Chile, and Uruguay. 5/17-20/1998, Santiago, Chile.

46 **GRUESSNER, R.W.G.:** Tacrolimus and Mycophenolate in Pancreas Transplantation. 2nd Joint Congress of the Transplantation Societies of Argentina, Brazil, Chile, and Uruguay. 5/17-20/1998, Santiago, Chile.

47 **GRUESSNER, R.W.G.:** Pancreas Transplantation. Present Status. 2nd Joint Congress of the Transplantation Societies of Argentina, Brazil, Chile, and Uruguay. 5/17-20/1998, Santiago, Chile.

48 **GRUESSNER, R.W.G.:** Current Status of Living Related Hepatic Transplantation. 62nd Annual Course on Advances in Hepatic, Biliary, and Pancreatic Surgery. 6/17-20/1998, Minneapolis, Minnesota.

49 **GRUESSNER, R.W.G.:** TIPS – Pro's and Con's. Meeting on 'New Horizons in Radiology and Gastroenterology. 11/13-14/1998, Zürich, Switzerland.

50 **GRUESSNER, R.W.G.:** Pancreas- and Kidney Transplantation. 30th Annual Meeting of the Swiss Society of Nephrology. 12/3-4/1998, Zürich, Switzerland.

51 **GRUESSNER, R.W.G.:** Accomplishments and Perspectives in Pancreas Transplantation. 18th Workshop of the AIDSPIT Study Group. 1/24-26/1999, Igls, Austria.

52 **GRUESSNER, R.W.G.:** Living Unrelated Donation – What Does This Mean for Transplantation? First Annual State-Of-The-Art Symposium. South-Eastern Organ Procurement Foundation (SEOPF). 1/27/2000, New Orleans, Louisiana.

53 **GRUESSNER, R.W.G.:** The Current Status of Pancreas Transplantation. The Canadian Society of Transplantation. 3/2-3/4/2000, Mont Tremblant, Quebec, Canada.

54 **GRUESSNER, R.W.G.:** Solid Organ Transplantation from Live Donors. Grand Rounds, University of Tennessee. 5/31/2000, Memphis, Tennessee.

55 **GRUESSNER, R.W.G.:** Pancreas Transplantation – A Registry Report. Korean Organ Transplantation Symposium. 6/10/2000, Seoul, Korea.

56 **GRUESSNER, R.W.G.:** The Use of Live Donors in Liver and Intestinal Transplantation. Korean Organ Transplantation Symposium. 6/10/2000, Seoul, Korea.

57 **GRUESSNER, R.W.G.**: Pancreas Transplantation from Live Donors. XVIII International Congress of the Transplantation Society. 9/1/2000, Rome, Italy.

58 **GRUESSNER, R.W.G.**: Pancreas after Kidney Transplantation. 3rd Annual Midwest Kidney Pancreas Transplant Advisory Board Meeting. 9/21/2000, Kohler, Wisconsin.

59 **GRUESSNER, R.W.G.**: Antibody Induction. Pancreas Transplantation Workshop. 3/29-31/2001, Farmington, Pennsylvania.

60 **GRUESSNER, R.W.G.**: Living Donor Issues and Results. Pancreas Transplantation Workshop. 3/29-31/2001, Farmington, Pennsylvania.

61 **GRUESSNER, R.W.G.**: Current Status of Intestinal Transplantation. Advances in Gastrointestinal and GI Laparoscopic Surgery. 6/16/2001, Minneapolis, Minnesota.

62 **GRUESSNER, R.W.G.**: How I Do it: Kidney and Pancreas. Transplant Immunosuppression 2001: The Complete Care of the Transplant Recipient. 10/26/2001, Minneapolis, Minnesota.

63 **GRUESSNER, R.W.G.** 2nd International Congress on Immunosuppression. 12/7/2001, San Diego, California.

64 **GRUESSNER, R.W.G.**: Liver Transplantation from Live Donors. 66th Annual Course in Surgery. Advances in Hepatic, Biliary, and Pancreatic Surgery. 6/12/2002, Minneapolis, Minnesota.

65 **GRUESSNER, R.W.G.**: Results of Living-Related Pancreas Transplantation. International Conference on Abdominal Organ Transplantation From Living Donors: State of the Art. 6/22/2002, Gubbio, Italy.

66 **GRUESSNER, R.W.G.**: History of Living-Related Intestinal Transplantation. International Conference on Abdominal Organ Transplantation From Living Donors: State of the Art. 6/23/2002, Gubbio, Italy.

67 **GRUESSNER, R.W.G**.: Update on Kidney/Pancreas Transplantation. Emory Transplant Conference, Visiting Professor, Emory University Hospital. 9/25/2002, Atlanta, Georgia.

68 **GRUESSNER, R.W.G**.: Solid Organ Transplantation from Live Donors. Grand Rounds, Emory University Hospital. 9/26/2002, Atlanta, Georgia.

69 **GRUESSNER, R.W.G**.: Risks and Benefits of Pancreas and Islet Transplantation. American Diabetes Association Meeting. 6/14/2003, New Orleans, Louisiana.

70 **GRUESSNER, R.W.G.**: Pancreas and Islet Transplantation in Diabetes Patients with End-Stage Renal Disease. Update Symposium on Metabolic Disease: Diabetes, June 28, 2003, Ibiza, Spain.

71 **GRUESSNER, R.W.G.**: Solitary Pancreas Transplantation. 9th Congress of the International Pancreas & Islet Transplant Association, July 8-11, 2003, Dublin, Ireland.

72 **GRUESSNER, R.W.G.**: Pancreas Transplant Alone. 9th Congress of the International Pancreas & Islet Transplant Association, July 8-11, 2003, Dublin, Ireland.

73 **GRUESSNER, R.W.G.**: Living Donor Pancreatectomy. Robert J. Corry Transplantation Workshop, October 30-November 2, 2003, Pittsburgh, Pennsylvania.

74 **GRUESSNER, R.W.G.**: Pancreas Transplantation for Exocrine Failure. Robert J. Corry Transplantation Workshop, October 30-November 2, 2003, Pittsburgh, Pennsylvania.

75 **GRUESSNER, R.W.G.**: Survival after Solitary Pancreas Transplantation. Robert J. Corry Transplantation Workshop, October 30-November 2, 2003, Pittsburgh, Pennsylvania.

76 **GRUESSNER, R.W.G.:** Pancreas after Kidney and Pancreas Transplantation Alone: Morbidity and Mortality in Solitary Pancreas Transplantation. American Society of Transplant Surgeons/American Transplant Congress, May 15-19, 2004, Boston, Massachusetts.

77 **GRUESSNER, R.W.G.:** Living Donor Pancreas Transplantation. 2nd International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 25-27, 2004, Taormina, Sicily**.**

78 **GRUESSNER, R.W.G.:** Living Donor Intestinal Transplantation: Indications and Technical Aspects. 2nd International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 25-27, 2004, Taormina, Siciliy.

79 **GRUESSNER, R.W.G**.: Living Donor Pancreas Transplantation. XX International Congress of The Transplantation Society, September 5-10, 2004, Vienna, Austria**.**

80 **GRUESSNER, R.W.G.:** Current Status of Kidney-Pancreas Transplantation. Transplant Asia 2004 Congress, December 1-4, 2004, Singapore.

81 **GRUESSNER, R.W.G.:** Comparing Pancreas and Islet Transplantation. Transplant Asia 2004 Congress, December 1-4, 2004, Singapore**.**

82 **GRUESSNER, R.W.G.:** Individualization of Short-Term Immunosuppression After Pancreas Transplantation. 3rd International Congress on Immunosuppression, December 8-11, 2004, San Diego, California.

83 **GRUESSNER, R.W.G.:** Solid Organ Transplantation from Live Donors. Hackensack University Medical Center, Grand Rounds, April 5, 2005, Hackensack, New Jersey.

84 **GRUESSNER, R.W.G.**: Pancreas Transplantation From Living Donors. 2nd San Raffaele Transplant Meeting, April 18, 2005, Milan, Italy.

85 **GRUESSNER, R.W.G.**: Antibody-Based Maintenance Therapy in Pancreas and Kidney Transplantation. Symposium on "Use of Antibodies to Optimize Outcomes in Solid Organ Transplantation". American Transplant Congress, May 20, 2005, Seattle, Washington.

86 **GRUESSNER, R.W.G.:** Comparison Between Pancreas and Islet Transplantation. 4th Starnberger Workshop, June 17, 2005, Munich, Germany.

87 **GRUESSNER, R.W.G.:** History of and Current Developments in Pancreas and Islet Transplantation. 9th Hokkaido Transplantation Forum, July 9, 2005, Sapporo, Japan.

88 **GRUESSNER, R.W.G.:** Antibody-Based Maintenance Therapy in Pancreas and Kidney Transplantation. Alemtuzumab Interspecialty Global Experts Meeting, Berlex Oncology, August 16, 2005, Laguna Beach, California.

89 **GRUESSNER, R.W.G.:** Improving the Outcome for Solitary Pancreas Transplant Recipients. Conference on Posttransplant Immunosuppression 2005 - Improving Recipient Outcome, September 30, 2005, Minneapolis, Minnesota.

90 **GRUESSNER, R.W.G.:** Antibody Therapy in Pancreas Transplantation. Second Annual Genzyme Review Committee (SRC) Investigator Meeting, October 22, 2005, Atlanta, Georgia.

91 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Molecular Medicine Research Seminar, Rangos Research Center, Department of Pediatrics, Children's Hospital of Pittsburgh, December 13, 2005, Pittsburgh, Pennsylvania.

92 **GRUESSNER, R.W.G.:** Living Pancreas and Intestinal Donation. Living Organ Donation Conference. American Foundation for Donation and Transplantation, March 24, 2006, Atlanta, Georgia.

93 **GRUESSNER, R.W.G.:** Evolution of Living Donor Liver Transplantation. 70th Annual University of Minnesota Surgery Course: Advances in Hepatic, Biliary and Pancreatic Surgery, June14-17, 2006, Minneapolis, Minnesota**.**

94 **GRUESSNER, R.W.G.:** Intestinal Transplants from Living Donors. 3rd International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 23, 2006, Sardinia, Italy.

95 **GRUESSNER, R.W.G.:** The Amsterdam and Vancouver consensus conferences – the status of living organ donation. 3rd International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 24, 2006, Sardinia, Italy.

96 **GRUESSNER, R.W.G.:** Laparoscopic Distal Pancreatectomy. World Transplant Congress, July 23-27, 2006, Boston, Massachusetts**.**

97 **GRUESSNER, R.W.G.:** Timing of Pancreas Transplantation in Kidney Recipients. World Transplant Congress, July 23-27, 2006, Boston, Massachusetts**.**

98 **GRUESSNER, R.W.G.:** Pancreas Transplantation. South Korean Transplant Society Meeting, September 26, 2006, Seoul, Korea.

99 **GRUESSNER, R.W.G.**: Status of Pancreatic Islet Transplantation. Advisory Committee on Organ Transplantation (ACOT), November 2-3, 2006, Washington, D.C.

100 **GRUESSNER, R.W.G.:** Pancreas Transplantation: What the Future Holds. 40th Pancreas Transplant Anniversary, University of Minnesota, December 8-9, 2006, Minneapolis, Minnesota.

101 **GRUESSNER, R.W.G.:** Recent Advances in Pancreas and Intestinal Transplantation. Grand Rounds, Department of Surgery, University of Arizona, December 20, 2006, Tuscon, Arizona.

102 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Surgical Grand Rounds, Banner Good Samaritan Medical Center, January 18, 2007, Phoenix, Arizona.

103 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Grand Rounds, Columbia University College of Physicians and Surgeons, February 21, 2007, New York, NY.

104 **GRUESSNER, R.W.G.:** The History and Current Status of Intestinal Transplantation from Living Donors. 19th Annual Meeting of the Japanese Society for Small Bowel Transplantation, March 10, 2007, Sapporo, Japan

105 **GRUESSNER, R.W.G.:** Benchmark Outcomes for Pancreas Transplantation. 2007 Annual Meeting of the American Hepato-Pancreato-Biliary Association, April 19, 2007, Las Vegas, Nevada.

106 **GRUESSNER, R.W.G.:** Living Donor Pancreas Transplantation Living Donor Small Bowel Transplantation. Second Beijing Transplantation Forum and Fifth Anniversary Celebration of Beijing (Peking) University's Transplant Center, May 26, 2007, Beijing, China.

107 **GRUESSNER, R.W.G.**: Living Donor Pancreas Transplantation: State of the Art. Third International Symposium on Living Donor Organ Transplantation, June 11-12, 2007, Essen, Germany.

108 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Transplant Grand Rounds, June 28, 2007, Xi'an University, Xi'an, China.

109 **GRUESSNER, R.W.G.:** The Uremic Diabetic: LD Kidney Followed by PAK is Preferred to a DD SPK – PRO. CTS-IPITA-IXA 2007 Joint Conference, Sept 15-20, 2007, Minneapolis, Minnesota.

110 **GRUESSNER, R.W.G.:** Transplantation of Extrarenal Abdominal Organs. Grand Rounds - University of New Mexico Health Sciences Center, Nov 9, 2007, Albuquerque, New Mexico.

111 **GRUESSNER, R.W.G.:** Living Donor Transplantation. Hospital General del Estado, Feb 28, 2008, Hermosillo, Sonora, Mexico

112 **GRUESSNER, R.W.G.:** Advances in Pancreas Transplantation. Annual Congress of the Japan Society for Pancreas and Islet Transplant, March 7-9, 2008, Kyoto, Japan.

113 **GRUESSNER, R.W.G.:** Extra Renal Transplant Liver & Small Bowel. Pediatric Grand Rounds—University Medical Center, May 2, 2008, Las Vegas, Nevada.

114 **GRUESSNER, R.W.G.:** Dual Organ Transplantation from Living Donors. 4th International Conference, Living Donor Abdominal Organ Transplantation: State of the Art, June 20-21, 2008, Sorrento, Italy.

115 **GRUESSNER, R.W.G.**: Living Kidney Donor Surgery - Are There Surgical Constraints? International Congress of The Transplantation Society. Aug 10-14, 2008, Sydney Australia.

116 **GRUESSNER, R.W.G.**: Transplant Surgery: Controversies and Dilemmas: Surgical Challenges for the Expert Panel. International Congress of The Transplantation Society.Aug 10-14, 2008, Sydney Australia.

117 **GRUESSNER, R.W.G.**: State-of-the-Art Symposium: Long-Term Outcomes in Pancreas Transplantation: Management of Surgical Complications of Pancreas Transplantation. International Congress of The Transplantation Society. Aug 10-14, 2008, Sydney Australia.

118 **GRUESSNER, R.W.G.**: Current Advances in Hepatopancreatico Biliary Surgery. Arizona Chapter, American College of Surgeons 2008 Annual Scientific Meeting. November 1-2, 2008, Tucson, Arizona.

119 **GRUESSNER, R.W.G.**: Current Status and Future Developments in Abdominal Organ Transplantation. Arizona Chapter, American College of Surgeons 2008 Annual Scientific Meeting. November 1-2, 2008, Tucson, Arizona.

120 **GRUESSNER, R.W.G.**: Intestinal and Islet Transplantation. Banner Good Samaritan Grand Rounds. March 12, 2009, Phoenix, Arizona.

121 **GRUESSNER, R.W.G.:** EPITA Post Graduate Course: Pancreas transplantation for type 2 diabetes. European Society for Organ Transplantation 14th Congress. August 30, 2009, Paris, France.

122 **GRUESSNER, R.W.G.:** Indications, Techniques and Results of Intestinal Transplantation in Children. 74th Meeting of the German Society of Pediatric Surgery. Sept 4, 2009, Mannheim, Germany.

123 **GRUESSNER, R.W. G.**: Recent Progress in Hepaticopancreaticobilliary Surgery. XXXIII International Congress in General Surgery. November 3, 2009, Acapulco, Mexico.

124 **GRUESSNER, R.W.G.**: Current Advances in Pancreatic Surgery. XXXIII International Congress in General Surgery. November 4, 2009, Acapulco, Mexico.

125 **GRUESSNER, R.W.G.**: Organ Allocation: Kidney/Pancreas. 3rd Annual Surgical Fellows Symposium, American Society of Transplant Surgeons. November 13, 2009, Scottsdale, Arizona.

126 **GRUESSNER, R.W.G.:** Innovation, Expansion, and Progress in Surgery and Transplantation at the University of Arizona. 260 Club of Green Valley, Inc. February 3, 2010, Green Valley, AZ.

127 **GRUESSNER, R.W.G.:** Rebuilding the Department of Surgery and Transplantation at the University of Arizona. Foothills Forum. February 9, 2010, Tucson, AZ.

128 **GRUESSNER, R.W.G.:** Pancreas Transplant: Techniques and management. The First Egyptian Organ Transplant Congress. March 24, 2010, Cairo, Egypt.

129 **GRUESSNER, R.W.G.:** Recent Advances in Transplantation and Complex Abdominal Surgery. Carondelet St. Joseph's Hospital Symposium. April 13, 2010, Tucson, AZ.

130 **GRUESSNER, R.W.G.:** Transplant Surgery. Carondelet St. Mary's Hospital Symposium. June 9, 2010, Tucson, AZ.

131 **GRUESSNER, R.W.G.:** Living Donor Pancreas and Intestinal Transplant: Are they still indicated? 5th International Conference on Living Donor Abdominal Organ Transplantation: State of the Art, June 25, 2010, Firenze, Italy.

132 **GRUESSNER, R.W.G.:** Rebuilding the Department of Surgery at the University of Arizona. Arizona Chapter American College of Surgeons, Nov 6-7, 2010, Tucson, AZ.

133 **GRUESSNER, R.W.G.:** Current State of Abdominal Transplantation. Texas Tech University Health Sciences Center Grand Rounds, Feb 15, 2011, El Paso, TX.

134 **GRUESSNER, R.W.G.:** Transplant Options for the Treatment or Prevention of Insulin-Dependent Diabetes Mellitus, 6th Scientific Session, Halsted Society Meeting ,September 10, 2011, Baltimore, MD.

135 **GRUESSNER, R.W.G.:** Transplant Coverage Cuts – How Arizona provides an example. Emerging Issues in Organ Transplantation - A Colloquium. Cleveland Clinic, October 15, 2011, Cleveland, OH.

136 **GRUESSNER, R.W.G.**: Transplant Options for Treatment and Prevention of Diabetes Mellitus, 39th Annual Congress of the Japanese Pancreas and Islet Transplantation Association. March 10, 2012; Asahikawa City, Hokkaido, Japan.

137 **GRUESSNER, R.W.G.**: Pancreas and Islet Transplantation: Past, Present and Future. Annual Meeting of the Belgian Transplantaton Society, March 29, 2012, Brussels, Belgium.

138 **GRUESSNER, R.W.G.**: Impact of Donor and Recipient Factors on Outcome After Pancreas Transplantation, Transplant Surgery Grand Rounds, University Hospital, March 31, 2012, Ghent, Belgium.

139 **GRUESSNER, R.W.G.**: Pancreas Transplant Alone. 72nd Scientific Session of the American Diabetes Association, June 8-12, 2012, Philadelphia, PA.

140 **GRUESSNER, R.W.G.**: An update on pancreas and islet transplantation, 2nd National Congress of the Spanish Society of Transplantation, June 24, 2012, Madrid, Spain.

141 **GRUESSNER, R.W.G.:** The Readiness of an Academic Surgery Department in the Case of a National Tragedy. AZ Chapter, American College of Surgeons, Nov. 10, 2012, Tucson, Arizona.

142 **GRUESSNER, R.W.G.:** Pancreas Transplantation from living donors, Dal passato al futuro dei trapianti di rene e di Pancreas (From Past to Future of the Kidney Transplantation), March 14, 2013, Pisa, Italy.

143 **GRUESSNER, R.W.G.:** Current Status of Whole Organ Pancreas Transplant for Diabetes. American Transplant Congress, May 20, 2013, Seattle, WA.

144 **GRUESSNER, R.W.G.:** What defines Success in Islet and Pancreas Transplantation? 14th World Congress of the International Pancreas and Islet Transplant Association (IPITA), September 26, 2013, Monterey, CA.

# Exhibit B

THE UNIVERSITY OF ARIZONA
College of Medicine

Office of the Dean

P.O. Box 245017
Tucson, AZ 85724-5017
Tel: (520) 626-4555
Fax: (520) 626-6252
www.medicine.arizona.edu

February 22, 2007

Rainer W.G. Gruessner, MD, FACS
7005 Valley View Road
Edina, MN 55439

Dear Rainer,

We are pleased to offer you the position as Head of the Department of Surgery (DOS) under Chapter 5 of the University Handbook for Appointed Personnel (UHAP), Administrative Personnel Policies and Procedures, and Section 6-101 of the Arizona Board of Regents Policy Manual, Conditions of Administrative Service. This employment offer is contingent upon the satisfactory outcome of any employment screening activities or criminal background checks that may be required under University policy or Arizona Board of Regents policy 6-709. You may also be subject to other background check requirements on behalf of UPH and UMC.

We share with you the vision of recruiting new faculty members of high quality who are committed to excellence and who share a sense of responsibility and accountability to the Department of Surgery. We also applaud your desire to establish two primary focus areas – surgical oncology and solid organ transplantation. Your intention to support faculty development and to reward and acknowledge excellence, whether in patient care, educational service, research, or combinations of these activities, is completely aligned with the goals of the College of Medicine, UMC and UPH.

In addition to your administrative appointment and based upon your previous academic experience and rank, we anticipate you will receive an appointment as a tenured Professor in the College of Medicine's Department of Surgery under Chapter 3 of UHAP, Faculty Personnel Policies and Procedures, and Section 6-201 of the Arizona Board of Regents Policy Manual, Conditions of Faculty Service, all of which are incorporated herein, effective _____, 2007. Your faculty appointment is subject to the approval of the College of Medicine Promotion and Tenure Committee, the University of Arizona President and University Physicians Healthcare (UPH). If you are providing clinical care to patients, you are required to have concurrent membership and employment with UPH, our clinical practice organization. You will be an employee of the Arizona Board of Regents in your teaching, service and research capacities, and an employee of UPH for the delivery of health care. References in this letter to the "University of Arizona" or "University" shall mean the Arizona Board of Regents.

Your appointment and subsequent renewal of employment with the University are contingent upon availability of funds, satisfactory performance, continued need for the position and membership and employment in good standing with University Physicians Healthcare (UPH) if you are engaged in clinical care of patients. You will need to maintain privileges at University Medical Center (UMC), which requires your compliance with all rules, regulations and bylaws of the University of Arizona College of Medicine, UMC, UPH and UPH Hospital at Kino (UPHK) and all other obligations, including the Member Services Plan of 1985 between the Arizona Board of Regents and UPH, all of which are incorporated herein by reference. Should UMC provide funding in support of this position such arrangements shall be set out in a separate Mission Support Statement between UMC and the College of Medicine.

As Head of the Department of Surgery you would have the responsibilities set forth below. Your appointment as an administrator would be a year-to-year appointment under the Conditions of Administrative Service, as stated above. Administrators shall be evaluated with respect to performance, professional development and future expectations at least once every 12 months. In accordance with UHAP 5.09, all Department Heads are accorded a comprehensive performance review during their fifth year of service.

We share your vision of building a department dedicated to excellence in clinical care, research and teaching. Accordingly we will make commitments to you which will allow you to move forward in each of these areas.

COMMITMENTS

**Salary and Appointment:**

Your total approved annualized University of Arizona/UPH salary would be $590,000. Of this amount, $145,000 (25%) represents your stipend for your position as Department Head of Surgery and $445,000 (75%) represents your faculty salary established at approximately the AAMC 75th percentile for Professors of Transplant Surgery. If the Dean of the College of Medicine determines that you would no longer maintain your administrative appointment as Department Head of Surgery, during the period between the effective date of your initial appointment in 2007 and June 30, 2016, you would retain your appointment as a tenured professor in the Department of Surgery should you elect to remain at the University of Arizona. Under the circumstances presented above, you would not receive the administrative stipend as Department Head; however, the College of Medicine commits to recalibrating your faculty salary to be at the 75th percentile of the AAMC salary benchmark for professors of transplant surgery, and would commit to that faculty salary level for an additional three years from the date that you are no longer Department Head of Surgery based on your faculty teaching, research and clinical activity as determined by the Dean and in accordance with established performance standards within the College of Medicine. Future salary levels will be determined based on your performance and productivity.

Expectations for you and the commitments to you in your role as Department Head reflected in this letter are independent of the individual serving as Dean of the College of Medicine.

Funds to cover your salary will be derived from a variety of sources. These include state support to the Department of Surgery, funds from UMC and UPH which will be provided to the College of Medicine in support of the mission of the Department of Surgery, and collections from your clinical practice.

The College of Medicine and the Department Administrator in the Department of Surgery will work with you to determine the appropriate allocation from each of these sources towards your salary. We understand that it will take some time to determine the level of clinical activity which you will be able to achieve and sustain given the myriad of responsibilities you will have as Department Head. As revenues from your clinical practice grow, we expect that relative contributions from that source will increase, allowing us to scale back the contributions from College of Medicine resources.

In addition to your base salary, you will have the opportunity to earn incentive compensation through two separate mechanisms: You will be eligible for 1.) a clinical incentive, based on your individual clinical activities, and 2.) a Department Heads incentive program, which would allow you to receive an incentive for success in the clinical, educational, research and administrative functioning of the Department.

Although you will receive one University check, your salary may be derived from several sources (state, UPH, grants, etc.). Your University salary and your UPH salary will be combined and payrolled under one University paycheck. Your UPH clinical salary will be based upon a UPH compensation plan that may change from time to time as determined by the UPH Board of Directors and the UPH Compensation Committee. UPH incentive payments, when distributed, are based on a departmental incentive plan. Further, the payments are dependent on UPH departmental expenses and professional fee and patient care related income, and as such, will vary from year to year. Your salary in subsequent years will be determined, as are the salaries for all faculty members, in accordance with University and Arizona Board of Regents rules and legislative appropriations, UPH compensation plans and determinations made by the Department regarding faculty salaries. Increases in your salary must be negotiated with the Dean.

**CLINICAL:**

**Faculty Positions:**

We will provide the necessary resources to expand the Department of Surgery. You have outlined your intentions to recruit 17-20 surgeons as clinical faculty. Our intent is to ensure that this expansion is distributed over 4-5 years, depending upon your assessment of the needs and priorities of the Department. As outlined below, these resources are committed to you in exchange for a shared understanding of expectations for the department and for the newly recruited faculty and for faculty retention.

For the first five years, we would commit the following resources for faculty recruitments.
Year 1: $2.5 million
Year 2: $3.0 million
Year 3: $3.5 million
Year 4: $2.0 million
Year 5: $1.5 million

You will have both the authority and the responsibility to distribute the funds as you deem necessary, as reflected in the business plan prepared for each faculty recruit. If recruiting efforts result in filling positions more quickly than projected, funds will be moved forward from later years to accommodate.

We encourage you to develop recruitment plans for the clinical faculty that maximize their chances to be self-sustaining within the first three years. This is intended to provide you substantial flexibility in accomplishing your recruitment goals, while simultaneously ensuring that available resources for recruitment are allocated in the most efficient fashion.

Relevant to the above, and subsequent to the first three years, we will evaluate the effectiveness of the recruitments, based primarily on clinical productivity of individual faculty and of relevant sections. Assuming satisfactory performance, we would mutually agree to provide the funding for years 4 and 5, as indicated above, to support remaining or additional placements.

Complementary to the above considerations, UMC has made a previous commitment for faculty recruitment to assist with program development in the Arizona Cancer Center, including UMC North. A Chief Operations Officer for the Arizona Cancer Center has been hired. This individual will oversee all clinical operations related to cancer medicine. You will work with this individual to determine the optimal configuration of surgical faculty recruitments in support of surgical oncology effort. Previous commitments for faculty recruitment made to the Director of the Arizona Cancer Center from the College of Medicine provide a second mechanism for joint program development with the Department of Surgery. These opportunities can best be implemented by a close interaction between you and the Director of the Arizona Cancer Center.

As you may know, a hospital's ability to support physician positions/practices is dependent upon compliance with various federal laws, such as Stark and anti-kickback regulations. Therefore, the type and amount of UMC support would be determined in accordance with such compliance with those laws.

Of course, the responsibilities and accountabilities of UMC/UPH/DOS Head/new faculty must follow institutional policies and procedures. This will be specified in greater detail as negotiations procced.

**ADDITIONAL CLINICAL AGREEMENTS MADE BY UPH AND/OR UMC:**

**Additional faculty:**

A commitment has been made to Dr. Steven Goldschmid, Head of the Department of Medicine, to recruit a hepatologist and a transplant nephrologist. These commitments are made to Dr. Goldschmid with the understanding that he will work with you to ensure that these faculty meet the needs outlined in your letter to

me. We would work with you, with Dr. Goldschmid, Head of the Department of Medicine, and with Dr. Ghishan, Head of the Department of Pediatrics, to develop the appropriate benchmarks, for both individual faculty productivity and for the transplant program volume, to support recruitment of additional hepatologists and transplant nephrologists.

**Clinical Operations Support:**
In order to establish a clinical reserve (Fund B) the Department of Surgery will be responsible for meeting the Board determined Fund A requirement (20% of operating expenses) and relieving its payable to the Corporation.

The UPH Board has approved a proposal to provide **$1,100,000** of Board-controlled funds for current clinical operations. These are available for completely offsetting the current deficit within the Department of Surgery, if you would choose to use them for this purpose. The funds could also serve as investment capital for the DOS, should you choose to use them for this purpose (and thereby for the corporation).

We will work with you to establish a reasonable timeline by which these financial milestones can be accomplished and we will make funds available to assist you in bringing stability to the Department.

In order to further incentivize positive DOS UPH financial performance, an additional $250,000 will be provided from UPH to the Department of Surgery after your first four years as Department Head when you demonstrate at least 2 years of sustained profitability (i.e., there must be a positive UPH DOS bottom line for at least years 3 and 4), and/or of sustained revenue growth in the department which substantially exceed departmental expenditures.

Collectively, we believe there are rapid and straightforward changes in the operations of the Department which would allow you to achieve a profitable status quickly. We would be glad to discuss these with you. Moreover, we will facilitate regular meetings with the Associate Dean for Clinical Affairs (Bob Berg), UPH CEO (Norm Botsford), and UPH CFO (Jean Tkachyk) to advise and support you in making the DOS a flourishing clinical operation. That is, we intend to provide you with the tools and support to be successful in your stewardship of the DOS clinical operations. In addition, we will work with you to identify the appropriate individual/s to manage the financial aspects of all Department activities. The ultimate decision on the selection is yours to make.

**Clinic Space and Clinic Capital Expenses:** UPH clinic functions occur in "provider-based" (hospital operated) clinics and non-provider-based clinics. For the provider-based clinics (UMC cancer clinics, UPH-K clinics), the hospital is responsible for the clinic capital expenditures. Much of the clinic growth is planned at a new UPH-K hospital-based clinic and new UMC cancer clinic. For other clinics UPH has a budget process for financial oversight of capital expenditures, and typically provides low interest loans to Departments for equipment acquisition. UMC is also considering management of selected surgery clinics as provider-based, and you will participate in those discussions.

**Operating Room Scheduling and Management:** You or your designee will have a seat on the Operating Room Committee of UMC and UPH-K.

**Operating Room upgrades:** Both UMC and UPHK are committed to developing and maintaining state of the art operative facilities. Competing demands for capital will be a factor in determining the scope and timing of upgrades, however both organizations view minimally invasive surgery as a market opportunity and will work with you to determine the optimal design and equipment placement at the clinical sites.

**UPH Board Subcommittees:** The UPH Board of Directors has established a new subcommittee, empowered to oversee the ongoing development of the faculty practice plan. This subcommittee has a representative from the Department of Surgery as a permanent voting participant.

**OFFICE AND ADMINISTRATIVE FACILITIES:**
Arizona Board of Regents (ABOR) guidelines suggest that faculty offices of 120-140nsf are appropriate, and these guidelines are followed throughout the College of Medicine.

Office and administrative space will be provided for newly recruited faculty. The attached floor diagrams (4th and 5th floors) illustrate a plan to provide 2,129 nsf of additional faculty office and administrative space. As per the diagrams, this will accommodate 12 faculty offices and administrative space for 6 support staff.

The College of Medicine will commit to you the necessary resources to accomplish the needed renovations. More detail on the renovation plans and the expected cost for those renovations is provided below. These renovations should be undertaken, in part or in toto, only after you have determined the needs for office space here, at UPH-Kino and at other locations, as part of the long term recruiting plan.

The College of Medicine has committed, in conjunction with University Physicians Healthcare at Kino, to finish out 8,000 nsf of space using open office planning systems in the Pima County Public Health Building. This faculty office space can be used to support Department of Surgery faculty based on the Kino campus. Cost of furnishing systems up to $10,000 per work station will be covered by the College of Medicine.

**ADMINISTRATION:**
We would work with you to configure the administrative staff of the Department to meet your needs. This would include ensuring that you have a dedicated Departmental Business Manager. Financial support for administrative operations in the Department of Surgery is derived from multiple sources, including state funds, UPH, clinical revenues, indirect costs and other sources. In order to facilitate an orderly transition of Departmental leadership, and to enable you to advance the objectives of the Department in the short term, a discretionary allocation of $150,000 per year for four years would be made available to you from the College of Medicine to support administrative operations. These funds can be used, at your discretion, for the additional support staff required in conjunction with the requested faculty recruitments. This allocation is incremental to the other sources of support, and will allow you to configure the administrative support to best meet your needs.

**RESEARCH:**
**Faculty and Staff Positions:**

You have outlined plans to recruit 6 research faculty. We will provide the necessary resources to accomplish these recruitments. As with the clinical faculty, our intent is to ensure that these faculty are recruited over the first 5 years.

The current model that we are using within the College of Medicine for recruitment of research faculty is as follows: new Department Heads and Center Directors are allocated new positions as 0.5 FTE packages. These allocations are meant to be paired with other units in order to complete the full recruitment.

All faculty must have a primary appointment in a University Department. Therefore, for individuals being considered by centers, institutes, and programs, the Department of Surgery is in an excellent position to partner with these units for a joint recruitment.

0.5 FTE Faculty Positions in Surgery for Development of the Research Program:
Funds to support 8 incremental 0.5 FTE positions would be provided by the College of Medicine, and/or through the mechanism described in the above paragraph. The College of Medicine will provide $400,000 per year for 5 years in support of these recruitments.

Subsequent to the first three years, we will evaluate the effectiveness of the recruitments, based primarily on academic success of the recruited faculty. Release of funds in Year 4 and 5 will be contingent, at a minimum, upon each faculty recruited 2 years earlier having submitted applications for funding with aggregate facilities

and administrative costs exceeding $200,000 annually, or having received an award with total annual facilities and administrative costs exceeding $100,000. Assuming satisfactory performance, we will mutually agree to additional funding to support remaining or additional placements.

Partnering units can be identified throughout the College of Medicine and University. As part of the commitments from the College of Medicine to recently recruited Department Heads, Center Directors and Program Directors, and/or anticipated recruitments for analogous positions, more than 70 0.5 FTE positions have been or will soon be allocated. We believe that identifying a partnering unit should therefore be straightforward.

In support of your recruitment, the Arizona Cancer Center will commit at least one 0.5 FTE, the Molecular Cardiovascular Research Program will commit one 0.5 FTE, and the Comprehensive Diabetes Center will commit one 0.5 FTE to pair with you to accomplish goals which are shared between these programs and the Department of Surgery.

Should you determine that you are either unwilling or unable to find a partnering unit for one or more of these recruitments, there are two options. The most preferable would be for you to provide the other 0.5 FTE from resources available in the Department of Surgery. Less preferable would be combining two of the 0.5 FTE positions to create a 1.0 FTE position.

The Dean's office, in conjunction with the Development Office of the College of Medicine, would also seek outside support for these recruitments, in the form of endowments and other analogous mechanisms. If successful in obtaining these additional resources, commitments from the Dean's office may be adjusted accordingly.

**Core Equipment:**

Funds for large equipment associated with core facilities are provided through a separate mechanism. Hence, resources to support large equipment purchases are not included in the commitment, but are available to newly recruited faculty.

**Research and Office Space:**

Laboratory space for your own program and for the faculty recruits above will be identified within the College of Medicine. This will include space currently assigned to the Department of Surgery, and incremental space identified for programmatically-defined initiatives, rather than departmentally assigned. For space assigned to the Department of Surgery, it is your decision as to the location of newly recruited faculty. Access of newly recruited faculty to incremental programmatic space will be determined based on their research orientation, and vetted through the Dean's Research Council Space Committee.

Office space for newly recruited research faculty will, in general, be adjacent to their research space. As above, the Arizona Board of Regents (ABOR) guidelines suggest that faculty offices of 120-140 nsf are appropriate, and these guidelines are followed throughout the College of Medicine.

College-wide guidelines for allocation and management of research space would apply.
These guidelines are available on line at:
http://www.medicine.arizona.edu/whatsnew/pdf/space-guidelines.pdf

The Master Plan for Research Space Allocation in the College of Medicine is available on line at:
http://medicine.arizona.edu/whatsnew/pdf/space-master-plan.pdf

The Department of Surgery is currently assigned 7,427 net square feet (nsf) of research space. As Department Head, you will be responsible for management of this space according to the guidelines outlined above. Newly recruited faculty can be located in this space at your discretion. As per the college-wide guidelines, each department should have a space committee, which monitors space allocation and usage.

We have carefully considered your request for incremental laboratory space for the Department of Surgery, in the context of our space master plan and our space allocation model. The attached floor diagrams (for the 4th and 5th floors) outlines our suggested plan to provide additional contiguous laboratory space to meet your needs. As diagrammed, this would provide 4,380 nsf of additional laboratory space.

In addition, we have diagrammed a plan to renovate the corridors on the 4th and 5th floors, to provide an engaging and modern appearance for all individuals working on, visiting, or transiting through the space.

We estimate the total cost for renovating of the spaces identified, including the corridors, to be approximately $3.5M. A project of this magnitude is considered a capital project and could require review and approval by the Arizona Board of Regents.

We believe this plan would satisfy your space requirements. More importantly, we believe that it illustrates the flexibility we have on the 4th and 5th floors for providing office and laboratory space for Department of Surgery faculty. We will work closely with you to determine the optimal final plan.

In addition to the above, incremental research space (see space master plan) has been identified in the College of Medicine, in multiple locations, and assigned to one of the following thematic areas: Biomedical Imaging, Cancer, Cardiovascular Diseases, Diabetes, and Human Neurological Sciences. A portion of this programmatic space is occupied or proposed to be occupied by current faculty. The remaining incremental space will be occupied by newly recruited faculty. Some of the recruits identified for the Department of Surgery could occupy research space in these locations.

The Dean's Research Council Space Committee (DRCSC) is charged with making recommendations to the Dean regarding all units including MRB. The make-up of the DRCSC and its function are described in the attached sheets. The DRCSC will work with you to identify the optimal location for your research program, and for the newly recruited faculty in your department.

**INDIRECT COST ALLOCATIONS:**
The guidelines for return of indirect cost dollars to units are available on line at
http://medicine.arizona.edu/whatsnew/idc_model.cfm

**EDUCATION:**

The College of Medicine has completed its review of state line funding to units to ensure that funds are distributed according to teaching and infrastructure needs and in a fashion that maximizes the academic mission. The committee overseeing that process has developed metrics for medical student, graduate student and resident teaching efforts. Funding to each department is being distributed formulaically, based on faculty involvement in those activities. Implementation of the new metrics was initiated on January 1, 2007, with a phase-in period extending over 4 years. With the exception of individual Department faculty who provide leadership roles in the educational process (i.e. block directors and thread directors), as outlined above, the allocation will typically not be altered by either recruitment or departure of any individual faculty member, since the allocation is driven by the aggregate expectations of Departmental faculty for teaching.

Based on the above process, the Department of Surgery will receive an annual state allocation of $2,214,130 by the end of the phase-in period plus an estimated $213,383 in designated funds. This represents an increase of $203,487 annually, in comparison to the FY05/06 state allocation.

<u>Administration of Medical Student and Graduate Medical Education:</u>
A dedicated residency program coordinator is currently in place as is a dedicated clerkship coordinator.

We encourage you to work closely with the Vice Dean for Academic Affairs, and the Associate Dean for Graduate Medical Education, to determine the optimal configuration of staff to meet the educational needs of the department. We are prepared to provide incremental support, as you determine those needs.

As described above, we have implemented a formulaic allocation of state dollars to Departments, for their infrastructure needs and teaching activities. These allocations include support for residency program and clerkship directors.

We expect the Department of Surgery to develop affiliated residency programs with University Physicians Hospital – Kino Campus. We understand that it will not be possible in the short term to establish a new surgical residency program at UPH-K. You or your designee should work with the Special Assistant to the Dean for Graduate Medical Education at UPH-K to coordinate that process.

Resident research stipends:
The College of Medicine will guarantee funding to support salary and fringe benefits for 9 residents to work in a research setting for one year. Support will be distributed as follows: year 1, one resident; years 2-5, two residents per year.

**INFRASTRUCTURE SUPPORT:**
We understand and agree with your desire to have an infrastructure which supports clinical research, development and publications.

Clinical Research:
We believe that the optimal fashion to build the infrastructure for clinical research is on a College-wide (and even broader) level, analogous to the creation and support of core services for laboratory-based research. We are in the midst of creating an improved infrastructure, through the auspices of the Clinical and Translational Science Award (CTSA) mechanism. More than $4M is dedicated to that process, over the next 5 years.

The following initiatives are underway, all of which will be available for your use:

- A new Institutional Review Board (IRB) has recently been formed, jointly between the office of the Vice President for Research and the College of Medicine, to expedite review of applications.
- The general clinical research center and clinical research unit are consolidated at a single site on the 1st floor of the AZCC.
- A Clinical Trials Office is being created within the College of Medicine. The staff for this office will assist with all clinical trials within the College of Medicine. In addition to full time staff currently being recruited, the Vice President for Research has committed staff to assist on site with compliance, human subjects protection, and contracting. As part of this process, we will be recruiting a biostatistician and/or clinical trials specialist, a data manager, and additional administrative support. We will commit resources to the Department of Surgery in support of these positions.

IT Support:
We will work with you to configure IT support for the Department of Surgery. We are implementing new financial management software, to come on line for all departments by July, 2007. In addition, we are centralizing selected IT activities, to provide improved service. We will ensure that appropriate support is provided to the Department of Surgery for your IT activities.

Development Support:
We understand and respect your interest in retaining professional development assistance for the department of surgery and concur that it is both important and necessary to cultivate and secure philanthropic resources. It is unlikely that those philanthropic contributions will flow to the department without a department director engaged in building relationships with grateful patients, interested citizens and other probable donors. At this early point in our new development program under the leadership of Bryan Rowland, Brian Bateman from the Tucson campus and Vonise Peterson at the Phoenix campus, all development resources for both campuses of the

college will be invested in the broad overarching initiatives we discussed in cancer, cardiovascular, diabetes, and medical neurosciences. Fortunately, your work in pancreatic transplantation ties in well with the diabetes initiative and will therefore bring a critical focus to fundraising needs in that area of surgery. With your leadership the Department of Surgery can begin to build a constituency, foster close ties with the community and begin to design a case for needs in surgery that in 3 to 5 years will warrant a full time professional staff member to support fundraising in that arena. Over that build-up period, we will commit incremental support for your development efforts.

Publications Office:
We will work with you to determine the optimal approach to meet your needs.

HOSPITAL SUPPORT:

CMS Accreditation:
Support will be provided for the liver transplantation program to achieve CMS accreditation. Similarly, support will be provided for intestinal transplantation to achieve CMS accreditation.

Islet Cell Facility:
We will work with you to determine the optimal location and configuration of an islet cell facility, constructed and maintained according to NIH guidelines.

Mid-level Providers:
Several mid-level providers (nurse practitioners and physician assistants) are currently in place to support the clinical practice within the Department of Surgery. The majority of these practitioners are employed by the hospitals in which they provide service. As the Department increases the number of faculty and develops new programs, we envision a concomitant increase in the number of mid-level providers placed to support this growth. This includes 1 perfusionist as the liver transplant program grows. As these resources represents an investment on the part of the hospitals, funding will be made available based upon the development and approval of business plans, inclusive of financial projections, similar to the approval process in place to ensure prudent investment in new faculty and capital acquisitions.

Other:
As described above, a Chief Operations Officer has been hired for the Arizona Cancer Center, to oversee the full scope of clinical activities related to cancer medicine. This individual will work closely with you to develop the surgical oncology program. For 2 years, we will provide funds for the salary, benefits, and administrative support for an individual charged with business development for the Department of Surgery.

PHOENIX PROGRAM OF THE COLLEGE OF MEDICINE:
As you know, the University of Arizona College of Medicine is developing a 4-year program in Phoenix. The planning for this program is underway, and includes the following processes:

The Department of Basic Medical Sciences houses the core basic science faculty responsible for developing and teaching the curriculum in Phoenix.

The title for individuals in charge of clinical departments for the Phoenix program is under discussion. For all clinical departments in the College of Medicine, the Liaison Committee for Medical Education stipulates that one individual must be designated as the party ultimately responsible for decision making. While this is irrespective of the titles used, we will endeavor to establish titles which appropriately reflect that governance structure. You would be designated as the individual with ultimate responsibility for the Department of Surgery at all campuses of the University of Arizona College of Medicine.

**ADDITIONAL PERSONNEL:**

You also have requested, and we have agreed, that certain named individuals, who shall be specifically identified in the final agreement, be approved and hired by the University of Arizona. Please provide the names, and titles, of those individuals that you plan to name in the final letter here:

See attachment

You should be aware that all personnel decisions, including salaries to be paid any employee, must comply with University and Human Resources rules and salary guidelines, and will need to be approved prior to assigning salaries and job titles to individuals you hire to work in the Department of Surgery. University rules require that we provide a copy of your official letter of offer to Human Resources, so that it may work with you in structuring the proper employment arrangements for these individuals. Please feel free to contact Cathy Nicholson, Director of Human Resources at Arizona Health Sciences Center, at (520) 626-4650, to make these arrangements and to develop job descriptions for these individuals. Any individuals not specified in your final letter of offer that you wish to hire must be hired through the normal competitive hiring process provided by University rules and guidelines.

**MISCELLANEOUS:**

We would request a joint appointment in the Department of Immunobiology in the College of Medicine.

**BENEFITS/INSURANCE:**

UPH and University of Arizona benefits are available to faculty in clinical departments who are employed by both the University of Arizona and UPH with a combined FTE of at least .50. Benefits include medical insurance, life insurance, dental insurance, vision insurance, and disability insurance as outlined on the attached sheet. These benefits are worth several thousand dollars. Enrollment must be completed within 31 days from date of hire. UPH benefit information is available from the office of the UPH Benefits Coordinator at (520) 874-7281.

You will receive a packet of information describing the benefits programs at the University of Arizona. You may also access benefits information on the Human Resources website at www.hr.arizona.edu. If you choose to participate in any of the benefit programs, **you must enroll within the first 31 days of your employment.** *Coverage will then become effective the first of the month after your enrollment application is received by Human Resources.* If you do not enroll within the 31-day enrollment period, you will waive your rights to participate in the benefits programs until the next annual open enrollment period. Under certain circumstances, you may be eligible to enroll or modify your elections if you experience a qualified life status event change. If you have any questions, please feel free to contact Jennifer de Laix, AHSC's Benefits Coordinator, at (520) 626-2234.

Effective with your date of hire or eligibility date, you will be enrolled automatically in the Arizona State Retirement System (ASRS) as the default retirement plan. Appointed personnel of the University of Arizona have a one-time opportunity to elect participation in the Optional Retirement Plan (ORP). Election in either retirement plan must be made on the appropriate form and returned to Human Resources within **30 days of your date of hire or eligibility date.** If you take no action within your 30-day election period, you will remain enrolled in the ASRS *plan during* your eligible employment with the University of Arizona.

The State of Arizona, by legislation, permits insurance carriers to obtain a test for HIV prior to issuing health or life insurance policies. At present, UPH's current insurance carrier does not require HIV testing for the basic life insurance policy. However, you may be required to take the test if supplemental insurance is requested.

## MALPRACTICE/INSURANCE:

UPH provides your malpractice insurance coverage under the terms of your Member Practice Agreement. UPH is presently self-insured for $3 million per occurrence and $15 million in the aggregate with umbrella policies up to $66 million dollars. The coverage is dependent upon you having a valid, completed and signed UPH agreement. You are covered for acts falling within your employment duties. If you are presently engaged in a clinical practice with "claims made" malpractice coverage, you need to know that it may be necessary for you to carry tail coverage upon termination of your policy. Please check with your present malpractice carrier for that cost and further information. If tail coverage is necessary, the Department of Surgery will not be able to cover the cost of that expense.

## LICENSURE/DEA/HOSPITAL PRIVILEGES:

In order to comply with the terms of your appointment and to see patients, you must be a licensed physician in the State of Arizona. This process is your responsibility. You need to initiate the paperwork as soon as possible as this process can be quite time-consuming. You also need to send in the attached DEA form in order to transfer your DEA number registration to Arizona. To begin clinical duties involving inpatient care, you must have medical staff privileges at University Medical Center and UPH-Kino. Forms to initiate the process are attached. It is your responsibility to see that completed forms reach the appropriate offices well in advance so that you can begin seeing patients on a timely basis.

Until both the University and you agree, no public announcement of this offer or your acceptance of this position will be made. Among other things, this will permit you to resolve any issues regarding your Arizona medical license and to make appropriate arrangements to withdraw from your current responsibilities and allow the University to complete any desired background checks.

## UPH MEMBER PRACTICE AGREEMENT/CREDENTIALING:

UPH is a nonprofit corporation made up of University of Arizona College of Medicine clinical faculty. If you are providing clinical care to patients, you will become a member and employee of UPH, the College of Medicine's private practice group; physicians providing clinical care to patients must be employees and members of UPH and all billings and collections for patient-care activities are done through this organization. The agreement and list of required credentialing information for such membership/ employment are enclosed for your signature. Please read the agreement carefully. Submission of all credentialing paperwork to the insurance carriers is a prerequisite to your appointment.

The University of Arizona and UPH have distinct employment policies and rules with which you should become familiar. Each entity maintains records related to your employment; however, in an effort to streamline processes for recording information related to your employment, these two entities have developed a centralized record-keeping function, and will share information related to your pay, leave balances, requests for leave, evaluative information, and disciplinary issues, if any.

## IMMIGRATION REFORM AND CONTROL ACT (IRCA):

The Immigration Reform and Control Act (IRCA) of 1986 requires that you produce certain documents that authorize you to work in the United States. On or before your first day of employment, you will be required to complete Section 1 of the I-9 form. Within three (3) business days of the date your employment begins, you must also present to your department original documentation to establish (1) true identity and (2) eligibility to be employed in the United States. Please consult with Cheryl Zimmer, in the Department of Surgery regarding these procedures.

**MOVING EXPENSES:**

Your moving expenses would be reimbursed to you up to a total of $25,000 from the COM and an additional $5,000 from UPH subject to any agreement with the University or UPH for repayment of these amounts should you leave employment prior to the time period established by either employer. Such agreement will be contained in your Member Practice Agreement with UPH, and is incorporated by reference herein. You should contact Sarah Hiteman, Assistant Dean, Finance COM at (520) 626-7669, who can advise you on procedures to follow related to your moving expenses.

I am required to call your attention to the fact that Arizona Board of Regents' policy provides that misrepresentation of an individual's qualifications or credentials in securing employment at the University may be grounds for dismissal.

My colleagues and I are very excited at the prospect of you assuming this role in the Department of Surgery. We believe that you are the ideal individual to strengthen and develop initiatives in the Department focused on clinical care, education and research.

This offer is valid until February 28, 2007. You may indicate acceptance by signing below and returning a signed copy of this letter to me at the above address by the deadline. Please contact me if you have any questions about the College, the Department in which you will have a faculty appointment, the University, or the terms of this offer. This letter constitutes the full terms of our employment offer and supersedes all other commitments either written or verbal that may have been made to you.

Sincerely yours,

Keith A. Joiner, MD, MPH
Vice Provost for Medical Affairs
Dean, College of Medicine

Norm Botsford
President and CEO
University Physicians Healthcare

The foregoing letter of agreement is accepted, subject to review of the documents referenced and as yet to be provided the undersigned and subject to the approvals and conditions stated above.

Rainer W.G. Gruessner, MD, FACS

2/25/2007
Date

cc: Human Resources

# 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.

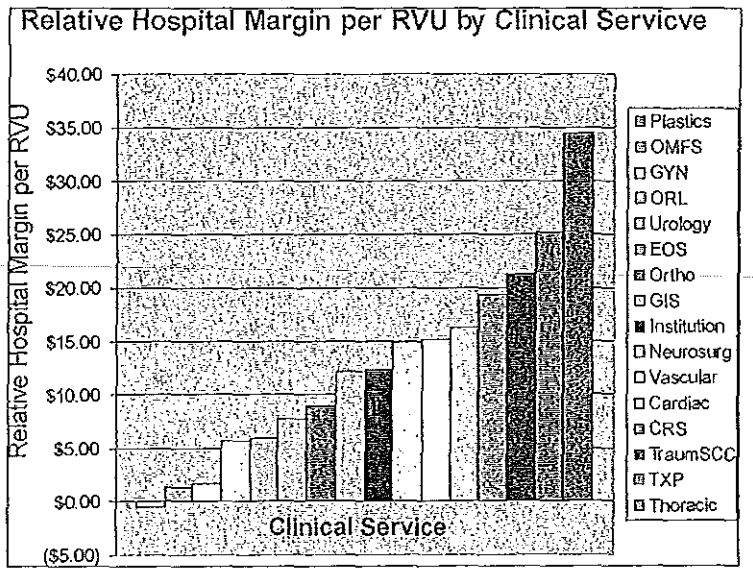


Figure Legend: Relative hospital margin (RHM0 per RVU varies greatly by service. Mean RHM per RVU was 12.64 mu (standard deviation = 9.76 mu) with range from a loss of 0.57 mu per RVU (plastic surgery) to a gain of 34.55 mu per RVU (thoracic surgery). GIS, gastrointestinal surgery; TXP, liver, kidney, 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.

# Exhibit D

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 Lèmole, 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 E

# The 2013 University of Arizona Department of Medicine Academic Program Review

**APR Committee:** Michael R. Bishop, MD, Professor of Medicine, University of Chicago (Chair); Howard Brown, M.D. (Alumnus); Patricia Finn, M.D., Professor and Department Head, Internal Medicine, University of Illinois; James Marsh, M.D., Professor and Chairman of Internal Medicine, University of Arkansas; David Nix, Pharm.D., Professor of Pharmacy Practice and Science, University of Arizona; Sam Keim, M.D., M.S., Head of Emergency Medicine, Director, Arizona Emergency Medicine Research Center, University of Arizona; (community); and Richard Robbins, M.D. (Community Reviewer)

## I. Introduction

The 2013 University of Arizona Department of Medicine (DOM) Academic Program Review (APR) was conducted on April 14-15, 2013 at the University of Arizona Health Science campus. In preparation for the APR, the Committee was provided a 121-page Department of Medicine Academic Program Review Self Study. The 2007 DOM APR summary document was not available for review. It was suggested that a formal DOM APR may not have been performed in 2007. The Vice Provost, Dr. Gail Burd, gave the APR Committee the charge of thoroughly reviewing all aspects of the DOM including, as appropriate, faculty, students, academic programs, administration, research, education, outreach efforts, diversity, and clinical care. The APR Committee subsequently met with the Dean of the College of Medicine (COM), Dr. Steve Goldschmid, University of Arizona Health Network (UAHN) President & CEO, Dr. Michael Waldrum, DOM leadership including the Department Chair, Dr. Thomas Boyer, section chiefs, faculty members, chief residents, and administrators. The committee also met with several Department chairs, University of Arizona medical students, and Tucson VA medicine attending physicians, all as groups. The committee was provided with a brief tour of physical facilities utilized by the DOM for clinical services. At the close of their visit, the APR Committee provided an oral summary of their findings and recommendations to Dr. Goldschmid and then finally with the Provost, Dr. Andrew Comrie and the Vice-Provost, Dr. Burd. The following is the formal report, prepared by the APR Committee.

## II. Major Findings and Recommendations

It was the DOM APR Committee's general impression that this is an underperforming department, which is perceived as being relatively average/mediocre both institutionally and nationally. The Department is not recognized as a national leader in any area, and only a small proportion of faculty has a national reputation. There is little clinical research being conducted and patient recruitment to trials is poor. The major problem identified is that the Department lacks a clear identity and focus; it appears that they are unsure of "what are we?" and "what do we want to be?," respectively. For the Department to move forward, a clear vision needs to developed and conveyed to all members.

Several major issues were identified within the Department:

- There is variability in division leadership and underperformance in several divisions, which appears to be directly related to division leadership. Some of the leaders are not providing adequate mentorship for junior and mid-level faculty. Leadership training should be considered, and mentorship should be mandated for junior faculty.
- Research (basic, translational, and clinical) is not a priority. A research culture is not embedded in the Department, and correction of this problem requires a long-term effort. There needs to be incentives for senior faculty to mentor junior faculty.
- There is a failure to attract good candidates to DOM internal medicine residency program, specifically University of Arizona (UA) medical students. Students are selecting other programs that have perceived better teaching environment, status and facilities. We are concerned that the match list requires a 5:1 ratio. There is a need to identify and actively recruit top medical students who have an interest in medicine.

- There is a lack of alignment between the Centers and the Department. Faculty members are divided in their "loyalties" towards their respective Center, the Department and respective division. This increases the inability to designate focus areas. Faculty members who are not members of a Center are inadequately supported relative to mentorship and administrative support for research. This is further exacerbated by the fact that departments do not get the same resources (indirect cost return) to address the problem.
- There is tremendous concern over the viability of the Section of Dermatology relative to providing clinical services and maintaining its residency program.
- There is an adverse relationship between the administration of Southern Arizona VA Health Care System and the medical faculty serving there. There is a lack of support for these faculty members, who provide critical teaching and instruction for residents and students. There needs to be significant outreach to include VA based faculty in the DOM and recognize those faculty as core members. This topic is addressed further in section **E.1** below.
- There are inadequate and substandard outpatient facilities to provide optimal care and necessary teaching. Clinic space is insufficient to provide efficient patient turn-around and to provide teaching of medical students and residents. Lack of adequate clinic space contributes to access problems and compromises patient care. An alternative to more and better space would be to consider if the number of residents exceeds capacity.
- There is a lack of diversity and no apparent plan to enhance it at the Department level. This was mentioned in 2006 DOM APR Self Study, and there was no documented progress. Two accomplished female faculty members raised a concern about gender bias.

Despite these significant issues, morale and collegiality remains relatively high in the Department. This can be attributed to the leadership of Dr. Boyer, who was repeatedly cited for providing stability for the Department as a whole and to individual faculty members, particularly junior faculty. It was clear that he is devoted to the Department, is acutely aware of the problems within it, and has attempted to address the major problems with limited resources. The leadership and contributions of Dr. Phillip Factor were also recognized. There are areas of excellence (e.g. Geriatrics) and several strong divisions (Hematology/Oncology and Cardiology), as well as emerging divisions (e.g. Pulmonary) and several talented mid-level and junior faculty members, which provide a strong foundation for the Department. However, there is concern for the Hematology/Oncology Division if the Cancer Center's NCI-designation is lost and Cardiology with its leadership in transition. Gastroenterology has several nationally recognized members, but these individuals have administrative roles outside of the Division that has diluted the focus of the division. The appointment of new senior leadership in the COM and the verbal commitment by these leaders to support the DOM provides potential for stability and potential opportunities for the Department.

The APR Committee identified several key areas to improve the DOM:

- As resources are limited, they should be invested in a few key programs (e.g. geriatrics), which have either demonstrated that they can be successful and/or have a high potential for success (e.g. diabetes). Collaborations with the solid organ transplantation program are encouraged.
- Provide intradepartmental support and infrastructure for grant preparation and clinical research. Consider partnering with other departments or colleges for pre-award assistance. Focus should be on clinical research initially.
    - Identify, nurture and invest in emerging leaders among junior faculty members. Support for leadership development is important. We met a number of dynamic individuals that should be nurtured. Individuals that we identified include: Laura Meinke, Tirdad Zangeneh, Eugene Trowers, Guadalupe Martinez, and Ken Knox; there are likely others of considerable promise. Support senior leaders including Mindy Fane, and Philip Factor.
- Integrative Medicine is a high profile section that will attract national and international attention. Further assimilation with internal medicine (including clinical care, research, and education) should be considered; however, differences in approach to care are acknowledged.

## III. Recommendation and Findings and Recommendations for Specific Areas

### A. Research

The DOM includes a number of distinguished investigators that are Department faculty members in addition to being center directors or members, although the majority of faculty has limited effort allotted to clinical and translational research. Research appears to be an area of potential growth if additional resources are made available, faculty recruitment and mentoring is increased, and a greater emphasis is placed on expanding research activities.

1. The following major issues were identified:
   - Technical and administrative support for research is available in varying levels within Centers of Excellence. Faculty members whose research focus does not fit within one of the Centers do not have support available. There are issues about the relationship of Centers to the DOM, and indirect cost returns that affect the ability of the Department to provide such support to Department faculty who are not members of the large Centers.
   - Although the Department has developed a faculty mentorship plan, most faculty members do not feel that this plan has been implemented. We spoke with junior faculty who feel that there are problems with protected time for research as well as help in developing a career advancement plan, and mentorship.
   - Space for research may be an issue; however, the space issue also is complicated given the overlap of Centers and the Department.
   - The research component of the Department appears to be disorganized, exhibits a lack of focus and vision.
   - The Arizona Health Sciences Center (AHSC) lacks a federally funded Clinical and Translational Science Award (CTSA), which would greatly facilitate expansion of clinical and translational research. In the absence of a CTSA, there needs to be a creative plan in place to stimulate growth of clinical/translational research.
2. Specific Research Programs
   A. University of Arizona Cancer Center – This is the largest Center in the Health Sciences area and is designated as a comprehensive cancer center (CCC) by the National Cancer Institute (NCI). We learned that because of low enrollment into clinical trials, renewal of the CCC designation by the NCI might be in jeopardy. In addition there is a search for a new Director. The Cancer Center members include faculty from at least 6 departments including DOM. Among medicine faculty, the focus is on cancer prevention; however, given the geographic location, a focus of skin cancers seems to be an opportunity. One major component of this focus will be recruitment of strong dermatology leadership and faculty.
   B. Cardiology – The Sarver Heart Center is currently led by a capable interim director with an ongoing search for a successor. There are obvious advantages of recruiting a center director who will also serve as division chief, aligning the Department and Center. This section does have potential for growth in research with strong leadership.
   C. Gastroenterology – The Liver Institute was started and led by the Department Chair and has demonstrated good success in clinical/translational research. Resources are needed to ensure growth and a succession plan after Dr. Boyer's decides to step down from this position. Others areas with potential strength include the pancreatic and other GI cancers (under the Cancer Center) and minimally invasive diagnostics (collaboration with optics and imaging). New faculty members are very busy with clinical activities, and there needs to be significant investments, including protected time and mentorship, to allow them to develop into successful clinical investigators.
   D. Geriatrics, General and Palliative Medicine – This program under the Direction of Dr. Mindy Fane has considerable potential to expand in research. Dr. Fane demonstrated a strong vision and enthusiasm to lead and grow of the Center for Aging, and this was identified as a "star" program that warrants further investment.

E. Rheumatology – The rheumatology program has a history of strong clinical research; however, recently, the Arthritis Center has been disorganized and understaffed. There is one promising young faculty member that received a K08 training grant, but was not given adequate resources and mentorship. This individual recruited her own mentoring committee including individuals from outside of the University. Fortunately, Dr. Boyer stepped in and gave this individual space in the Liver Institute and provided some of the support that she needed. Given the limited resources, recruitment of established research faculty has been difficult and this is likely to continue. In order to grow the research enterprise, the Department needs to provide a culture of faculty development and mentorship with the aim of moving some of the junior faculty into clinical research.

F. All of NIH RO1's are awarded to Center members and not administered through the DOM. The idea of a Center makes sense to pull together a multidisciplinary team and focus on a specific area. University leadership has indicated that greater research across disciplines is part of their vision, but they need to find creative ways to support both the Centers and Departments and ensure that credit (financial and scholarly accomplishments) is appropriately shared.

G. Arizona Respiratory Center – Research productivity and funding for this Center is strong and perhaps growing. The Head of the Center is in pediatrics, and faculty in the DOM feel somewhat like "orphan" members. It is not clear from the report how much of the Center's activity is related to faculty in the DOM; however, given the resources and mentorship that is available, this is a promising area for research growth. Again, there needs to be some creative solutions to crediting the DOM for research efforts of their faculty.

H. Endocrinology, Diabetes and Hypertension – Diabetes is found disproportionately in Native Americans and Hispanics, and these populations represent large groups within Arizona. Diabetes care and research is included in the vision for AHSC and this is an area of opportunity for growth. There is an internationally recognized program in limb salvage already, and having a strong program in ophthalmology, nephrology, cardiology, and endocrinology with a diabetes focus is important. Three of these subspecialties are within the DOM.

3. Recommendations

- Need to develop applications for K08 and T32 awards. This is critical to developing new clinical investigators to help drive growth of research
- Do a better job of identifying and supporting junior faculty and residents that have interest in clinical research.
- Enhance and promote a culture of research through mentorship of young investigators.
- Provide some centralized support for preparing grant applications, and ensure implementation of the mentorship plan.
- Focus resources on areas with the greatest potential for growth.
- Find a creative solution to acknowledging the Department's role in Centers.
- Contracting remains a bottleneck for industry-funded research. One possible approach is to house an ORCA representative in the health science center to promote increased dialog.

## B. Education

1. Undergraduate Medical Education

A. First and Second Year - In Year 1 and 2, the Department has some participation in lectures, conferences and problem-based learning exercises. The degree of involvement by the faculty appears to be satisfactory, and it appears there is some interest in further engagement. Arrangements to pay for faculty time involving teaching activities also appear to be satisfactory.

B. Third Year Medicine Clerkship - This 12-week course is viewed by students and faculty as a critical part of medical school education. Inpatient and outpatient teaching occurs at numerous sites; a strength of the clerkship is that there is more than adequate number of patients for student clinical exposure. The success of the clerkship, however, appears to be mixed.

The quality and engagement of faculty appears quite variable. Some faculty members are highly engaged and appear to be terrific educators at the bedside and in the clinic. Others play a limited role as educators: they supervise students and residents on rounds but are otherwise inaccessible and do not take the students aside for individual or small group teaching. Students

report a lack of feedback, formal and informal, from faculty members. Review of admission notes and progress notes appears to be spotty, often taking 2 weeks instead of 2 hours to return to the students. The teaching faculty appear to be viewed as kind and highly professional, but perhaps kind to a fault, failing at times to give clear messages about where improvement is needed. The course could be improved by more formal training of the teaching faculty in teaching methods and methods of providing feedback. The perception of inadequate number and commitment of teaching faculty in the Year 3 Clerkship should be noted as a concern for the LCME self-study, and it needs to be addressed.

A significant concern is shortage of faculty members to teach in the outpatient setting. This is a substantial issue, as there is a national mandate to move more of internal medicine education to the outpatient setting, particularly for residents, but also for students. It appears that a major obstacle to more robust outpatient education is inadequate space for internal medicine clinics: the space is not patient friendly, is antiquated, and is not well-designed for student and resident education.

There is broad criticism from the students that the clerkship is poorly organized and administered. Students receive little, and sometimes inaccurate information on where they are supposed to report for inpatient and outpatient learning activities; and the faculty at times appears to be as confused about their teaching assignments.

There has been some turnover in the third year clerkship educational leadership. It is hoped that the course leadership will become solidified. There appears to be a significant shortage of faculty development for educators in the Department. It is recommended that education leaders be strongly encouraged to take part in faculty development programs on campus or workshops available for clerkship directors available at national meetings such as the Alliance for Academic Internal Medicine (AAIM) meeting in the autumn. Educational leadership skills are specific skills to be developed. Students hold the Pediatrics Year 3 Clerkship as a model. The Internal Medicine Clerkship may benefit from adopting much of the structure and function of the Pediatric Clerkship.

C. Fourth Year Electives - The subspecialty electives appear to be functioning reasonably well. The APR has little data available to assess these electives in detail.

2. Residency Programs

A. Dermatology - The Dermatology residency is operated by the DOM. It appears to be in dire straits, with shortage of faculty and shortage of suitable patient exposure. A major concern is that the clinical experience is very heavily weighted toward dermatological malignancies. Options include closing the residency or hiring additional faculty members, who will have significant protected time for teaching, and identifying additional teaching sites that will broaden the clinical exposure.

B. Internal Medicine (IM) Residencies - There are two IM residencies. One is based on the South campus (UAMC-South), and a larger residency based at UAMC - Campus, each with several training sites. They have a few distinctive features but many common issues that need to be addressed.

It is evident that UAHN and the COM have adopted a strategy of expanding residencies as a primary approach to meet physician workforce shortfalls. The hospitals are above their cap for CMS support for residencies; an additional 11 positions have been approved for medical residencies this year. However, a price is being paid for this in the medical residencies: the residencies are weak and probably too large. Data to support these conclusions include the following:

- Board pass rates for both IM residencies are unacceptably low, with a particular problem in the South campus residency. This may be stabilizing and improving but needs major attention: the residencies will receive citations for this and if not remedied, may lead to probation for the programs, which will lead to further weakening of the program. The State of Arizona is not well served if the institution is turning out weak physicians who cannot pass boards.
- The IM residencies are viewed by UA medical students as not highly desirable. The number of medical students who match in internal medicine and stay at a UA medical residency has been low for several years; this year it was zero. This is extremely uncommon for medical residencies across the US, and it is undeniably a red flag.
    - The match statistics are unfavorable. In order to fill 31 PGYI positions in the match this year, the UAMC - Campus program went down their rank list to 140. If there are additional positions to fill next year, one can predict even less competitive applicants will be matched. By comparison, good to average medical residencies match at a ratio of 2-3 (in this case, 60-90 on the list); outstanding residencies match at a ratio of 1.5 to 2.

- There were widely-voiced concerns by residents and faculty that there are too few IM faculty members to teach the number of residents, that the infrastructure for the residency is inadequate, and that the ambulatory teaching facilities are inadequate (noted above under Year 3 Clerkship). All of these concerns appear to be valid. The resident learning environment at the VA appears to be adequate, but at the Tucson Medical Center (TMC) the educational experience has been poor. Apparently, there was a proposal in the past to pull out of TMC completely; but for the coming year, there was a cut back rather than elimination of residency positions there.
- There are some strengths in the residency program: there is a new program director, Dr. Meineke, who shows considerable promise. Additionally, there are two enthusiastic associate program directors, Drs. Dr. Tirdad Zangeneh, 3rd Year Clerkship Director, and Dr. Eugene Trowers, 4th Year Sub-internship Director. There has been turnover in the program director position, and this position needs to be stabilized. Moreover, a major asset of the residency program is a PhD educator, Dr. Guadalupe Martinez, who is talented and a rising star. It is recommended that these key educators receive careful mentoring, and they should be provided training specific to their education leadership positions at AAIM workshops or other national meetings. They must have the tools to be successful. It appears that none have had these education responsibilities for more than a year.
- New internal medicine clinic facilities are extremely important for a host of clinical, fiscal, service, and educational reasons. It will be very difficult to rebuild the residency without new clinic space. If temporary space can be found for clinics while new clinics are being designed and built, it would be an important enhancement. Of note, there is a national movement, led in part by ACGME requirements, that there be a major shift of medical resident training to the outpatient setting. Traditionally, about 10% of resident training has been in the outpatient setting. The new mandate is for about 33%. There is simply no way that this mandate can be met with the current facilities. This shift also has important implications for inpatient resident workforce considerations. Both the lack of clinic space and teaching faculty supervision is providing an immediate threat to the central campus residency program. The residency leaders state that it is not possible to meet the current mandate for 130 half-day clinic sessions over three years for the residents. A remedy for this issue needs to be a high priority.

Taken together, there are many indicators that at the current time, the medical residencies are too large to function well in their educational roles. It is recommended that consideration be given to decreasing the size of the residencies with more inpatient services being provided by hospitalists and/or mid-level providers; and additionally, consolidating more inpatient residency training at UAMC - Campus and the VA. The highest priority for resources, to the extent available: new clinic space, hiring additional faculty with major teaching roles, and providing specific training for residency program leaders.

3. Fellowship Programs
   The APR committee did not examine the fellowship programs in any depth. The fellowships appear to be sought after, and UA residents do seek positions in the fellowships. One area of concern is the unacceptably high failure rate on subspecialty board exams for many of the fellowship programs. The committee cannot determine if this reflects a poor educational experience for the trainees or academically weak trainees. This is addressed more broadly below.
4. Board Failure Rates for Residency and Fellowship Programs
   This is a major threat to the residencies and fellowships. It will lead to residency review committee citations and may lead to probation and possibly program closure – it must be vigorously addressed. It is relatively easy to predict which applicants will have trouble with board exams, based on the applicant's prior demonstrated ability to score well on examinations. Therefore, it is suggested to not include in any position on the national match rank list, more than 10% of candidates who will likely be at risk for board failure. This will limit the exposure to board failure risk. It is probably preferable to not fill a program or to purposefully downsize a program, rather than having trainees who will not pass their boards.
5. Diversity
   Lack of diversity was a significant finding in the 2007 DOM APR Self Study report. Specifically, it stated that racial and gender diversity was a problem, and that a plan needed to be implemented. For the residencies, ethnic diversity remains a problem, and there is no evident plan to address this. Outside resources exist to help residencies develop and implement a plan to improve recruitment of

underrepresented minorities. It is a recommendation that the residency program directors seek these resources (AAMC and AAIM provide resources) and be accountable for developing a written plan and implementing it.

## C. Clinical Programs

1. Overview - The Department Faculty appears to be a dedicated group that provides good care. The medical center reports strong quality metrics including top 100 status. In-patient care is provided at both UAMC – Campus and UAMC - South and includes both adult hospitalist and ICU services. Subspecialty consultation service is provided at both sites from twelve sections. Outpatient service is delivered at multiple sites.
2. Major Issues:
   - Outpatient clinical space at University Campus is strikingly inadequate and out of date. The committee members could hardly believe that both the general and subspecialty outpatient care was being provided in these current settings. Patient satisfaction, patient access, education and clinical research are substantially challenged and negatively impacted by this. The space is viewed by faculty, residents and students as a significant obstacle to providing excellent care.
   - Subspecialty Care in some areas is lacking. Dermatology is suffering a severe shortage and the limited range of faculty expertise. Expertise is heavily weighted toward dermatological malignancies. General Medicine Primary Care, Infectious disease, Nephrology, Endocrinology and Rheumatology appear to be understaffed as well.
   - Communication between physicians and patients has been rated as below national norms by patients at both inpatient sites. Studer communication initiatives have been implemented with some success per leadership and faculty but more training, feedback and accountability is needed to reach excellence goals set by institution.
   - Faculty, staff and leaders all agreed that access to care was a significant problem. A call center initiative has been implemented but all agreed major progress has yet to be witnessed. Clinic availability is also limited by lack of adequate physician staffing.
   - The new EPIC electronic health record implementation has potential for aiding patient care in the long term but will likely significantly challenge access to care initially.
3. Faculty Compensation - A new system to reward productivity was implemented recently that is RVU-based. Faculty members and leaders uniformly praised this system as having resulted in better workloads and productivity. Faculty members feel the new system is fair and sustainable.
4. Specific Divisions:
   a. Cardiology – The committee believes Cardiology is strength of the DOM and is a key to future DOM success. Appointment of a strong permanent Division director will assure that evolution.
   b. Dermatology – The committee feels that the Division's status is weak and that this is a major threat to the DOM. Considering the needs of the Department, this is a major weakness.
   c. Endocrinology – The committee was impressed with early successes with the Diabetes Clinic but otherwise felt the Division was understaffed and therefore underperforming.
   d. Gastroenterology – The committee felt that the Division is performing well despite losing key faculty to major administrative positions. Space and faculty size are inadequate.
   e. Geriatrics, General Medicine and Palliative Medicine – The Division is involved in multiple innovative care models and overall has an impressive vision and performance. General Primary Care has inadequate staffing.
   f. Hematology/Oncology – The Division appears to have inadequate faculty and several key faculty are retiring this year. New Cancer Center leadership as well as integration of UPH and UMC are hoped to have a positive impact.
   g. Infectious Diseases – The committee felt that the Division was understaffed and that this substantially impacts the overall success of its faculty.
   h. Inpatient Medicine - The faculty praised the growth of the hospitalist service and believes it functions well overall. There is substantial turnover however and innovations to retain this faculty are encouraged.

i. Integrative Medicine – A unique and innovative Division that could integrate more with other Divisions to provide a marketable service. The Division Chief and other faculty stated that integration has not been a priority and even blocked by members of the DOM and institution.
j. Nephrology – The committee felt this was an underperforming Division that is understaffed and has recent instability.
k. Pulmonary/Critical Care – The committee felt this Division was strong and believes it to be a key to future DOM success.
l. Rheumatology – The committee believes the Division to be understaffed and lacking in leadership. A new Division Chief has been recruited and will start this summer.

## D. Administration

The DOM administration is noted to have several strengths. Dr. Boyer, the Chair, has provided stable leadership throughout multiple administration changes at higher levels. Dr. Boyer has recently appointed 3 vice chairs: Dr. Phillip Factor [Clinical Affairs], Dr. Bruce Kaplan [Research], and Dr. Ken Knox [Education]. The committee met with 2 of the vice chairs (Drs. Factor and Knox) who were capable and energetic. Additional administrative leadership in education (e.g. Dr. Guadalupe Martinez) is judged as providing relevant expertise and commitment. For the most part DOM administrative leadership is viewed favorably by the faculty. Notably, major HR issue (faculty, staff) appeared to be rare, supporting the concept of a non-toxic, positive environment.

Nevertheless, the DOM appears to be understaffed relevant to the size of the department, and the ongoing issues with retention and recruitment. Notably, a number of the faculty members are senior level, and no succession plans are articulated. The DOM suffers from lack of integration and support from the Centers. To date, center budgets are not transparent to the DOM Chair. There is a plan for the Centers to allow transparency of Center budgets to the DOM. While the budget transparency may be helpful, the DOM still suffers from lack of resources to accomplish its goals. For example, while the DOM Chair is responsible for recruiting, retention and promoting, the indirect cost recovery is returned to the Centers, not to the DOM.

The committee heard from the Dean that improved alignment between the Centers and the DOM (via the sections) is anticipated. Similarly, the proposed fund to increase transparency of Centers fund to the DOM is viewed as a step in the right direction.

Threats abound for DOM administration and leadership. The aforementioned current lack of alignment between the Centers and the DOM Sections weakens sense of academic community. The DOM continues to sustain increases in duties and responsibilities without a committed increased support. Nowhere is this more evident than in the DOM relation to the Center, i.e. increased credentialing and promotion activity without any increase in support. The new location in Phoenix may provide some additional research opportunities, but may also provide competition for limited funds.

## E. Special Topics

**1. Tucson Veterans Administration Hospital -** As pointed out in the last 2 Self Study reviews, "Strained relations between the University and its affiliated Veterans Hospital (VA) have had a negative impact on morale of the faculty and the efficacy of our teaching program". This is a problem which is noted to traverse the other departments of the University of Arizona, and although the self review from 7 years ago was optimistic, the affiliation has further declined.

Several examples of the deteriorating relationship include the faculty feeling they were "second class citizens" without time for research and no rewards for teaching. The departure from the VA for the University of senior faculty such as John Galgiani (ID), Steve Klotz (ID), Mindy Fain (geriatrics), Ken Knox (pulmonary/critical care/sleep), and Sai Parthasarathy (pulmonary/critical care/sleep) without replacement has left several medicine sections short-handed. In addition, the retirement of Dick Sampliner (GI) and the departure of Ronnie Fass (GI) have left the VA with only one gastroenterologist. The premature deaths of Harinder Garewal (Hem-Onc) and Murray Katz (nephrology) have further depleted the VA of senior leadership. As the VA has moved to a hospitalist system, failure to hire the planned number of hospitalists has resulted in subspecialty faculty providing coverage of the hospitalist service in addition to their usual duties. The declining number of

faculty with heavy clinical commitments has led to a shell of a research service with funding last in comparison to other academically affiliated VA's of comparable size.

It seems unlikely that relations are likely to improve under the present VA leadership which has not changed for several years. This was further evidenced by the recent apparent hiring of a new chief of staff without or with minimal input from either the University or VA faculty. The candidate was felt to be academically unqualified having only one coauthor publication and no research experience and was not felt to be qualified as an academic leader or to provide mentorship to young faculty.

Despite these weaknesses, a few strengths were identified. Student ratings from the VA are relatively good in comparison to the University. According to the students the committee interviewed, this was because of the electronic healthcare record which allows them to enter notes. It was felt that the installation of the Epic electronic healthcare record at the University will likely strengthen the popularity of the University rotations. The residents were also reasonably well pleased because of the autonomy they receive due to faculty understaffing. Teaching, especially the daily "Goldman Rounds" was thought to be valuable. Concern was raised that an apparent decline in the number of quality faculty may be eroding teaching and will eventually lead to declines in most patient-centered outcomes.

A suggestion was made to assess the morale of the faculty at the VA be by email survey. If morale is as poor as the interviews would indicate, this data could be used to support change or potentially call for an academic review from the Veterans Integrated Service Network in Phoenix or VA Central Office in Washington. Another suggestion was that division meetings be held after regular VA hours in order to give the VA faculty the opportunity to attend.

Some on the committee voiced the opinion that the difficulty of interacting with the VA may exceed any monetary, teaching or research benefits. With the possible overexpansion of the medicine residency in relation to the numbers of teaching faculty at the University, some felt the VA residency could be eliminated. Selected VA faculty could then be hired at the University to correct the inadequate number of faculty doing patient care, teaching and clinical research. It was noted that there were few midlevel faculty at the VA. Older VA faculty would be able to retire from the VA but could potentially work at the University. Younger faculty with less than 10 years of VA service would not have sufficient time invested in the VA retirement system to make leaving overly financially onerous.

2. **Community Outreach** - At the current time, University of Arizona Medical Center is not necessarily viewed as an asset to the community by physicians outside its walls. The perception of many of the community-based providers is that the University feels it is "above them". This was clearly demonstrated by Dr. Boyer (current Department of Medicine Director) when he made a statement, and we paraphrase, "the community has not come to our aid when we need doctors to help enrich the learning experience of our students and residents". It is here that the University and especially the Department of Medicine has a unique opportunity to foster change in its public perception. Developing a community outreach approach would go far in putting the University back into a positive public light.

Reaching out to the community could bring back a large referral base to the University. At the current time, there are so many physicians that have recently left the University system that community physicians feel they can get the University experience without dealing with the University politics and answering service. Since the majority of primary care is being delivered by physicians outside the University, it stands to reason that by mending fences and fostering a strong relationship with the community, patients would start to flow back into the University system. This increase in patient referrals could help the Oncology division and Cancer Center fill trials and the Endocrine division to get people into the Diabetes program. These are to name just a few.

In order for the above to work, the University system needs to find a way to improve communication with the providers outside its walls. It is currently very difficult to get a direct message through to a University physician. Consult notes are not always sent out in a timely fashion and it is very difficult to get through to the doctor who dictated them. This is one of the most frustrating aspects of dealing with the Department of Medicine and its staff. This was even stated as a problem for departments within the University Hospital, where consult calls were not answered in a timely fashion.

A possible solution to getting the University and the community to "be on the same page" is to have the Department of Medicine work with key members of the medical community who are well known and respected. This collaboration would help foster this team approach and put the specialists at the university in the forefront of community physicians' minds. Large primary care groups could be targeted as a way to get the most "bang for the buck". There are many alumni of the University programs in town and it should not be hard to bring back that feeling of "team" that was had when they were house-staff and Fellows. This relationship also brings the opportunity for medical students and house staff to gain access to provider offices where initial diagnoses are made and treated. It could then be used as a funnel to get these patients into specialist offices at UMC when specialty care is needed. The community is a resource that the Department of Medicine needs to tap into. At the current time, this resource is being severely overlooked.

# Exhibit F

**McCarthy, Michael S.**

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**From:** McCarthy, Michael S.
**Sent:** Wednesday, September 11, 2013 5:01 PM
**To:** Mlawsky, Karen D.; Stubbs, Nicolette (Nikki)
**Subject:** RE: Editing of Surgeon Field In OTTR
**Attachments:** Liver Surgon Change Log.xls

From a review of the OTTR change log I have recreated what the original Liver Surgeon Entries were in OTTR – they are in the attached spreadsheet.

The columns Primary_Surg and Second_Surg are the current data. The column 'Original Entry' has what the data was originally.

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**From:** McCarthy, Michael S.
**Sent:** Wednesday, September 11, 2013 4:05 PM
**To:** Mlawsky, Karen D.; Stubbs, Nicolette (Nikki)
**Subject:** Editing of Surgeon Field In OTTR

Karen,

Here is the sequence of events.

1. Dr Gruessner requested counts of primary and secondary surgeon for Liver Transplants (Monday Sept 9 in the AM) over the phone
2. On verbally giving him the numbers he replied that the counts were incorrect and asked how they were generated. I replied that the Transplant Coordinator on Call when the transplant occurred entered them. He indicated that that was the source of the miscount and that they should have waited for the dictated operation note.
3. He then asked me to pull the op notes and correct the entry.
4. I printed the OR dictation notes for the most recent 20-30 Liver cases Monday afternoon from SCM.
5. On Tuesday Morning I received a call to meet with Dr. Gruessner and go over the Op dictations. He reviewed the reports and indicated who was the primary surgeon after looking at who performed what function in the transplant (I believe related to the sewing of the Anastomosis). He wrote who should be primary and secondary surgeons on the printed out Or dictated report. (Nikki Stubbs has these printouts)
6. I edited the records that didn't match his notation later on Tuesday morning/afternoon.

It must be noted that OTTR is not a primary document and that at no time did I modify any information in SCM.

It should also be noted that for these surgeries there are numerous surgeons in the OR with each one reporting sometimes a different 'Attending surgeon' for the same surgery. The idea of looking at who performed what functions in the OR did seem like the best way to resolve who was in fact the 'Primary Surgeon'. I also asked Dr. Gruessner if using who was billed as the primary surgeon would be a way to double check these entries (I assume billing is coded that way).

I am in the process of reviewing the change log in OTTR and will send a spreadsheet of what the original and current data are in the OTTR database.

Mike

**Michael McCarthy**
Manager Business Systems, Transplant Services
University Medical Center

# Exhibit G

**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 H

**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

# Exhibit I

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, MW
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 J

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.

# Exhibit K

THE UNIVERSITY OF ARIZONA
MEDICAL CENTER

October 24, 2013

[redacted]

Dear: [redacted]

This letter is to inform you that there has been a significant change in the surgical leadership of the Auto Islet Cell Transplant program at The University of Arizona Medical Center. Due to this change our program cannot remain active. We sincerely regret the impact this program closure will have on your medical treatment at our hospital.

Through this transition, Terry B. Concannon, RN, BSN will serve as your contact for questions and concerns. Mrs. Concannon can be reached over the next 90 days at 520 694-7562 and/or at Terry.concannon@uahealth.com .

Again, we sincerely regret the inconvenience this change poses to you and your family.

Marguerite Brown, RN, MSN
Interim Director, Transplant Services

Karen Mlawsky
CEO, UAHN

Alexander Chiu, MD
Acting Head, Department of Surgery

Transplant Services
1501 N. Campbell Avenue • Tucson, Arizona 85724-5144
Telephone - 520.694.7365 • Toll-Free - 800.297.1250 • Fax - 520.694.2580

# Exhibit L

**From:** Rainer Gruessner < rgruessner@surgery.arizona.edu >
**Sent:** Friday, September 20, 2013 10:30 AM
**To:** comrie@email.arizona.edu; Waldrum, Michael R. president@email.arizona.edu; Ann W. Hart (hartaw@email.arizona.edu); skipgarcia@email.arizona.edu; Steve Goldschmid; Kraig J. Marton
**Subject:** Notice of Placement of Leave

Dear Drs. Comrie and Waldrum:

This is to acknowledge receipt of your Notice of Placement of Leave With Pay.

You indicate that I have 15 days to contest being placed on this leave. While I intend to do so, let me here tell you that am stunned about these allegations and that I emphatically deny engaging in any impropriety about records or otherwise.

In order to respond to these grave allegations, I will need to receive detailed information. You indicate that you have "received information" that I have "altered or directed others to alter records related to transplant procedures". The problem with this is that it is too general and too vague to respond to.

Please identify specifically in which cases (1) I substituted my own name as primary surgeon for others who may have actually served as primary surgeon and (2) where I removed my 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.

If the matters involve patient charts, please allow me to have access to those charts.

You cite an ABOR policy that gives me the right to respond to the allegations. For this policy to have meaning, I am entitled to fair notice of the actual allegations, and access to information needed to respond. Your one sentence summary is insufficient since it is not the allegations. Instead, the "information" you received is the allegations.

In summary, please provide me with the specific allegations and access to the information needed to answer them.

Sincerely,

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 M

**From:** Comrie, Andrew C - (comrie) [mailto:comrie@email.arizona.edu]
**Sent:** Friday, September 20, 2013 5:19 PM
**To:** Rainer Gruessner
**Cc:** mwaldrum; Garcia, Joe GN - (skipgarcia); Steve Goldschmid
**Subject:** RE: Notice of Placement of Leave

Dear Dr. Gruessner:

As you note, the University has placed you on leave with pay based on "information" it received from UPH. It appears that you have requested further clarification about the records on which it based its conclusion that you failed to follow protocol in modifying records, resulting in their placing you on leave with them as well. In light of your request to UPH, I will extend the time for you to respond to the action by the University until you have had an opportunity to review the underlying records with UPH and gain a better understanding of its concerns. Once the University learns that you have had this opportunity, I will notify you when we will expect a response to the University's placing you on leave with pay.

I noticed on the email you sent to me and others that you also included your counsel. If you are represented by counsel in this matter, please ask that he communicate directly through our counsel, rather than communicating directly with me and other University administrators about this matter. He can continue to work with Vicki Gotkin in the Office of the General Counsel.

Thank you for your anticipated cooperation.

Sincerely,

Andrew Comrie

Andrew C. Comrie, Ph.D.
Senior Vice President for Academic Affairs & Provost
University of Arizona

---

**From:** Rainer Gruessner [mailto:rgruessner@surgery.arizona.edu]
**Sent:** Friday, September 20, 2013 10:30 AM
**To:** Comrie, Andrew C - (comrie); mwaldrum
**Cc:** UA President; Hart, Ann W - (hartaw); Garcia, Joe GN - (skipgarcia); Steven Goldschmid; kjm@jaburgwilk.com
**Subject:** Notice of Placement of Leave

Dear Drs. Comrie and Waldrum:

This is to acknowledge receipt of your Notice of Placement of Leave With Pay.

You indicate that I have 15 days to contest being placed on this leave. While I intend to do so, let me here tell you that am stunned about these allegations and that I emphatically deny engaging in any impropriety about records or otherwise.

In order to respond to these grave allegations, I will need to receive detailed information. You indicate that you have "received information" that I have "altered or directed others to alter records related to transplant procedures". The problem with this is that it is too general and too vague to respond to.

Please identify specifically in which cases (1) I substituted my own name as primary surgeon for others who may have actually served as primary surgeon and (2) where I removed my 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.

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You cite an ABOR policy that gives me the right to respond to the allegations. For this policy to have meaning, I am entitled to fair notice of the actual allegations, and access to information needed to respond. Your one sentence summary is insufficient since it is not the allegations. Instead, the "information" you received is the allegations.

In summary, please provide me with the specific allegations and access to the information needed to answer them.

Sincerely,

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 N

**From:** Kraig J. Marton
**Sent:** Thursday, September 26, 2013 11:34 AM
**To:** Amy J. Gittler (GittlerA@jacksonlewis.com)
**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** information to Dr. Gruessner
**Attachments:** Dr. Gruessner suspended.pdf

Dear Amy,

It was good talking to you and it was even better hearing that you expect to have information for us early next week. There are a number of reasons for this email.

First, I want to confirm that Dr. Gruessner need not respond within 15 days of September 19, since we do not yet have the information. As you know, per the suspension paperwork (copy attached) he is to respond within that time, but we are glad that time limit has been waived.

Second, I want to be clear about the documentation we expect to receive. Here is a list of what we request:

1. The Provost's 9/19/ Memo says he "received information from UAHN" – we expect to receive a copy of that same information;

2. The Provost also says that his information is that Dr. Gruessner "either altered or directed others to alter records related to transplant procedures." As to this allegation:

    a. If it is truly claimed that Dr. Gruessner "altered" record, we would like to see the allegedly altered records and whatever evidence you have that he altered them;

    b. Even if the claim is that Dr. Gruessner "directed others to alter records", we wish to see those records, even if they were not altered; and

    c. If you have evidence of how Dr. Gruessner "directed others" we request that evidence, too;

3. Since the records involve transplant patients, Dr. Gruessner needs access to each patient's medical chart. For now, we simply ask that you provide us with the operative report of each transplant, but Dr. Gruessner may need access to other portions of the charts after reviewing the operative reports.

4. The Provost's memo also refers to the "usual protocol established by UAHN for identifying potential anomalies." Please provide us with a copy of that protocol.

5. We also request any other documentation that reflects the conduct that has resulted in this suspension.

To the extent that we are requesting Protected Heathcare Information under HIPAA ("PHI"), Dr. Gruessner is fully entitled to access all information as a treating physician, and I am willing to agree to any reasonable protocol desired in order to maintain the privacy of all PHI, even to the extent of a Business Associates Agreement with Dr. Gruessner. Please do not delay production of PHI just because of my involvement – at a minimum provide all PHI directly to Dr. Gruessner.

Finally, let me confirm that this request is made pursuant to various ABOR polices and pursuant to Dr. Gruessner's due process rights. However, since Dr. Gruessner has been directed to communicate only though me, and I am only to communicate through you, please also consider this a Public Records request pursuant to A.R.S. § 39-121 et seq. If you do not accept this email as a formal Public Records request, please advise and let me know who the request should be addressed to; also please conform that Dr. Gruessner will not be in violation of the directive to him sent by email from Mr. Sahlman dated September 20, that "from this point on, all further communications between yourself and UPH should be conducted through our respective attorneys."

We look forward to hearing from you.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com

**From:** Kraig J. Marton
**Sent:** Tuesday, October 1, 2013 2:12 PM
**To:** Amy J. Gittler (GittlerA@jacksonlewis.com)
**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** RE: information to Dr. Gruessner

Amy,

I thought I would be hearing from you by now. When can we expect something from you or your clients?

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com



**From:** Kraig J. Marton
**Sent:** Thursday, September 26, 2013 11:34 AM
**To:** Amy J. Gittler (GittlerA@jacksonlewis.com)
**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** information to Dr. Gruessner

Dear Amy,

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First, I want to confirm that Dr. Gruessner need not respond within 15 days of September 19, since we do not yet have the information. As you know, per the suspension paperwork (copy attached) he is to respond within that time, but we are glad that time limit has been waived.

Second, I want to be clear about the documentation we expect to receive. Here is a list of what we request:

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    a. If it is truly claimed that Dr. Gruessner "altered" record, we would like to see the allegedly altered records and whatever evidence you have that he altered them;

    b. Even if the claim is that Dr. Gruessner "directed others to alter records", we wish to see those records, even if they were not altered; and

    c. If you have evidence of how Dr. Gruessner "directed others" we request that evidence, too;

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4. The Provost's memo also refers to the "usual protocol established by UAHN for identifying potential anomalies." Please provide us with a copy of that protocol.

5. We also request any other documentation that reflects the conduct that has resulted in this suspension.

To the extent that we are requesting Protected Heathcare Information under HIPAA ("PHI"), Dr. Gruessner is fully entitled to access all information as a treating physician, and I am willing to agree to any reasonable protocol desired in order to maintain the privacy of all PHI, even to the extent of a Business Associates Agreement with Dr. Gruessner. Please do not delay production of PHI just because of my involvement – at a minimum provide all PHI directly to Dr. Gruessner.

Finally, let me confirm that this request is made pursuant to various ABOR polices and pursuant to Dr. Gruessner's due process rights. However, since Dr. Gruessner has been directed to communicate only though me, and I am only to communicate through you, please also consider this a Public Records request pursuant to A.R.S. § 39-121 et seq. If you do not accept this email as a formal Public Records request, please advise and let me know who the request should be addressed to; also please conform that Dr. Gruessner will not be in violation of the directive to him sent by email from Mr. Sahlman dated September 20, that "from this point on, all further communications between yourself and UPH should be conducted through our respective attorneys."

We look forward to hearing from you.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com

**From:** Kraig J. Marton
**Sent:** Wednesday, October 2, 2013 8:51 AM
**To:** Vicki Gotkin (VickiG@email.arizona.edu)
**Cc:** Chenoweth, Karen M. (Phoenix); Gittler, Amy J. (Phoenix); RWG Gruessner (gru1rg@gmail.com)
**Subject:** RE: information to Dr. Gruessner

Ms. Gotkin:

Dr. Gruessner was placed on immediate administrative leave on September 19 for grave accusations but with vague reasons, and was told he had 15 days to respond. When he complained that he did not know enough to respond, the Provost answered him on September 20 and said, in part:

> "As you note, the University has placed you on leave with pay based on "information" it received from UPH. It appears that you have requested further clarification about the records on which it based its conclusion that you failed to follow protocol in modifying records, resulting in their placing you on leave with them as well. In light of your request to UPH, I will extend the time for you to respond to the action by the University until you have had an opportunity to review the underlying records with UPH and gain a better understanding of its concerns."

I then spoke to UPH's designated attorney, Amy Gittler and followed up with the below email interchange.

It has now been almost two weeks since Dr. Gruessner was placed on immediate administrative leave, and Dr. Gruessner still does not have any information or documentation. Based on the below email interchange, we have no idea when he will receive the information.

I am writing for a number of reasons:

First, I want to formally object to these delays. The suspension has been leaked to and widely publicized in the media, in the internet and discussed in hospital hallways. The implication of wrongdoing is significant. Dr. Gruessner has been removed from seeing patients, and his reputation is being seriously tarnished when he did absolutely nothing wrong. If there is anything you can do to get the process moving quickly, we ask you to do so.

Second, we made a records request, below. To the extent your client has any of the requested records, we ask that you provide them. In addition, I hereby extend my public records request to you. If the request should be made to others, please advise.

Third, we question whether ABOR policy or basic due process have been followed here, especially since no one even asked Dr. Gruessner for any information before he was placed on this immediate leave. We do not waive our right to pursue claims because of what has already happened.

Finally, I want to know if this suspension involves quality of care issues. If it is seen to be reportable to the National Practitioners Data Bank and to the Arizona Medical Board then Dr. Gruessner's due process rights have been seriously trampled on. Can you tell me whether this is seen as a reportable suspension?

This entire process of suspending Dr. Gruessner was unnecessary and, it would appear, malicious. Thank you for looking into this matter further and providing whatever assistance you can provide.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com

**From:** Gittler, Amy J. (Phoenix) [mailto:GittlerA@jacksonlewis.com]
**Sent:** Tuesday, October 01, 2013 5:26 PM
**To:** Kraig J. Marton
**Cc:** Chenowth, Karen M. (Phoenix)
**Subject:** RE: information to Dr. Gruessner

Kraig, thanks for your email. When we talked last week, it had been my hope to have something for you early this week. My client is still gathering the information, and I will be meeting with my client on Thursday. I hope to obtain the information at that time, to share with you. I will keep you informed.

I did want to clarify a few things. First, I represent UPH and The University of Arizona Health Network. I do not represent the University of Arizona, so your references to the Provost's letter, or any issues regarding Dr. Gruessner's faculty position, should be addressed to the University counsel, Vicki Gotkin, not to me. Finally, because UPH and the University of Arizona Health Network are not public entities, your request for public records does not apply to my clients.

Thanks.

Regards,

Amy J. Gittler
Attorney at Law
Jackson Lewis LLP
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.***



**From:** Kraig J. Marton [mailto:kjm@jaburgwilk.com]
**Sent:** Tuesday, October 01, 2013 2:12 PM
**To:** Gittler, Amy J. (Phoenix)
**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** RE: information to Dr. Gruessner

Amy,

I thought I would be hearing from you by now. When can we expect something from you or your clients?

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

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602 297 5017 (Direct Fax)
www.jaburgwilk.com



**From:** Kraig J. Marton
**Sent:** Thursday, September 26, 2013 11:34 AM
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**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** information to Dr. Gruessner

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3. Since the records involve transplant patients, Dr. Gruessner needs access to each patient's medical chart. For now, we simply ask that you provide us with the operative report of each transplant, but Dr. Gruessner may need access to other portions of the charts after reviewing the operative reports.

4. The Provost's memo also refers to the "usual protocol established by UAHN for identifying potential anomalies." Please provide us with a copy of that protocol.

5. We also request any other documentation that reflects the conduct that has resulted in this suspension.

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protocol desired in order to maintain the privacy of all PHI, even to the extent of a Business Associates Agreement with Dr. Gruessner. Please do not delay production of PHI just because of my involvement – at a minimum provide all PHI directly to Dr. Gruessner.

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We look forward to hearing from you.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com

# Exhibit O

Representing Management Exclusively in Workplace Law and Related Litigation

jackson lewis
Attorneys at Law

Jackson Lewis LLP
2398 East Camelback Road
Suite 1060
Phoenix, AZ 85016
Tel 602 714-7044
Fax 602 714-7045
www.jacksonlewis.com

| | | | |
|---|---|---|---|
| ALBANY, NY | GRAND RAPIDS, MI | NEW ORLEANS, LA | RALEIGH-DURHAM, NC |
| ALBUQUERQUE, NM | GREENVILLE, SC | NEW YORK, NY | RAPID CITY, SD |
| ATLANTA, GA | HARTFORD, CT | NAPA, CA | RICHMOND, VA |
| AUSTIN, TX | HOUSTON, TX | NORFOLK, VA | SACRAMENTO, CA |
| BALTIMORE, MD | INDIANAPOLIS, IN | OMAHA, NE | ST. LOUIS, MO |
| BIRMINGHAM, AL | JACKSONVILLE, FL | ORANGE COUNTY, CA | SAN DIEGO, CA |
| BOSTON, MA | LAS VEGAS, NV | ORLANDO, FL | SAN FRANCISCO, CA |
| CHICAGO, IL | LONG ISLAND, NY | PHILADELPHIA, PA | SAN JUAN, PUERTO RICO |
| CINCINNATI, OH | LOS ANGELES, CA | PHOENIX, AZ | SEATTLE, WA |
| CLEVELAND, OH | MEMPHIS, TN | PITTSBURGH, PA | STAMFORD, CT |
| DALLAS, TX | MIAMI, FL | PORTLAND, OR | TAMPA, FL |
| DAYTON, OH | MILWAUKEE, WI | PORTSMOUTH, NH | WASHINGTON DC REGION |
| DENVER, CO | MINNEAPOLIS, MN | PROVIDENCE, RI | WHITE PLAINS, NY |
| DETROIT, MI | MORRISTOWN, NJ | | |

MY DIRECT DIAL IS: 602-714-7057
MY EMAIL ADDRESS IS: GITTLERA@JACKSONLEWIS.COM

October 4, 2013

**VIA ELECTRONIC MAIL**

Kraig J. Marton
Jaburg & Wilk PC
3200 North Central, Ste. 2000
Phoenix, AZ 85012

Re: Rainer Gruessner, M.D.

Dear Kraig,

UPH will be providing to Dr. Gruessner the records he used to direct that a change be made as to the primary surgeon for specific transplant operations. These records will be hand delivered to Dr. Gruessner at his home today. Within 5 business days of receipt of the documents, 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. His explanation must address the following:

- All factual bases for Dr. Gruessner's direction that these changes be made;
- Why he chose to direct that the changes be made when he did;
- Any supporting authority, citation or other documents upon which he relied, or which he believes, support his actions.

After I receive the information, then we can set a time to meet. Thank you for your anticipated cooperation.

Very truly yours,

JACKSON LEWIS LLP

*/s/ Amy J. Gittler*

Amy J. Gittler

AJG/kmc

4837-6415-8998, v. 1

# Exhibit P

**From:** Kraig J. Marton
**Sent:** Friday, October 4, 2013 2:17 PM
**To:** Amy J. Gittler (GittlerA@jacksonlewis.com)
**Cc:** RWG Gruessner (gru1rg@gmail.com)
**Subject:** FW: Dr. Gruessner
**Attachments:** Ltr to Kraig Marton.pdf

Amy,

I just reviewed your letter (attached) and we have a problem. Dr. Gruessner told me he was going to be out of town for some medical event, I think involving the American College of Surgeons. I just tried to call him and there was no answer – he may already be on a plane. He also said he would not be back in town until next Thursday (I think that was the day). In the context of your letter, this state of affairs is concerning. Here is my reaction:

1. While I am glad you are having records delivered to him, please make sure Dr. Gruessner actually is there and that he actually receives them. If he has already left, it would be a bad idea to just leave them at his home for so long.

2. Your request for such a prompt answer is, obviously, not possible.

3. You state that Dr. Gruessner is receiving "the records he used to direct that a change be made as to the primary surgeon for specific transplant operations." While that is good, you make no mention about our request for other records. Please review my email to you dated September 26, 2013 at 11:34 AM where I provide a list. Specifically:

    a. I asked for all operative reports and you say there are "31 liver transplants involved". Will he receive the op. reports for those transplants?
    b. I asked that Dr. Gruessner be given access to the remainder of the medical records for the same involved patients. Will he be given that access?
    c. I asked for a copy of what the Provost described as the "usual protocol established by UAHN for identifying potential anomalies." Will you provide that protocol?
    d. I asked for "any other documentation that reflects the conduct that has resulted in this suspension." Is there any other such documentation?

I will not be able to tell you when Dr. Gruessner can answer the questions you pose until I speak to him, but in the meantime there are many unanswered questions that you should be addressing.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012

602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com



**From:** Gittler, Amy J. (Phoenix) [mailto:GittlerA@jacksonlewis.com]
**Sent:** Friday, October 04, 2013 1:54 PM
**To:** Kraig J. Marton
**Cc:** Chenowth, Karen M. (Phoenix)
**Subject:** Dr. Gruessner

Please see the attached.

Regards,

Amy J. Gittler
Attorney at Law
Jackson Lewis LLP
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 th

# Exhibit Q

**From:** Gittler, Amy J. (Phoenix) < GittlerA@jacksonlewis.com >
**Sent:** Wednesday, October 09, 2013 11:30 AM
**To:** Kraig J. Marton
**Cc:** Chenoweth, Karen M. (Phoenix)
**Subject:** Dr. Gruessner

Kraig, thanks for your email and your call on Friday. The documents were delivered to Dr. Gruessner's residence, and someone there signed for them. With respect to your other requests, below is my client's response:

a. I asked for all operative reports and you say there are "31 liver transplants involved". Will he receive the op. reports for those transplants?

   **Yes, this is among what was delivered to his house on 10/4.**

b. I asked that Dr. Gruessner be given access to the remainder of the medical records for the same involved patients. Will he be given that access?

   **No. To our knowledge, he didn't access the remainder of the medical records before ordering that the database be changed. If he didn't need the additional records to make the changes, he doesn't need them to explain why he made the changes.**

c. I asked for a copy of what the Provost described as the "usual protocol established by UAHN for identifying potential anomalies." Will you provide that protocol?

   **The Provost's letter was inartfully worded; there is no written protocol. UAHN has an unwritten protocol for determining who the primary surgeon is for a given surgery which has been used consistently, but not a specific protocol for "identifying potential anomalies."**

d. I asked for "any other documentation that reflects the conduct that has resulted in this suspension." Is there any other such documentation?

   **I believe my client has provided Dr. Gruessner with all the responsive documents.**

Regards,

Amy J. Gittler
Attorney at Law
Jackson Lewis LLP
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.***

# Exhibit R

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.

# Exhibit S

jackson lewis
Attorneys at Law

Jackson Lewis LLP
2398 East Camelback Road
Suite 1060
Phoenix, AZ 85016
Tel 602 714-7044
Fax 602 714-7045
www.jacksonlewis.com



MY DIRECT DIAL IS: 602-714-7057
MY EMAIL ADDRESS IS: GITTLERA@JACKSONLEWIS.COM

October 21, 2013

**VIA ELECTRONIC MAIL**

Kraig J. Marton
Jaburg & Wilk PC
3200 North Central, Ste. 2000
Phoenix, AZ 85012

Re: Rainer Gruessner, M.D.

Dear Kraig,

This letter responds to yours of October 10, 2013.

First, as to the alleged violation of HIPPA or HITECH by delivering the documents to Dr. Gruessner's house, the documents were in an envelope that was both sealed and taped shut. My client did not disclose any protected health information (PHI). If Dr. Gruessner's housekeeper opened the envelope (which you have not alleged and which I highly doubt, or if she did, likely was against all instructions he had given), then it was Dr. Gruessner who violated HIPPA, and that is his problem. Your suggestion that my client violated HIPPA is without merit.

Your letter stating that Dr. Gruessner merely saw some inaccuracies in the OTTR database and pointed out that they needed fixing belies the facts, and is inconsistent with what you told me in our conversation on September 26, 2013. Rather, on Monday, September 9, 2013, Dr. Gruessner called OTTR database administrator Mike McCarthy and asked for the number of liver transplants on which he had been the primary or secondary transplant surgeon. Mr. McCarthy told Dr. Gruessner the number. Dr. Gruessner responded that the number must be wrong and asked Mr. McCarthy to pull the Operative Reports for the liver transplants and correct the OTTR database. Mr. McCarthy responded that he would not make changes without understanding why the changes were going to be made. Dr. Gruessner then asked Mr. McCarthy to print out only his own Operative Reports on every liver transplant that has been

done at the University of Arizona Medical Center ("UAMC") since he arrived in July of 2007. Before September of 2011, UAMC used a different software program called TransTrack. Mr. McCarthy told Dr. Gruessner that he could get the op reports from 2007 to 2011 but it that would take some time. Dr. Gruessner responded by saying, essentially, "Get me what you can now" or words to that effect. Mr. McCarthy printed out Dr. Gruessner's liver transplant Operative Reports going back to about September of 2011, when UAMC first began using OTTR to keep track of its transplant statistics, and he provided those reports to Dr. Gruessner.

On Tuesday, September 10, just hours before he resigned as the UNOS Surgical Director for UAMC, Dr. Gruessner told Mr. McCarthy which transplant records to change and how to change them. Dr. Gruessner called Mr. McCarthy into Dr. Gruessner's office and showed him in the Operative Reports who did the hepatic artery anastomosis and told him that this is who should be the primary surgeon. Dr. Gruessner wrote on the Operative Reports the initials of the surgeons who should be primary and secondary, respectively, for each particular surgery on which he instructed Mr. McCarthy to change the database, and he gave those Operative Reports back to Mr. McCarthy. Mr. McCarthy then followed Dr. Gruessner's instructions to change the OTTR database.

Unbeknownst to Mr. McCarthy, who describes himself as "just a computer guy," the question of who performs the hepatic artery anastomosis has never been a determinant (or even relevant) factor in who UAMC says is the primary surgeon. Although there is no written protocol for how UAMC determines who the primary transplant surgeon is, the actual protocol for determining the primary surgeon has been the same at UAMC since at least 1994 and well-known in the UAMC transplant service. So, either Dr. Gruessner knew the protocol and ignored it when he instructed Mr. McCarthy to alter the OTTR database, or he didn't know the protocol after six years as both Department Chair and UNOS Surgical Director. Either way raises serious concerns. Moreover, if the primary surgeon was incorrect in 18 cases, all of these were coded and reported to UNOS while Dr. Gruessner was the UNOS Surgical Director. His suggestion after the fact that over a two year period, at least 18 surgeries were incorrectly reported to UNOS based upon incorrect information in the OTTR database, raises further concerns about Dr. Gruessner's oversight as the UNOS Surgical Director and as Chair of the Department of Surgery.

UAMC finds it significant that in twelve of the cases in which Dr. Gruessner ordered changes regarding the primary surgeon, he replaced Dr. Jie's name with his own. Dr. Gruessner obviously knew he would be resigning as the UAMC primary abdominal transplant UNOS surgeon on the same day that he ordered the database to be changed and inappropriately communicated that resignation directly to UNOS with no advanced notice to UAMC. He also knew that Dr. Jie would be UAMC's logical choice to replace him. Dr. Gruessner's conduct was an obvious attempt to harm the UAMC abdominal transplant program by taking numbers away from Dr. Jie that, under UAMC's protocol, rightfully did belong to Dr. Jie.

UAMC also finds it significant that one of the changes Dr. Gruessner ordered was to remove his own name from a case in which he actually was the primary surgeon under UAMC's protocol and the patient died on the table during Dr. Gruessner's portion of the surgery.

As noted above, Dr. Gruessner didn't want to go back just two years to make changes; he wanted to go back to July 2007, but he didn't have time to do that before he unexpectedly resigned his UNOS position on Tuesday, September 10. He didn't innocently bring alleged errors to the hospital's attention; he wanted to change six years' worth of records before his UNOS resignation but had only time to make sure changes were made to two years' worth, because he had already decided to send his resignation to UNOS on September 10th. He then waited a week to send his email to Karen Mlawsky about "inaccurate records." Dr. Gruessner's email to Ms. Mlawsky was a transparent attempt to create a false record.

Even if Dr. Gruessner was correct in suggesting changes to the database on certain cases, it was not his place to order McCarthy to change the database unilaterally. Dr. Gruessner made sure the changes were made and then resigned his UNOS position, communicating that resignation directly to UNOS. The proper protocol would have been to bring his concerns to Administration (and not to a database manager) without ordering any changes and also to have given the Administration advanced notice of his intent to resign his UNOS position. Administration then could have determined his replacement and communicated with UNOS. The manner in which he conducted himself put the entire abdominal transplant program at risk, as evidenced by the email from UNOS to Hospital CEO Karen Mlawsky shortly after UNOS received Dr. Gruessner's resignation.

Finally, as for the investigation, in my experience, an individual is often put on leave pending an investigation, and that is how UAHN handles its investigations, including this one.

Based on the facts as my client understands them, and as described above, we request a meeting with you and your client to attempt to negotiate a transition for Dr. Gruessner. Please let me know when you and your client are available to meet. I will meet in Phoenix or Tucson.

Very truly yours,

JACKSON LEWIS LLP

*/s/ Amy J. Gittler*

Amy J. Gittler

AJG/kmc

# Exhibit T

**From:** Gittler, Amy J. (Phoenix) < GittlerA@jacksonlewis.com >
**Sent:** Friday, October 25, 2013 3:14 PM
**To:** Kraig J. Marton
**Cc:** Jeffrey A. King (Jeffrey.King@uahealth.com); Gotkin, Vicki – (vickig) (vickig@email.arizona.edu); Chenoweth, Karen M. (Phoenix)
**Subject:** Dr. Gruessner's suspension/leave with pay

Kraig—answers below in red.

This is to acknowledge your client's position on reinstatement. I asked you to reinstate Dr. Gruessner before we would agree to negotiate about anything. You answered saying that UPH will not lift the suspension at this time, but is willing to negotiate lifting the suspension as one of the terms to be discussed. I told you I would be talking to Dr. Gruessner and will get back to you, but I do not believe that will be acceptable to him.

I then asked you questions which you said you would endeavor to answer, and you asked me to list them in an email:

1. Is Dr. Gruessner's suspension/leave based on any policy, rule, regulation, contract or bylaw of UPH? In other words, are his employment rights at UPH subject to any such matters? If so, could you send me a copy? I am aware of ABOR rules, but am looking for UPH material.

   **Dr. Gruessner's actions precipitated the leave in order to allow UPH to investigate information which had come to light as described in my letter to you of October 21, 2013. If we are unable to reach a resolution, UPH will determine if Dr. Gruessner has violated any policy or bylaw.**

2. Has Dr. Gruessner been reported to the National Practitioner's Data Bank and/or the Arizona Medical Board?

   **Not as of this time.**

3. Just what type of suspension is this? Does UPH claim it has anything to do with the quality of his medical care or his actions as a physician? Or does it solely involve administrative issues?

   **The suspension is not based on the quality of his care.**

Thank you for whatever answers you can provide.

Regards,

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

602.714.7057 | Direct
602.714.7045 | Fax

gittlera@jacksonlewis.com

www.jacksonlewis.com

# Exhibit U

**From:** Kraig J. Marton
**Sent:** Wednesday, October 30, 2013 1:59 PM
**To:** Amy J. Gittler (GittlerA@jacksonlewis.com)
**Cc:** Vicki Gotkin (vickig@email.arizona.edu); Johnson, Laura T – (ltj); Dr. Rainer W.G. Gruessner (gru1rg@gmail.com); Aaron K. Haar
**Subject:** Dr. Gruessner's suspension/leave with pay

Amy,

We asked UPH to reinstate Dr. Gruessner before he will negotiate about anything and your client refused. The University takes the position that they are following UPH's lead. After Dr. Gruessner and I explained the issues in a letter to you, you wrote back with a letter that is unsubstantiated, non responsive and without factual foundation.

The purpose of this email is to request, yet again, that Dr. Gruessner be immediately reinstated and to explain the consequences if he is not reinstated.

To be specific, Dr. Gruessner wants an unconditional reinstatement because the accusations were not only wrong and unfounded, but also malicious. At the core of all of this is that fact that the hospital has refused to take responsibility for its duty to submit correct records to UNOS.

Dr. Gruessner will not be blackmailed to come to the negotiating table and to talk, then, about reinstatement.

There is nothing more to negotiate at this time, at least until Dr. Gruessner has been fully reinstated to the positions he held before the unfortunate September 19 "leave". Your client must either reinstate him, or take action on the "leave".

Let me be specific. If Dr. Gruessner is not reinstated by close of business this Friday (November 1), we will file a lawsuit on Tuesday, November 5. The lawsuit will not seek damages, but will seek an injunction requiring him to be immediately reinstated. Your client and the University will have to decide for themselves about the implications of what will be a publicly available lawsuit.

If Dr. Gruessner is reinstated, we are thereafter willing to discuss how to proceed with future negotiations.

You have until close of business this Friday.

Kraig J. Marton
Jaburg & Wilk, P.C.
3200 North Central #2000
Phoenix, AZ 85012
602 248 1017 (DID)
602 297 5017 (Direct Fax)
www.jaburgwilk.com